PRINTED: 10/25/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177		B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	343177	1 2: *******		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	20/2021
INAME OF TH	TOVIDER OR GOLT EIER				05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER			PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
E 000	Initial Comments		E	000			
		certification survey was					
		ough 3/11/21. The facility					
		nce with the requirement ency Preparedness. Event					
	ID# CYOP11.	ency Freparedness. Event					
F 000	INITIAL COMMENTS	3	F	000			
	A recertification and	complaint investigation					
		conducted 3/8/21 to 3/11/21.					
	Event ID# CYOP11.						
		for Medicare and Medicaid					
		recertification and complaint conducted from 3/8/21 to					
		ed and continued from					
	9/14/21 through 9/20/	/21. Event ID# CYOP11.					
	The statement of defi						
		iciencies was amended and ons F686 and F842 was					
		I citations were found during					
		nvestigation at F580, F585,					
	F656, and F689.						
	11 of the 18 complain	nt allegations were					
	substantiated resultin						
		ficiencies was amended on					
	changed from 2 to 11	r of substantiated allegations					
F 550	Resident Rights/Exer		l F	550			4/8/21
SS=D	CFR(s): 483.10(a)(1)		'`	550			1,0121
	§483.10(a) Resident						
		ght to a dignified existence,					
		nd communication with and and services inside and					
		cluding those specified in					
L ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed 03/26/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345177	B. WING _			l	C 20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	HAB & LIVING CENTER		STREET ADDRESS, CI 205 RATTLESNAKE T PINEHURST, NC 2	TRAIL	, 00.	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
F 550	with respect and digresident in a manner promotes maintenanther quality of life, recindividuality. The fact promote the rights of \$483.10(a)(2) The fact access to quality car severity of condition, must establish and in practices regarding the provision of services residents regardless. §483.10(b) Exercise The resident has the rights as a resident or resident of the Unity of the Unity of the fact interference, coerciof from the facility. §483.10(b)(2) The fact reprisal from the facility.	ity must treat each resident nity and care for each and in an environment that ce or enhancement of his or cognizing each resident's illity must protect and if the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her of the facility and as a citizen	F	550			
	and resident intervie	view, observation and staff ws, the facility failed to illing to provide privacy cover		F550 Address how	corrective action will be		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245477	B WINC			С	
		345177	B. WING_			09/	20/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	NS AT PINFHURST RE	HAB & LIVING CENTER		20	05 RATTLESNAKE TRAIL		
THE OILE	INO ALL INCLIONO I NE	A LIVING SERVER		Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	residents with an ind (Resident # 10) and doors or to ask perm room for 3 of 3 resid (Residents # 1, #10). Findings included: 1a. Resident # 10 was 9/12/17 with multiple retention. The quart (MDS) assessment of Resident #10's cogn an indwelling urinary. Resident #10 was of 9:30 AM and at 1:30 urinary catheter and covered. The cathete and was visible to be interviewed, Resident feel much better with covered so her urine others. On 3/8/21 at 1:31 PM interviewed. She state Resident #10. NA # drainage bag and state that it was not cover would get a drainage it right away. She reand nurse responsib drainage bag always. On 3/8/21 at 1:32 PM	age bag for 1 of 2 sampled welling urinary catheter failed to knock on resident's assistion to enter on resident's ents observed for privacy & # 3). The as admitted to the facility on a diagnoses including urinary erly Minimum Data Set dated 12/21/20 indicated that ition was intact, and she has a catheter. The asserved in bed on 3/8/21 at PM. She has an indwelling the drainage bag was not er bag was facing the door er roommate. When the #10 stated that she would in the drainage bag being a would not be seen by M. Nurse Aide (NA) # 4 was asted that she was assigned to 4 observed the urinary ated that she didn't notice end. NA #4 replied that she was assigned to 4 observed that it was the NAs illity to make sure urinary is has a privacy cover. M. Nurse # 2 was interviewed.	F	550	accomplished for those residents found have been affected by the deficient practice; The licensed nurse replaced the privace bag for resident #10 on 3/10/21. Residents number 1, 10 and 3 were notified by the Director Of Nursing on 3/12/21 of the education that would be provided to staff. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice A 100% audit of all residents with a catheter was completed by the Director Nursing on 3/22/21 and there were no other residents identified to be affected not having a dignity bag at that time. A resident with an indwelling catheter has the potential to be affected by the deficipractice. The facility has ordered the catheter bags with the built-in privacy cover and disposed of the drainage bag without the covers. Resident #10 was identified as having been impacted by the deficient practice when staff failed to knock on her door a announce themselves prior to entering room. No other residents were identifie as being impacted yet all facility resided have the potential to be affected by the deficient practice. Resident #10 was informed that staff would be educated or resident rights including her right to privacy and the requirement to knock on her door and announce themselves prior to entering her room	y ner ; Of by ny sient gs and her d nts on	
		was assigned to Resident nat nurses and NAs were			Address what measures will be put into)	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		345177	B. WING		09/20/2021	
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 550	was covered. Nurs didn't notice that the covered when she is this morning. On 3/10/21 at 3:55 (DON) was interviee expected urinary drall times for dignity facility has a blue cexpected the staff to fithe bag was not. 1b. Resident # 10 v 9/12/17 with multiple retention. The quare (MDS) assessment Resident #10's cog. On 3/10/21 at 8:18 observed to enter Fith knocking on the docenter. On 3/10/21 at 8:20 interviewed. She sistaff to knock on here	e #2 further stated that she e urinary drainage bag was not administered her medications PM, the Director of Nursing wed. She stated that she ainage bag to be covered at purposes. She added that the olored drainage bag which she o use to ensure the contents visible to the public. was admitted to the facility on e diagnoses including urinary rterly Minimum Data Set dated 12/21/20 indicated that	F 550	place or systemic changes made to ensure that the deficient practice will recur; Central supply ordered bags built in privacy bags and the facility disposed of the old drainage bags of 3/12/21. Every new admission or readmission from the hospital that he catheter in place, will have the catheter bag exchanged to the current system built in privacy bags. The Assistant Director of Nursing provided educate the nursing staff regarding Resident Right to dignity. The systemic change for resident rights included re-educating staff about resident's rights and the exercise of rights. On 3/19/21 the Assistant Director provided an educational in-service on residents rights to dignand privacy. The right to dignity for on providing residents with catheter leaf drainage bag with a build in privacy focused on knocking on a resident soom. Any staff present or education will be educated prior to returning to work.	with n as a eter m with ion to s ghts those ector e nity used s a fig racy nts to If prior aff not	
	interviewed. She st the doors were clos knock when the doo On 3/11/21 at 3:55	AM, Housekeeper #1 was ated that she knocked when sed but she did not have to ors were open. PM, the Director of Nursing wed. She stated that she		Indicate how the facility plans to mo its performance to make sure that solutions are sustained; The Director of Nursing/ Assistant Director of Nurses will audit all new admissions with catheters and any resident with a new order for a catheter.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 9/20/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		9/20/2021	
				205 RATTLESNAKE TRAIL	-		
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		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) COMPLETION DATE	
F 550	Continued From pag	e 4	F 5	50			
	permission before er The DON added that open or closed, staff	knock on doors or to ask tering a resident's room. In no matter if the door was were expected to knock.		ensure that the appropriate dra has been applied five times pe four weeks then weekly for two The Environmental services di Social Worker, Human Resour	er week for o months. rector, rce Director,		
	was unsuccessful.	Housekeeping Director but		Medical records director and A Director will monitor the halls f weekly for four week and then two months to ensure that staf	ive times weekly for f are		
	8/9/19 with multiple of Congestive Heart Fa Fibrillation. The qual (MDS) assessment of	Idmitted to the facility on diagnoses including ilure (CHF) and Atrial rterly Minimum Data Set lated 2/18/21 indicated that derate cognitive impairment.		knocking and announcing ther prior to entering the room. The Worker will interview 5 alert ar residents weekly for 4 weeks a monthly for two months to vall employees are knocking and a themselves prior to entering ro	e Social and oriented and then 10 idate that announcing		
	observed to enter Reknocking on the door enter.	M, Housekeeper #1 was esident #1's room without or asking permission to		The _Director of Nursing and Administrator will review the aumonthly to identify patterns/tre adjust the plan as necessary to compliance.	udits nds and will		
	staff knocking so he entering his room. H	in, Resident #1 was ed that he would appreciate would know who was le added that he wished the nock, even the door was		The Administrator and Director will review the plan during the QAPI meeting and the audits wat the discretion of the QAPI co	monthly vill continue		
	interviewed. She stat	M, Housekeeper #1 was sed that she knocked when d but she did not have to s were open.		Indicate dates when corrective be completed; 4/8/21	e action will		
	(DON) was interview expected all staff to be permission before er The DON added that	M, the Director of Nursing ed. She stated that she knock on doors or to ask stering a resident's room. In no matter if the door was were expected to knock.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
					С	
		345177	B. WING		09/20/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REH	IAB & LIVING CENTER		205 RATTLESNAKE TRAIL		
THE ORLE	INO ALL INCLIONO I NEI	AD a LIVING SERVER		PINEHURST, NC 28374		
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F 550	Continued From page	5	F 55	50		
	Attempted to call the was unsuccessful.	Housekeeping Director but				
	11/20/20 with multiple schizophrenia. The q (MDS) assessment da	dmitted to the facility on diagnoses including uarterly Minimum Data Set ated 2/25/21 indicated that are cognitive impairment.				
	observed to enter Res	//, Housekeeper #1 was sident #3's room without or asking permission to				
	interviewed. She state	M, Housekeeper #1 was ed that she knocked when I but she did not have to s were open.				
	(DON) was interviewed expected all staff to ke permission before ent The DON added that	M, the Director of Nursing ed. She stated that she nock on doors or to ask ering a resident's room. no matter if the door was were expected to knock.				
F 561 SS=D	Attempted to call the was unsuccessful. Self-Determination CFR(s): 483.10(f)(1)-6	Housekeeping Director but	F 56	51	9/20/21	
	promote and facilitate through support of res	nination. right to and the facility must resident self-determination sident choice, including but s specified in paragraphs (f)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY IPLETED	
		345177	B. WING _		09	C 9/20/2021	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		03/20/2021	
(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 CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 561	activities, schedules waking times), healt care services consist assessments, and proposed applicable provision §483.10(f)(2) The reschoices about aspect facility that are significable states about aspect facility that are significable with members of the community activities facility. §483.10(f)(8) The rescommunity activities facility. §483.10(f)(8) The respondence in other at religious, and community facility. This REQUIREMENT by: Based on observation interviews and recomprovide showers accomprovide showers accompressed for activities findings included:	ris section. Issident has a right to choose (including sleeping and h care and providers of health stent with his or her interests, lan of care and other is of this part. Issident has a right to make cots of his or her life in the ficant to the resident. Issident has a right to interact is community and participate in its both inside and outside the insident has a right to interact in the ficant to the resident in the state of the inside and outside the insident has a right to interact in the inside and outside the insident has a right to interact in the insident in the facility failed to	F 5		ts found to ient 3/9/21.		
	Resident #43's quar (MDS) dated 1/18/2 cognitively intact, ex	ral Vascular Accident (CVA). terly Minimum Data Set 1 indicated Resident #43 was hibited rejection of care red total assistance with		that resident # 43 had a shower which was not her scheduled shas well. In review of resident showers on the following dates: 1,6,8,12,15,19,22,25,& 29 and i	on 3/6/21 nower days record it dent had January		

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		345177	B. WING			l	20/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
THE GRE	ENS AT PINEHURST REI	HAR & LIVING CENTER		2	05 RATTLESNAKE TRAIL		
THE OILE	ENO AT T INCHOROT REI	IAD & EIVING GENTER		Р	PINEHURST, NC 28374		
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F 561	Continued From page	e 7	F:	561			
	bathing.				on 2,5,9,12,16,19 and 23. Resident #4	3	
					refused a shower on 2/26/21. Resident		
		re planned for activities of lf-care performance deficit,			#43 will receive showers per preference on Tuesdays and Fridays day shift (е	
		such as refusal of care,			between 7a-3pm). The Director of Nurs	sing	
		a, and yelling out and care			spoke with the resident on 3/12/21 and	-	
		alse statements toward staff			discussed her preference for showers.	_	
		come into room during was revised on 2/8/21.			The resident stated she was okay with current schedule for showers.	her	
	Silit). The care plant	was revised on 2/6/21.			current schedule for showers.		
	Review of Resident #	43's Physician orders for					
	-	rch 2021 indicated she was			Address how the facility will identify oth	er	
		owers on Tuesday's and			residents having the potential to be		
	Friday's on first shift.				affected by the same deficient practice 100% audit was done by the Director of		
	Review of Resident #	43's Medication			Nursing on 3/12/21 for all alert and	•	
		ds (MAR) from 1/1/21 to			oriented residents currently in house		
		nurses documented she			regarding their shower preference and		
	on first shift.	s every Tuesday and Friday			their care plans and kardexes were updated to reflect their preferred		
	on mot ormi.				schedule.		
	_	g assistant's ADL charting					
		1 indicated she received a			Address and the second state of the second sta		
	snower on 2/9/21, 2/2 3/5/21.	23/21, 2/26/21, 3/1/21 and			Address what measures will be put into place or systemic changes made to)	
	0/0/21.				ensure that the deficient practice will n	ot	
	Review of a grievance				recur;		
		d she was not getting her			The nursing department staff were	_	
		nce read that Resident #43 ot of work but she wanted to			educated on 3/19/21 by The Director of Nursing regarding the shower preference		
		nce read that Resident #43			and completing a shower sheet for each		
	_	er and washed her hair on			resident who is offered a shower. This		
	2/27/21.				education will be added to the orientati		
	 	ad imtamiana an 0/0/04 -t			process for new nursing department hi		
		nd interview on 3/8/21 at #43 was in bed. Her hair			Any nursing department staff not present for the education will be educated prior		
		. She was absent of odors			returning to work.	ເບ	
	and there was no evid				The facility initiated shower sheets on		
	incontinence care. Re	esident #43 stated she was			3/5/21 prior to the survey process. The		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(С
		345177	B. WING			09/	20/2021
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHLIRST RE	EHAB & LIVING CENTER		2	05 RATTLESNAKE TRAIL		
THE GILL	INS AT FINEHORST RE	TIAD & LIVING CENTER		Р	INEHURST, NC 28374		
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F 561	showers according the preference. She start staff were really bus getting her showers in January 2021. In an observation are 8:20 AM, Resident # she got a shower any yesterday. She appeabeen washed. In an interview on 3/ stated she was not a by Resident #43. In an interview on 3/ Manager (UM)# 1 stany ADL refusals by In an interview on 3/ Assistant (NA) #1 started she was not a she was not a stated she	at she was not getting her to her schedule and ted she understood that the y but she had not been at scheduled since sometime and interview on 3/10/21 at 4/43 was in bed. She stated and had her hair washed eared clean and her hair had aware of any shower refusals	F	561	Certified Nursing Assistants (CNAs) are fill out the shower sheets every time a resident is offered a shower and then to that into the nurse to verify that the resident has had a shower or has refuse a shower. The nurse then turns these shower sheets into the Director of Nursing. These shower sheets will be utilized for all residents and monitored verified that showers are being given president preference. If the resident refuses a shower the nurse is to document that in the resident schart. new admission that are Alert and orient will have their shower preference discussed at admission and that preference will be added to their care pand Kardex. Any resident without preference will be assigned showers 2 times per week and well as daily bed baths. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of nursing/Administrative nurse will interview 5 alert and oriented resident weekly for 4 weeks and then monthly for two months to ensure that showers are given per their preference. The Director of Nursing will review the audits monthly to identify patterns/trend and will adjust the plan as necessary to maintain compliance.	to er All ted	
		/10/21 at 12:24 PM, NA #3 company used shower sheets			The Director of Nursing and Administra will review the plan during the monthly	tor	

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		345177	B. WING _				C 20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			20/2021
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F 561	using shower sheets. restarted using the slago. She stated sheer refusal by Resident # room on the skilled haveek. She stated it will fixed by maintenance shower room on the roof order due to the till renovations. In an interview on 3/1 Maintenance Director that the skilled hall shall show so he unclogged staff had been able to room since last week stated because of the rehabilitation hall, the hall and caused staff into the shower room rehabilitation hall showorking order next will have beginning of March beginning of March be expectation of Corpo shower sheets was a showers were given a slaways witness the slashower sheets and givalidated the shower.	A did not want the aides NA #3 stated the facility hower sheets about a week was not aware of any shower all was not working last ras not draining but it was a last week. She stated the rehabilitation hall was still out a floor and ongoing 10/21 at 12:30 PM, the restated he was made aware hower room was draining d drain last week. He stated to use the skilled hall shower The Maintenance Director a remodeling on the a tile was removed from the difficulty wheeling residents safely. He stated the wer room should be in the december of the service of the shower sheets at the the ecause it was the trate that the use of the	F	561	QAPI meeting and the audits will continuate the discretion of the QAPI committee. Indicate dates when corrective action where the completed: 4/8/21	.	
		provide Resident #43's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHA	AB & LIVING CENTER	1	STREET ADDRESS, CITY, STATE, 2 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	ZIP CODE	33,20,232.	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
She stated the staff we as scheduled and prefetended to refuse a show her shower on a non-state staff obliged her du The DON indicated the when she requested or ensure she was getting Notify of Changes (Inju CFR(s): 483.10(g)(14)(§483.10(g)(14) Notification (i) A facility must immerconsult with the resider consistent with his or here resentative(s) when (A) An accident involving results in injury and has physician intervention; (B) A significant change mental, or psychosocial deterioration in health, status in either life-threcolinical complications); (C) A need to alter treating a need to discontinue at treatment due to adversommence a new form (D) A decision to transforesident from the facility §483.15(c)(1)(ii). (ii) When making notification, the staff of the section, the section, the staff of the staff of the section, the section of the section the sec	and per her preference. For providing her showers For providing her showers For providing her showers For and then request on Scheduled day. She stated For a staff gave her showers For a so that the facility could For gave her showers For a so that the facility could For gave her showers For a so that the facility could For gave her showers For a so that the facility could For gave her showers For a so that the facility could For gave her showers For a so that the facility could For gave her showers For a staff gave her showers For a the facility could For a staff gave her showers For a the facility inform the resident; For a there is For a the resident which For a the resident which For a the potential for requiring For a the resident in the resident is, a mental, or psychosocial For a the facility inform of the facility for for or discharge the For a specified in For a specified in For a specified in \$483.15(c)(2) For a showers For a stated For a stated For a showers For a stated For a stated For a showers For a stated For a st		580		10/11/21	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _		09/20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 33/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 580	when there is- (A) A change in roo as specified in §483 (B) A change in res State law or regular (e)(10) of this sectic (iv) The facility mus update the address phone number of the representative(s). §483.10(g)(15) Admission to a come that is a composite §483.5) must disclos its physical configurations that comp part, and must spector om changes betwoe under §483.15(c)(9) This REQUIREMEN by: Based on record reand Physician Assis failed to notify the pressure ulcers res treatment orders for was for 1 of 4 resid ulcers (Resident #85 The findings include Resident #85 was a 11/25/20 with multip dementia, atrial fibr	m or roommate assignment 3.10(e)(6); or ident rights under Federal or cions as specified in paragraph on. It record and periodically (mailing and email) and he resident most in its admission agreement ration, including the various rise the composite distinct cify the policies that apply to meen its different locations of the policies that apply to meen its different locations of the policies that apply to meen its different locations of the policies that apply to meen its different locations of the policies that apply to meen its different locations of the policies that apply to meen its different locations of the policies that apply to meen its different locations of the policies that apply to meen its different locations. The policies that apply to meen its different locations of the policies that apply to meen its different locations. The policies that apply to meen its different locations. The policies that included in the policies that included illation, coronary artery experienced that included illation, coronary artery experienced the main policies and main policies. The policies that included illation, coronary artery experienced the main policies and main policies. The policies that included illation, coronary artery experienced the main policies and main policies.	F 5	F 580 At the time of survey the facility have a treatment nurse. The Dir Nursing was receiving the communication/reviewing the documentation for skin issues. (a new treatment nurse was in p The resident affected by the def practice #85 was sent to the ho 2/11/21 due to respiratory distre not return to the facility. Address how the facility will ider	Dn 3/16/21 Dlace. Ticient Spital on Ss and did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 20/2021	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021	
					5 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER			NEHURST, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From pag	ne 12	, F 5	580				
		num Data Set (MDS)			residents having the potential to be			
		2/1/20 indicated Resident			affected by the same deficient practice	; All		
		nitive impairment. He			current facility residents are at risk to b			
	_	ssistance from staff for bed			affected. A 100% audit of all current			
		, was incontinent of bowel			residents was completed on 2/25/21 by	,		
	and bladder, and wa	s at risk for pressure ulcers.			the Director Of Nursing and there were	no		
	The assessment furt	her revealed he had no			other resident noted to be affected.			
	pressure ulcers or ot	ther skin conditions, but a						
	pressure reducing de	evice was present to the bed.						
					Address what measures will be put into)		
		note dated 1/28/21 indicated			place or systemic changes made to			
		und to have open areas to			ensure that the deficient practice will no	ot		
		el with mild drainage and the			recur;			
	-	e wound nurse was notified,			The Director of Nursing/Assistant Director	tor		
		nsed, and a dry dressing was			of Nursing completed education on			
	•	eas. Resident #85's spouse			2/26/21 for the licensed nurses and	_		
		ounds. There was no			nursing assistants, regarding the woun			
		ian or physician's assistant			protocol. Nursing staff were not permitt to work until the education had been	ea		
	(PA) were made awa	ile.			received. When a resident is admitted			
	Posidont #85's phys	ician orders, Medication			readmitted or if a skin injury is identified			
		rd (MAR) and Treatment			the licensed will assess the resident s			
		rd (TAR) for January 2021			skin and notify the physician to obtain			
		here was no order or			treatment orders. The licensed nurse w	/ill		
		ed for the right or left heel			complete weekly skin assessments in			
	pressure ulcers.	S .			Point Click Care (PCC) electronic med	cal		
	•				record on current facility residents and			
	A physician's assista	ant (PA) progress note for			notify physician and residents or their			
	2/3/21 was reviewed	and indicated Resident #85			Responsible Party (RP) regarding any			
	was seen for new wo	ounds to his bilateral heel.			new skin issues and initiate treatment			
	-	t rest and minimal discomfort			orders. The licensed nurse will docume			
		assessment of the wounds.			the injury in the wound communication			
		unexpected weight change,			book as well as the medical record and			
		to the right or left leg and his			will complete a Braden risk assessmen	t.		
		dry. The left heel was			The nursing assistants will complete a	_		
		in length and 2 cm in width			shower sheet that will be used to identi	-		
	_	nd unstageable pressure			any areas to the resident s skin. Thes	е		
	_	was described as 4 cm in			sheets will be turned into the license	ĺ		
	⊟ength and 3 cm in w	idth with non-blanchable			nurse who will initiate the protocol and		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				20/2021
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021
					05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER			INEHURST, NC 28374		
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F 580	Continued From pag	e 13	F 5	580			
	when pressed) and we pressure injury. A nursing progress n	ess that does not turn white was classified as deep tissue ote dated 2/5/21 indicated und to have two small open			then place these sheets in the wound communication book for follow up by the wound nurse. He wound nurse will monitor the communication book daily during the work week and will complete follow up assessment of wounds that a	e a	
		. The first was centrally m and the second smaller ock. No drainage was			identified. The wound nurse will review treatment orders with the physician. The wound nurse will completed the wound	the ie	
	present, or pain expr areas were cleansed the wound care nurs	essed by Resident #85. Both , dry dressings applied, and e was notified. There was no ysician or PA were notified of			evaluation assessment in PCC weekly and update the wound log at that time. The wound nurse along with the Interdisciplinary Team (IDT) will review wounds weekly and will make suggestions/changes as needed to		
	Room on 2/11/21 dudid not return to the f	•			promote wound healing. The Registere Dietician will be updated weekly by the DON/wound nurse on the condition of current wounds and any new wounds		
	on 3/11/21 at 11:00 A Resident #85 on 1/28 1/28/21 the newly for	as conducted with Nurse #3 AM, who was assigned to B/21. She explained on und pressure areas to both his to the former wound care			identified. The wound nurse/MDS will update the resident⊡s care plan.		
	nurse as well as noti member.	fied Resident #85's family			Indicate how the facility plans to monitority its performance to make sure that solutions are sustained;	or	
	with Nurse #4 who w on 2/5/21. Nurse #4 open areas on Resid were 2 small, superfi alerting the former w pressure areas, as w spouse. Another into Nurse #4 on 9/14/21	M, an interview occurred as assigned to Resident #85 stated when he observed the ent #85's buttocks there cial openings. He recalled ound care nurse to the new rell as Resident #85's erview was completed with at 4:10 PM and recalled kin breakdown to Resident			The DON/ADON will review and compashower sheets, skin assessments and progress notes 5 times per week for 4 weeks and then 3 times per week for 2 months to validate that treatment orde are in place, the Physician and RP have been notified and the wound documentation is complete. The _Director of Nurses will review the audits monthly to identify patterns/trend	r e	
		ne notified the former wound s Resident #85's spouse. He			and will adjust the plan as necessary to maintain compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _		,	C 09/20/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 580	nurse would have be the physician or PA The Director of Nursely phone on 3/11/2 was aware Residenthis heels and buttoo time, the staff nurse nurse of the woundand she would have notifying the physicistated she expected open area to obtain the facility's wound physician. The Medical Director on 9/14/21 at 1:21 FResident #85 and sometified himself or the #85 developed skin was unaware the nowneds were first of 2/5/21. The Medicato be notified when first identified either care nurse. A phone interview wound care nurse of her employment at was able to recall Resident #85 and the recombination of the physician of the physician was unaware the nowneds were first of 2/5/21. The Medicator be notified when first identified either care nurse.	t time the former wound care een responsible for notifying . sing (DON) was interviewed 1 at 12:07 PM and stated she at #85 had pressure areas to cks. She further stated at the es informed the wound care is when they were identified, to been responsible for ian or PA. The DON further id the nurse who identified the a treatment order by following protocol or calling the end was familiar with tated the facility staff had the facility PA when Resident breakdown. Although, he obtification was not when the beserved on 1/28/21 and al Director stated he expected areas of skin concerns were by the staff nurse or wound was conducted with the former on 9/15/21 at 2:00 PM who left the facility in March 2021. She desident #85 and stated she	F 5	,	nthly QAPI ntinue at the ttee.			
	heel wounds and in dress the wounds u at them on 1/28/21. the facility PA on the	or nurse telling her about his structed the nurse how to ntil she could get there to look She went onto say notified e date of the initial wound and requested the facility PA						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 9/ 20/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		9/20/2021		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 580	former wound care in by the floor nurse with breakdown to his burecalled assessing to (2/8/21) and notified the new areas on the assessment. The form acknowledged the factor have been notified of first identified. On 9/15/21 at 2:38 If held with the facility Resident #85. She stated she was notifinurse on 2/2/21 regit to both heels and as day. She stated the herself or the Medic #85 developed skin was unaware the nowneds were first of 2/5/21. The facility expectation for either Director to be notified concerns were first in wound care nurse. Another phone inter Nurse #3 on 9/15/21 assigned to Resider explained when she to Resident #85's he this to the former work how to cleanse and the Director of Nurse notified Resident #85's notified Resident #85's he stated the Resident #85's he this to the former work to cleanse and the Director of Nurse notified Resident #85's he stated the Resident #85's he this to the former work to cleanse and the Director of Nurse notified Resident #85's he stated the Resident #85's he this to the former work to cleanse and the Director of Nurse notified Resident #85's he stated the Resident #85's he this to the former work to cleanse and the Director of Nurse notified Resident #85's he stated the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he this to the former work the Resident #85's he t	ds the following day. The nurse recalled being informed then Resident #85 developed attocks area on 2/5/21, those wounds a few days later the facility PA/physician of the same day as the remer wound care nurse facility PA or physician should on the day the wounds were the property of the same day as the received the mounds were the property of the same day as the reviewed her notes and field by the former wound care farding Resident #85's wounds seessed them the following facility staff had notified all Director when Resident breakdown, however, she of the seerved on 1/28/21 and	F 5.	30				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 09/20/2021
	ROVIDER OR SUPPLIER Ens at Pinehurst Re	EHAB & LIVING CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPROPRIES OF T	JLD BE COMPLETION
F 585 SS=D	interviewed on 9/16/ was their expectatio as the resident and/ notified the same da Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievance §483.10(j)(1) The re grievances to the fact that hears grievance reprisal and without reprisal. Such grieva respect to care and furnished as well as furnished, the behav residents, and other facility stay. §483.10(j)(2) The re facility must make p	nd current DON were 21 at 1:40 PM and stated it in for the physician/PA as well or responsible party to be by a skin issue was observed. -(4) es. sident has the right to voice cility or other agency or entity es without discrimination or fear of discrimination or ances include those with treatment which has been that which has not been vior of staff and of other concerns regarding their LTC sident has the right to and the rompt efforts by the facility to he resident may have, in	F 54	30	10/11/21
	on how to file a grieve to the resident. §483.10(j)(4) The far grievance policy to e of all grievances regulations contained in this par	cility must make information vance or complaint available cility must establish a ensure the prompt resolution arding the residents' rights agraph. Upon request, the			
	ı ·	copy of the grievance policy grievance policy must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _		0	C 9/20/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	<u> </u>	
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F 585	postings in promin facility of the right (meaning spoken) grievances anony of the grievance or can be filed, that is address (mailing anumber; a reasonation completing the revito obtain a written grievance; and the independent entition be filed, that is, the Quality Improvemed Agency and State program or protect (ii) Identifying a Gresponsible for own receiving and track conclusions; leading by the facility; mainformation associexample, the identifying and track conclusions; leading by the facility; mainformation associexample, the identifying and track coordinating with second in the independent of the identification of the ident	age 17 Int individually or through Itent locations throughout the Itent locations through to file Imously; the contact information Ifficial with whom a grievance Ise, his or her name, business Indie mail) and business phone Itent locations the right Itent location of Itent locations Itent location regarding his or her Itent location of Itent location regarding his or her Itent location location is location to location location to location in the location location in the location in lo	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 09/20/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	20/2021		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE		
F 585	include the date the summary statemen the steps taken to i summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropri accordance with St of the residents' rig or if an outside entit the State Survey AQ Organization, or loc confirms a violation rights within its area (vii) Maintaining eviresult of all grievand 3 years from the iss decision. This REQUIREMEND.	-	F	Address How Corrective active	on will be			
	and staff interviews written grievance refollow the facility powas for 1 of 1 resid (Resident #8). The A review of the undread as follows: - All grievances recommendations of family groups concoin the facility will be	, the facility failed to provide a esponse summary and failed to slicy regarding grievance. This ent reviewed for grievances		accomplished for those reside have been affected by the depractice; The facility retained a copy of grievance letter that had been the resident sresponsible particular to the facility to pick up a copy worker pulled the grievance particular to the original letter and could be the grievance particular to the facility to pick up a copy worker pulled the grievance particular to the original letter and could be the grievance particular to the facility to pick up a copy worker pulled the grievance particular to the original letter that had been accomplished to the facility to pick up a copy worker pulled the grievance particular that the province part	ents found to ficient If the nailed to arty (RP) on ber 9, 2021 er received I she come y. The Social packet and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C / 20/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	/LU/LUL1	
				20	05 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER	PINEHURST, NC 28374		INEHURST, NC 28374			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 585	1 3		F t	585				
	rationale for the resp	onse.			gave it to the RP. During our survey wh	nich		
	-	of a grievance and/or			began September 14, 2021 the survey			
	•	ance Officer will review and			showed the administrator a copy of the	:		
		ations and submit a written			letter that was sent to them by the			
	_	gs to the Administrator within			resident□s RP. The facility also showe	d		
		ceiving the grievance and/or			the survey team the grievance packet			
	complaint.				which included the original grievance			
		or person filing the grievance			investigation form, documentation	. 11		
	and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of				collected during the investigation as we			
		I the actions that will be taken			as the facility copy of the grievance lett On October 12, 2021 another letter	.ei.		
	to correct any identif				regarding this grievances was drafted	and		
	•	ninistrator, or his/her designee,			sent via certified mail to the residents			
		ts orally within 5 working			Address how the facility will identify oth			
		he grievance or complaint			residents having the potential to be			
	with the facility.	·			affected by the same deficient practice	;		
	b) A written	summary of the investigation			An audit was completed the administra			
	will also be provided	to the resident, and a copy			on September 22, 2021 of all grievance	es		
	will be filed in the bu	siness office.			from July to present and no other			
					residents were affected nor have there			
		mitted to the facility on			been other reports of residents or			
	_	ses that included a recent			responsible parties not receiving writte	n		
		emorrhage, end stage renal			notification about a grievance.			
	disease on hemodia				Address what measures will be put into			
		it. The admission Minimum			place or systemic changes to ensure the deficient practice will not recur;	IE		
		essment dated 6/25/21 8 had moderately impaired			The Social Worker and External			
	cognition.	o nad moderately impaired			Marketer/Social Worker have been			
	oogriidori.				educated on the grievance process by	the		
	Review of the facility	grievance logs indicated a			administrator on 9/22/2021 to include t			
	_	initiated on 8/16/21 by			all grievance letters must be on compa			
	•	ng missing dentures. The			letter head, specify the grievance and t	•		
	_	ated the grievance was			resolution and be completed within the			
		n investigation results, dated			required time frame. Additionally, they			
	8/17/21 and did not i	ndicate whether Resident #8			were educated that written notification	is		
	-	Party was updated verbally or			mandatory and must be checked off or	1		
	· ·	sponse of the grievance			the grievance report.			
	_	ance was signed by the			How will the facility monitor its			
	Administrator and da	ated 8/26/21.			performance to make sure that solution	าร		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	C 20/2021
	OVIDER OR SUPPLIER	IAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 SS=E	occurred with the Soc explained she had be the facility when she of report for Resident #8 with the RP for Resid- mailed a generic lette the grievance but failed the grievance form. I she failed to send a coast she was unaware. The Administrator wa 9/17/21 at 2:30 PM. Streport for Resident #8 form was incomplete notified both verbally Administrator stated if the Grievance Officer regulatory guidelines copy of the written grieto the RP. A phone interview occur Resident #8 on 9/20/2 she had not received form via mail or in per Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revi	AM, a phone interview sial Worker (SW) who en employed for 2 days at completed the grievance 3. She explained she spoke ent #8 on 8/17/21 and regarding the outcome of ed to indicate any of this on addition, the SW stated opy of the grievance report, it was needed. Is interviewed via phone, on She reviewed the grievance and acknowledged the as to whether the RP was and in writing. The t was her expectation that /SW adhered to the and should have provided a evance response summary curred with the RP for 21 at 9:00 AM and confirmed the written grievance report reson as requested.		585	are sustained; The administrator will review all grievances monthly and validate that a appropriate grievance letter has been written and that the grievance report reflects that written notification has beesent. Indicate dates when corrective action whose complete; September 22, 2021 The Administrator will review the audits monthly to identify patterns/trends and adjust the plan as necessary to maintaic compliance. The Interdisciplinary Team will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Completed action by 9/22/2021	en vill s will in he	4/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 20/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021
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THE GREE	ENS AT PINEHURST REI	1AB & LIVING CENTER			PINEHURST, NC 28374		
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F 641	Continued From page	e 21	F 6	341			
F 641	failed to code the Mir assessment accurate medications (Resider urinary catheter (Resident #76), skin smoking (Resident # reviewed. The findings included 1) Resident #21 was facility on 7/5/16 with history of a pulmonar and cerebrovascular A review of the Medic (MAR) for Resident # revealed he received mouth twice a day for The quarterly Minimulassessment dated 2/ #21 had moderately is was not coded for an On 3/10/21 at 10:20 with the MDS Nurses 2/19/21 MDS and Fe	nimum Data Set (MDS) ely in the areas of nts #1, #10, #21, #29, #235), ident #14), weight loss condition (Resident #78) and 1) for 8 of 20 residents I: originally admitted to the diagnoses that included a ry embolism (a blood clot) disease. cation Administration Record field from 2/13/21 to 2/19/21 Eliquis 5 milligrams (mg) by r an anticoagulant. Im Data Set (MDS) 19/21 indicated Resident Impaired cognition and he ticoagulant use. AM, an interview occurred #1. She reviewed the	F	641	Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; The residents identified as having inaccurately coded assessment had reviews and modifications made to their assessments by Minimum Data S (MDS) Nurse as follows: 1) The MDS nurse completed a modification of the 2/19/21 MDS assessment for Resident #21 on 3/10/2 to include coding of an anticoagulant. 2) The MDS nurse completed a modification of the 2/9/21 MDS assessment for Resident #76 on 3/10/2 to include coding of weight loss. 3) The MDS nurse completed a modification of the 2/11/21 MDS assessment for Resident #78 on 3/10/2 to remove inaccurate coding of skin condition. 4) a) The MDS nurse completed a modification of the 8/27/20 MDS assessment for Resident #1 on 3/18/2 to include coding that resident did use tobacco during the assessment period. b) The MDS nurse completed a modification of the 2/18/21 MDS assessment for Resident #1 on 3/10/21 to include coding of an anticoagulant.	Set 21, 21, 1,	
	Director of Nursing in	on 3/10/21 at 4:56 PM, the dicated it was her DS to be coded accurately.			5) The MDS nurse completed a modification of the 12/21/20 MDS assessment for Resident #10 on 3/10/21, to include coding of an anticoagulant.		
		originally admitted to the h diagnoses that included ase on hemodialysis,			6)a) The MDS nurse completed a modification of the 1/8/21 MDS assessment for Resident #29 on 3/10/2	21,	

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THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		F	PINEHURST, NC 28374		
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F 641	Continued From page	e 22	F	641			
	dysphagia (difficulty s schizophrenia.	swallowing), diabetes, and			to remove inaccurate coding of Gradua Dose Reduction (GDR) for an	al	
	Resident #76's weigh	it data revealed the following			antipsychotic medication. b) The MDS nurse completed a		
	weights during the MI	DS assessment look back			modification of the 2/16/21 MDS		
		0 to February 2021, which			assessment for Resident #29 on 3/10/2	21	
	showed a weight loss				to include coding of a GDR for an		
	8/12/20 154.4 pounds	s (lbs.)			antipsychotic medication.		
	9/9/20 155.5 lbs. 10/22/20 156.2 lbs.				7) The MDS nurse completed a modification of the 1/4/21 MDS		
	11/18/20 154.1 lbs.				assessment for Resident #14 on 3/10/2	21	
	12/15/20 155 lbs.				to remove inaccurate coding of a urinal		
	1/25/21 153.4 lbs.				catheter.	. 9	
	2/3/21 120.7 lbs.				8) The MDS nurse completed a		
	2/8/21 122.4 lbs.				modification of the 2/25/21 MDS		
					assessment for Resident #235 on		
	The quarterly MDS as	ssessment dated 2/9/21			3/10/21, to include coding of an		
		76 was cognitively intact.			anticoagulant.		
		or weight loss of 5% or more					
		loss of 10% or more in the			All residents have the potential to be		
	last 6 months.				affected by inaccurate coding of		
	O:- 0/40/04 -+ 0:50 D	NA i			assessments in the areas related to;		
	On 3/10/21 at 2:56 Pl				anticoagulants, weight loss, skin		
		IDS Nurse #1 who stated the coded the nutritional section			condition, smoking, antipsychotic use, GDR and urinary catheter.		
		ent. She reviewed the			The MDS nurses completed an audit of	n	
		it data and confirmed the			3/19/21 of the last completed MDS		
		en coded with a weight loss.			assessments for residents receiving		
	MB 6 chould have be	on obaba mar a woight loco.			anticoagulants, weight loss, skin		
	During an interview o	n 3/10/21 at 4:56 PM, the			condition, smoking, antipsychotic		
	Director of Nursing in				medication, GDR of antipsychotics, and	d	
		DS to be coded accurately.			indwelling catheter, to validate that		
					assessments were coded accurately.		
		curred with the Registered			There were three other residents noted		
		at 9:25 AM. She reviewed			be affected and those MDS were modif	fied	
		t dated 2/9/21 and Resident			on 3/19/21		
	_	d indicated it should have					
	been coded with a we	eight loss.			Address what measures will be put into place or systemic changes made to)	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING			l	C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				20	05 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST REF	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION : TAG CROSS-REFERENCED TO THE A DEFICIENCY)			(X5) COMPLETION DATE
F 641	Continued From page		F	641	ensure that the deficient practice will no	ot	
		originally admitted to the h diagnoses that included age renal disease on			recur; When an MDS assessment is complete prior to locking, the second MDS nurse will review and validate for accuracy of coding. The MDS assessment is then	;	
	lesions to the foot, a skin tear. There was	d (MAR) revealed no to Resident #78 for open surgical wound, burns or			sent to a MDS scrubber (Scrubber is a software tool utilized for improvement or resident assessment data accuracy) the will identify a potential inaccuracy with coding. The MDS will be corrected as necessary, locked and submitted. The Director of Reimbursement provided education to the MDS nurses on 3/10/2	of at ed	
		ursing progress note dated any skin condition concerns			regarding accuracy of coding according the RAI manual and validation of accur prior to locking and submitting the MDS assessment.	g to acy	
	dated 2/11/21 indicate cognitively intact. She	e was coded with open			Newly hired MDS nurses will be educa during new hire orientation.		
	lesions to the foot, a surgical wound, burns and skin tear. The area for skin and ulcer treatments had pressure reducing device for bed marked only.				Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) or the Administrator will audit 5 MDS	or	
		8 had a scab to the left her arms, a dialysis shunt			assessments weekly for 4 weeks, then MDS assessments monthly to validate accuracy of coding related to anticoagulants, weight loss, skin condition, smoking, antipsychotic use,	10	
		Nurse #1 who stated she ion section of the MDS			GDR and catheter. The DON and/or the Administrator will review the audits monthly to identify patterns/trends and will adjust the plan necessary to maintain compliance.	as	
	Director of Nursing in	n 3/10/21 at 4:56 PM, the dicated it was her DS to be coded accurately.			The DON and/or the Administrator will review the plan during the monthly QAI meeting and the audits will continue at		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021
				20	05 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER		PI	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 641	Continued From page	24	F 6	641	discretion of the QAPI committee. Indicate dates when corrective action vibe completed; 4/8/21	vill	
	8/9/19 with multiple d Congestive Heart Fail	ure (CHF) and Atrial ral Minimum Data Set (MDS) 27/20 indicated that			•		
		noking assessment and he was assessed as t supervision (unsupervised					
	The care plan that wa included a problem th smoker".						
	The nurse's note date that Resident # 1 wer occasionally.	ed 3/4/21 at 5 PM revealed at outside to smoke					
		viewed on 3/10/21 at 10:58 e had been smoking since					
	2:50 PM. She stated completed the annual longer employed at the verified that Resident the assessment perior assessment and the complete the complete the states.	that the MDS Nurse who MDS dated 8/27/20 was no le facility. MDS Nurse #1 #1 had used tobacco during dibased on the smoking care plan. She added that dis 8/27/20 should have been les, but it was not.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	03/20/2021	
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F 641	on 3/10/21 at 3:55 expected the MDS accurately. She ad MDS Nurses and be at the facility few markers are supported by the facility few markers are supported	PM. The DON stated that she assessments to be coded ded that the facility had 2 both nurses just started working conths ago. Was admitted to the facility on a diagnoses including failure (CHF) and Atrial carterly Minimum Data Set at dated 2/18/21 indicated that both received anticoagulant the assessment period. Modication Administration evealed that Resident #1 had ice a day during the code in the field that Resident #1 was on served Eliquis during the in February 2021. She stated bow that she had to code Eliquis	F 6	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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	VIDER OR SUPPLIER S AT PINEHURST RE	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	9/20/2021
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5 9 F M 1 m a F m c c c c c c c c c c c c c c c c c c	ol/12/17 with multiple Pulmonary Embolism Minimum Data Set (I 2/21/20 indicated the eceive an anticoagus assessment period. Resident #10 had a milligrams (mgs.) by of PE. The December 2020 Records (MARs) reveceived Eliquis during MDS Nurse #1 was acceived Eliquis and had receive assessment period in the Director of Nurse and 3/10/21 at 3:55 Pexpected the MDS accurately. She add MDS Nurses and boot the facility few most the facility few most accurate the most accurate that and disturbance. A physician 's order	s admitted to the facility on a diagnoses including in (PE). The quarterly MDS) assessment dated that Resident #10 did not allant medication during the doctor's order for Eliquis 5 mouth twice a day for history in Medication Administration are aled that Resident #10 had ang the assessment period. Interviewed on 3/10/21 at a red that Resident #10 was on sived Eliquis during the in December 2020. She oot know that she had to code allant medication. Interviewed on M. The DON stated that she issessments to be coded alled that the facility had 2 th nurses just started working anths ago. Is admitted to the facility on a diagnoses that included ementia without behavioral dated 4/5/20 indicated otic medication) 50 milligrams	F 64	11		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 9/20/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3/23/2021	
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F 641	Seroquel 50 mg (in active order. 1a. The quarterly assessment dated was rarely/never or administered rout 7 of 7 days. The indicated Residen Reduction (GDR) 1/15/21. This was Assessment Reference medications section was coded by MD. An interview was on 3/10/21 at 2:30 assessment dated #29 had a GDR or on 1/15/21 was resulted this GDR should in 1/8/21 MDS as it was a finite of the compact of	Resident #29 's order for initiated on 4/5/20) remained an Minimum Data Set (MDS) d 1/8/21 indicated Resident #29 understood. She was ine antipsychotic medication on medications section of the MDS at #29 had a Gradual Dose of antipsychotic medication on s 7 days after the 1/8/21 MDS rence Date (ARD). The on of this MDS for Resident #29	F	541			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 9/20/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	9/20/2021	
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F 641	An interview was coron 3/10/21 at 2:30 Pt assessment dated 2/Resident #29 had no medication was revie The physician 's ordindicated Resident #2 was reviewed with M this was an MDS errothat this 1/15/21 GDF on this 2/16/21 MDS #29. An interview was coron Nursing on 3/10/21 ashe expected the MD The annual Minimum assessment dated 1/'s cognition was severoded for an indwellic coded for occasional The catheter and incomposition was coded by Manual Manual Minimum assessment dated 1/'s cognition was severoded for an indwellic coded for occasional The catheter and incomposition was coded by Manual Manual Minimum assessment dated 1/'s cognition was severoded for an indwellic coded for occasional The catheter and incomposition was coded by Manual Manual Minimum assessment dated 1/'s cognition was severoded for an indwellic coded for an indwellic coded for occasional The catheter and incomposition was coded by Manual Manual Minimum assessment dated 1/'s cognition was severoded for an indwellic coded for a	dications section of this MDS a coded by MDS Nurse #1. Inducted with MDS Nurse #1 Inducted with MDS Nurse #1. Inducted with MDS Nurse #1. Inducted with MDS Nurse #1 Inducted With MDS Nurse #1 Inducted With WDS Nurse #1 Inducted With WDS Nurse #1 Inducted with the Director of the 4:56 PM. She stated that with WDS Nurse #1 Inducted with the Director of the WDS Nurse #1 Inducted With WDS	F	541			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	00/20/2021
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F 641	Assistant (NA) #6 o stated that she was She indicated that she was November 2020 and had no urinary cath An interview was co on 3/10/21 at 2:30 Hassessment dated #14 had a urinary c MDS Nurse #1. She She stated that she button as Resident An interview was co Nursing on 3/10/21	onducted with Nursing n 3/10/21 at 9:05 AM. She familiar with Resident #14. she worked at the facility since d since that time Resident #14	Fé	41		
	diagnosis of Atrial F Resident #235's ad included an order for milligrams in the model. A.Fib. Review of Resident Data Set (MDS) dat the use of Eliquis (a An interview was code PM with MDS Nurse #235's admission M	mission orders dated 2/24/21 or Eliquis (anticoagulant) 5 orning and at bedtime for #235's admission Minimum ted 2/25/21 was not coded for				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345177	B. WING			09/2	20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST REF	IAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP (205 RATTLESNAKE TRAIL PINEHURST, NC 28374	CODE		
(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 ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 641	PM with the Director of stated it was her expe	ducted on 3/10/21 at 5:00 of Nursing (DON). She ectation that Resident #235's ecurate and coded for the	F	541			
F 656 SS=G	use of an anticoagula Develop/Implement C		F	356			10/11/21
	implement a compreh care plan for each respectives and timefra medical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.24, §483.24, §483.25, provided due to the result of the following treatment under §483.30 (iii) Any specialized sprovided as a result of recommendations. If findings of the PASAF rationale in the reside	cility must develop and bensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ided in the comprehensive inprehensive care plan must grant 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 ling the right to refuse \$1.10(c)(6). Bervices or specialized is the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		1 03/20/2021	
(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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	desired outcomes. (B) The resident's pituture discharge. Fawhether the residen community was assilocal contact agencientities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on record refacility failed to develop plan for the risk of p	reference and potential for cilities must document t's desire to return to the essed and any referrals to es and/or other appropriate	F6	Address how corrective action wi accomplished for those residents have been affected by the deficie practice; Resident #85 was discharged to t	found to nt the	
	11/25/20 with multip dementia, atrial fibridisease and muscle The admission Minimassessment dated 1 #85 had severe cogextensive assistance and toileting, was in bladder, and was at assessment further ulcers or other skin. The pressure ulcer osummary dated 12/2	dmitted to the facility on le diagnoses that included llation, coronary artery weakness. mum Data Set (MDS) 2/1/20 indicated Resident nitive impairment, required e from staff for bed mobility continent of bowel and risk for pressure ulcers. The revealed he had no pressure		hospital on 2/11/2021 and did not the facility. Address how the facility will identified residents having the potential to be affected by the same deficient practurent facility residents are at rist affected. The MDS coordinator completed on October 8, 2021 to identify curesidents that are at risk for pressulcers based off of the Braden Scassessment, and validate that curesidents have a care plan for At pressure ulcers. All current reside identified as high risk, had an At care plan in place. Address what measures will be puplace or systemic changes made ensure that the deficient practice recur;	ify other be actice; sk to be an audit rrent sure cale urrent risk for ents t risk ut into to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING	_		l	20/2021
NAME OF PE	ROVIDER OR SUPPLIER		 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021
					05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F 6	56	The Degional Clinical Director provided		
		ed mobility, weakness, and all be care planned as such.			The Regional Clinical Director provided education on 9/21/2021, for the MDS nurse regarding implementation of At ri		
	The care plan for Res	sident #85 was reviewed and			for pressure ulcer care plan for residen		
		sure ulcers was initiated on			that are identified as a high risk, using t	the	
		on 2/8/21, that read in part,			Braden Scale assessment.		
	•	development to sacrum			Upon admission, readmission or		
		ilateral heels. Is at risk for development related to			significant change of condition, the licensed nurse will complete the Brader	n	
	impaired bed mobility				Assessment. If the resident is identified		
	•	was no original care plan			as an high risk for pressure ulcer, the		
	-	of pressure ulcers as			MDS nurse will initiate an At risk for		
		ulcer CAA summary dated			pressure ulcer care plan.		
	12/14/20.				Indicate how the facility plans to monito	or	
	An interview was com	pleted with MDS Nurse #2			its performance to make sure that solutions are sustained;		
		A and indicated it was an			The Director of Nursing (DON) and/or		
		op an initial care plan for the			Administrator will audit all new admission	on,	
		s as Resident #85 was			readmission and significant change	,	
	incontinent and had d	lecreased mobility.			resident care plans weekly for 4 weeks		
					then monthly for 2 months, to validate t		
		M, an interview occurred			if the resident was identified as a high r		
	Nursing. They both s	and current Director of			for pressure ulcers, that a care plan for risk for pressure ulcer was initiated.	Αt	
	expectation for the ca				The DON or Administrator will review the	ne	
		eatient centered. They both			audits monthly to identify patterns/trend		
		summary a risk for pressure			and will adjust the plan as necessary to		
	ulcer care plan should	d have been developed as			maintain compliance.		
		akness, incontinence, and			The DON or Administrator will review the	ne	
	decreased mobility.				plan during the monthly QAPI meeting		
					and the audits will continue at the		
					discretion of the QAPI committee. Indicate dates when corrective action w	,iII	
					be completed;	viil	
					Completed action by 10/07/2021		
F 658 SS=E	Services Provided Me CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 6	58			4/8/21

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 09/20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
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F 658	Continued From page §483.21(b)(3) Compre		F 65	58	
	The services provided as outlined by the cormust- (i) Meet professional: This REQUIREMENT by: Based on record reviperation of the services of	d or arranged by the facility, imprehensive care plan, standards of quality. It is not met as evidenced sew, staff interview, and at interview, the facility failed be physician 's orders e order for PRN (as needed) edication). This was for 1 of #41) reviewed for ions.		Address how corrective action will be accomplished for those residents four have been affected by the deficient practice; The licensed nurse discontinued the duplicate order for resident #41 on 3/10/21. An audit of the medical recorshowed no evidence that the medicat had been given twice at any time. Address how the facility will identify or residents having the potential to be affected by the same deficient practic A 100 % audit of all current residents completed on 3/17/21 by the DON and there were no other resident affected. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will recur; Licensed nurses were educated on 3/19/21 on the importance of discontinuing the previous order prior	rd ion ther e; was d . to
		m Data Set (MDS) 14/21 indicated Resident moderately impaired. She		placing another order into the system nurses not present will be educated p to returning to work. This education w	. All rior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING _				C 20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RATTLESNAKE TRAIL INEHURST, NC 28374	1 03/	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	received PRN (as neroutine pain medicatifrequently at a rating #41 was administere days. A review of pharmacy 6/12/20 through 3/8/2 the Pharmacy Consurecommendations on to the duplicate Ultra recommendations in Administration Recororders for Ultram 50 instructions. The Ph. "Because this is a duone of these orders for Resident #41's activifocus area of pain. The part, evaluating the expression of the second of the seco	eded) pain medications, no ons, and reported pain of 02 out of 10. Resident d opioid medication on 2 of 7 y recommendations from 21 for Resident #41 revealed litant made 12/2/20 and 3/3/21 related m 50 mg PRN orders. Both dicated the Medication d (MAR) showed 2 active mg with the same armacy Consultant wrote, plication, please discontinue rom her MAR".	F	658	added to the orientation process for all newly hired nurses. Indicate how the facility plans to monitority performance to make sure that solutions are sustained; The Director of Nurses/ ADONS will review all orders during the daily clinical meeting to validate no duplicate orders are present. This review and audit will done five times per week for four week and then twice weekly for three months. The Director of Nurses will review the audits monthly to identify patterns/trend and will adjust the plan as necessary to maintain compliance. The Director of Nursing and Administrativill review the plan during the monthly QAPI meeting and the audits will continuat the discretion of the QAPI committee.	al be s s. ds o tor	
	ability, and impact or A review of Resident orders was conducte active orders for Ultra same instructions for was initiated on 9/25 initiated on 6/12/20. A review of the MAR: 6/12/20 through 3/8/2 both PRN Ultram 50 administered during the second or the	Its, impact on functional a cognition. #41 's active physician 's d on 3/8/21 and revealed 2 am 50 mg PRN with the administration. One order /19 and the other order was so for Resident #41 from 21 showed no instances of mg orders being			Indicate dates when corrective action v be completed; 4/8/21	vill	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3372372321
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F 658	regularly assigned to second active orders for PF reviewed with Nurse not noticed this before going to speak with (PA) and would have discontinued. Nurse of the same orders Resident #41 could 50 mg twice during. A phone interview we pharmacy Consultar Resident #41 's active active or was reviewed with the Pharmacy Conrecommendations to PRN Ultram 50 mg recommendations to PRN Ultram 50 mg recommendations for the pharmacy Consultar shadministered both Form the pharmacy Conrecommendations for the pharmacy Conrecommendations for the pharmacy Consultar shadministered both Form the pharmacy Consultar sha	M. She reported that she was o Resident #41. Resident #41 's orders that revealed 2 RN Ultram 50 mg was e #6. She revealed she had ore. She indicated she was the Physician 's Assistant e one of the orders e #6 acknowledged that with 2 in place, there was a risk that be administered PRN Ultram the same time period. Was conducted with the nt on 3/10/21 at 3:25 PM. Eive physician 's orders that ders for PRN Ultram 50 mg he Pharmacy Consultant. Sultant stated that she made 2 to discontinue one of these orders, but her had not been responded to. aving a duplicate order in for Resident #41 being PRN Ultram 50 mg orders	F	558		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00/20/202
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	place created a risk f administered both PF same time period. S orders for PRN Ultra would be discontinued Treatment/Svcs to PF CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility r	aving a duplicate order in for Resident #41 being RN Ultram orders during the he stated that one of the m 50 mg for Resident #41 ed. revent/Heal Pressure Ulcer (i)(ii) grity ure ulcers. ehensive assessment of a	F 65		10/11/21
	professional standard pressure ulcers and ulcers unless the indidemonstrates that the (ii) A resident with professional starpromote healing, prenew ulcers from deverthis REQUIREMENT by: Based on record reviphysician interviews, treatment order when identified for 1 of 4 repressure ulcers (Resident #85 was ac 11/25/20 with multiple	ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to vent infection and prevent eloping. T is not met as evidenced view, staff and wound the facility failed to obtain a pressure ulcers were first esidents reviewed for ident #85). It: Imitted to the facility on e diagnoses that included ation, coronary artery weakness. He was		F 686 At the time of survey the facility did have a treatment nurse. The Directon Nursing was receiving the communication/reviewing the documentation for skin issues. On 3 a new treatment nurse was in place The resident affected by the deficien practice #85 was sent to the hospit 2/11/21 due to respiratory distress a not return to the facility.	or of 8/16/21 e. nt al on

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EICATION NI IMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER			5 RATTLESNAKE TRAIL		
				PII	NEHURST, NC 28374		
(X4) ID PREFIX TAG			ID PREFI) TAG				(X5) COMPLETION DATE
F 686	Continued From pag	ne 37	F 6	886			
	The November 2020	physician orders included to					
	perform a weekly ski on day shift.	in assessment every Monday			Address how the facility will identify oth residents having the potential to be affected by the same deficient practice	; All	
		Nursing Assessment on			current facility residents are at risk to b	е	
		esident #85 had intact skin			affected. A 100% audit of all current		
but numerous bruises to his upper extremities. Review of the facility's weekly skin assessment		es to his upper extremities.			residents was completed on 2/25/21 by the Director Of Nursing and there were		
		's weekly skin assessment			other resident noted to be affected.	110	
		indicated there were no skin					
	issues noted at the time of admission.						
					Address what measures will be put into	,	
	The weekly skin ass	essment form for 11/30/20			place or systemic changes made to		
	revealed there were	no skin issues noted.			ensure that the deficient practice will no	ot	
					recur;		
		num Data Set (MDS)			The Director of Nursing/Assistant Director	tor	
		2/1/20 indicated Resident			of Nursing completed education on		
	_	nitive impairment. He			2/26/21 for the licensed nurses and		
		ssistance from staff for bed			nursing assistants, regarding the woun		
		, was incontinent of bowel			protocol. Nursing staff were not permitt	.ed	
		s at risk for pressure ulcers.			to work until the education had been		
		her revealed he had no			received. When a resident is admitted	<i>'</i>	
	· ·	ther skin conditions, but a			readmitted or if a skin injury is identified		
	pressure reducing de	evice was present to the bed.			the licensed will assess the resident □s		
		. (0.4.4)			skin and notify the physician to obtain		
	-	care area assessment (CAA)			treatment orders. The licensed nurse w	/III	
		4/20 revealed Resident #85			complete weekly skin assessments in		
	_ ·	ure ulcer development			Point Click Care (PCC) electronic med	cal	
		ed mobility, weakness, and			record on current facility residents and		
	incontinence and wo	ould be care planned as such.			notify physician and residents or their	ſ	
	Daview of the Die	and There are a distant according			Responsible Party (RP) regarding any	ĺ	
	Review of the Physical Therapy discharge				new skin issues and initiate treatment	4	
	•	4/20 indicated Resident #85			orders. The licensed nurse will docume		
		boots to reduce the risk of			the injury in the wound communication		
	•	to his decreased mobility			book as well as the medical record and		
	status.				will complete a Braden risk assessmen	ı.	
	The manufacture of the				The nursing assistants will complete a	·c.	
	The weekly skin ass	essment report on 12/28/20			shower sheet that will be used to identi	ıy	

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NAME OF P	ROVIDER OR SUPPLIER		-		REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021	
TO UNE OF TH	TO VIDER OR GOLL ELER				5 RATTLESNAKE TRAIL			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC 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 686	Continued From page	e 38	F 6	886				
	indicated there were	no skin abnormalities found.			any areas to the resident⊡s skin. Thes sheets will be turned into the license	е		
		skin assessment form for were no skin abnormalities			nurse who will initiate the protocol and then place these sheets in the wound communication book for follow up by the wound nurse. He wound nurse will	ne		
	The weekly skin assessment form dated 1/25/21 revealed no new skin conditions were found. A nursing progress note dated 1/28/21 indicated Resident #85 was found to have open areas to the right and left heel with clear drainage and the				monitor the communication book daily during the work week and will complete follow up assessment of wounds that a			
					identified. The wound nurse will review treatment orders with the physician. The	the ie		
	size of a quarter. The	wound nurse was notified,			wound nurse will completed the wound evaluation assessment in PCC weekly			
		sed, and a dry dressing was as. Resident #85's spouse			and update the wound log at that time. The wound nurse along with the			
	was notified of the wo	ounds.			Interdisciplinary Team (IDT) will review wounds weekly and will make			
		sident #85 was reviewed and			suggestions/changes as needed to	.1		
		sure ulcers was initiated on on 2/8/21, that read in part,			promote wound healing. The Registere Dietician will be updated weekly by the			
	-	r development to sacrum			DON/wound nurse on the condition of			
		oilateral heels. Is at risk for			current wounds and any new wounds identified. The wound nurse/MDS will			
	further pressure ulcer development related to impaired bed mobility, weakness and incontinence". The interventions included: - Administer treatments as ordered and monitor				update the resident⊡s care plan.			
	for effectiveness Assess/record/mon	itor wound healing weekly			Indicate how the facility plans to monitor	or		
	and as needed Monitor nutritional s	tatus. Serve diet as ordered,			its performance to make sure that solutions are sustained;			
	monitor intake and record. - Alternating pressure mattress to bed due to noncompliance with turning and repositioning was initiated on 2/8/21. Resident #85's physician orders, Medication Administration Record (MAR) and Treatment				The DON/ADON will review and compa shower sheets, skin assessments and	are		
					progress notes 5 times per week for 4 weeks and then 3 times per week for 2 months to validate that treatment orde			
					are in place, the Physician and RP hav been notified and the wound			
	Administration Recor were reviewed and the	d (TAR) for January 2021 nere was no order or			documentation is complete. The _Director of Nurses will review the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		343177	D. WING _			09	/20/2021		
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER		20	05 RATTLESNAKE TRAIL				
				PI	INEHURST, NC 28374				
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F 686	Continued From page	÷ 39	F 6	886					
	treatment documente pressure ulcers.	d for the right or left heel			audits monthly to identify patterns/trend and will adjust the plan as necessary to maintain compliance.				
	2/1/21 indicated no ne	y skin assessment dated ew skin conditions were 85 had previously identified			The Director of Nurse/ Administrator w review the plan during the monthly QA meeting and the audits will continue at discretion of the QAPI committee.	PI			
	- Right heel unstagea in the facility on 1/28/ (cm) in length, 3 cm in (non-viable tissue due and could look like dr and stringy. Colors ra or black), scant seros (drainage that is pale - Left heel unstageab the facility 1/28/21, m cm in width, 50% slouthe wound bed), 50% red, bumpy tissue in the scant serosanguinous. The form indicated the notified, and a treatm with silver (a dressing infection, absorbs drain.	1 indicated the following: ble pressure ulcer acquired 21, measured 4 centimeters n width, 90% necrotic tissue to reduced blood supply y leathery tissue or moist nge from yellow, tan, brown			Indicate dates when corrective action vibe completed; 4/8/21	vill			
	left heel with wound of calcium alginate with cover with a thick dre dressing wrap every of	orders: 21 to cleanse the right and 21 to cleanse the right and 31 cleanser, pat dry, apply 32 silver to the wound bed, 33 ssing and secure with a 34 day and as needed. 32 for a wound consult for							

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F 686	Continued From pa	ge 40	F 6	886			
	2/3/21 was reviewed was seen for new was seen for new was no pain was present with the There had been no there was no edem skin was warm and described as 2.4 cr with 100% slough a ulcer. The right heel length and 3 cm in erythema (skin redrivhema (skin redrivhema pressed) and pressure injury.	cant (PA) progress note for d and indicated Resident #85 younds to his bilateral heel. at rest and minimal discomfort e assessment of the wounds. unexpected weight change, a to the right or left leg and his dry. The left heel was in in length and 2 cm in width and unstageable pressure was described as 4 cm in width with non-blanchable ness that does not turn white was classified as deep tissue					
	Resident #85 was f areas to his buttock located on the sacr one was on the but present, or pain exp	note dated 2/5/21 indicated ound to have two small open as. The first was centrally um and the second smaller tock. No drainage was pressed by Resident #85. Both ad, dry dressings applied, and use was notified.					
	flowsheet dated 2/8 - Sacral pressure u 2/5/21, measured 4 and 0.1 cm in depth moderate serosang - Right buttock pres on 2/5/21, measure length and 0.1 cm i moderate serosang The form indicated notified, and a treat	lity's wound evaluation 3/21 indicated the following: Idea acquired in facility on 5 cm in width, 1 cm in length 6, 100% granulation, and 7 suinous drainage. 7 sure ulcer acquired in facility 7 sd 2 cm in width, 1 cm in 7 n depth, 100% granulation, 7 uninous drainage, and no odor. 7 the doctor and family were 7 ment order of a dry protective 7 ned for the buttock wounds. In					

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F 686	described the left ar follows: - Right heel pressure length and 2.5 cm in specified as unstage area, and serosange care order was unchaltered Left heel pressure length and 2 cm in vas unstageable with tissue that adheres spongy or leather-like	evaluation flowsheet and right heel wounds as the ulcer measured 4 cm in a width. The area was eable with 100% slough to the uinous drainage. The wound hanged. The wound hanged and the area was described 100% eschar (dry, dead to the wound bed and has a see appearance) and inage present. The wound	F	586			
	former wound care it was applied to the s wound could be furt care physician. The 2/9/21 VOHRA management group; were reviewed and it seen as an initial womultiple wounds. The Resident #85 was 5 (lbs.). There was no pulses were present area. Protective bod and a pressure redubed. He was noted decreased mobility, intake. The wounds - The left heel wounds	y wound care progress notes indicated Resident #85 was bund evaluation due to be progress note stated 8 and weighed 220.1 pounds to be dema present and pedal at to both his left and right tibial at were present to both feet locing mattress was on the to have heart disease, dementia, and a fair oral were described as follows: d had been present for					
	approximately 12 da	ays and was unstageable due osis, measured 4.1 cm in					

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F 686	serosanguinous draii - The right heel was duration, measured 4 width. Sharp's debri (performed by a skilli instruments such as forceps. This type of wound healing by rei - Sacrum wound was stage 3 with greater measured 5.7 cm in 0.1cm in depth. Shar performed The right buttock w Stage 3 with greater Measurements were width and 0.1 cm in of drainage. A review of the physi indicated there was re documented to the s 2/10/21. After 2/10/2 present on the physic - An order dated 2/10 and left buttock wound dry, apply Hydrogel (debridement and car healing) to the wound dressing every day a - An order dated 2/10 right heel with normal Santyl ointment (rem wounds so they can a dry dressing every Resident #85 was tra Room on 2/11/21 due	approximately 12 days in 4.5cm in length and 2.9 cm in dement was performed ed practitioner using surgical a scalpel, scissors, and debridement promotes moving dead tissue). It length, 1.3 cm in width and rp's debridement was ound was classified as a than 4 days duration. It length, 1.3 cm in width and rp's debridement was ound was classified as a than 4 days duration. 1.5 cm in length, 0.9 cm in depth with light serous dician orders, and TAR, no order or treatment acral pressure ulcer prior to 1 the following orders were cian orders and TAR: 1.2/21 to cleanse the sacral ands with normal saline, pat (used to facilitate autolytic in help to maintain wound dibed and cover with dry and as needed. 1.2/21 to cleanse the left and all saline and pat dry. Apply and soves dead tissue from start to heal) and cover with day. 1.2. ansferred to the Emergency de to respiratory distress. He	F	886				
	right heel with normal Santyl ointment (rem wounds so they can a dry dressing every Resident #85 was tra	al saline and pat dry. Apply noves dead tissue from start to heal) and cover with day. ansferred to the Emergency e to respiratory distress. He						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 9/ 20/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		(3/20/2021		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 686	2/11/21 indicated Rewell-developed and person. His skin was redness or rashes p wrapped in gauze w place to the right he was present to the state of	rgency Room record dated esident #85 was a chronically ill-appearing is not pale and there was no resent. Both heels were ith a protective garment in el. A stage 2 pressure ulcer facral area. and Physical summary dated dent #85 had superficial fineel ulcers with no signs of fare consult was made. Insult note dated 2/12/21 85 was assessed with a fineer to his sacrum and fineer areas to both heels. There is of arterial insufficiency with fineer to his sacrum and fineer areas to both heels. There is of arterial insufficiency with fineer to his sacrum and fineer areas to both heels. There is of arterial insufficiency with fineer to his sacrum and fineer areas to both heels. There is of arterial insufficiency with fineer to his sacrum and fineer areas to both heels. There is of arterial insufficiency with solutions are consulted as a fineer to demential related and repositioning. The wound	F6	·				
	cm width with no od infection A stage 3 pressure sacrum with multiple	asured 3.5 cm in length and 3 dor, redness, or signs of a ulcer was present to the gopen areas within areas of and measured 1 cm in length						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345177	B. WING_			C 9/20/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		9/20/2021		
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 686	indicated Resident # and unstageable bila seen in consultation who recommended a debridement and wa protein-calorie malnu. A phone interview was on 3/11/21 at 11:00 A Resident #85 on 1/2 1/28/21 she assessed that were free from a former wound care in and applied a dry dre. On 3/10/21 at 3:26 F with Nurse #4 who won 2/5/21. Nurse #4 open areas on Resid were 2 small, superfalerting the former w pressure areas, clead dressing to the sacra areas. Nurse #4 stat and obtained orders unable to state why orders documented wounds until 2/10/21. The Director of Nurse by phone on 3/11/21 was aware Resident his heels and buttood time, the staff nurses	ge summary on 2/21/21 85 had a stage 3 sacral ulcer ateral heel ulcers. He was by the Wound Care team a gel treatment for autolytic is noted to have moderate utrition. as conducted with Nurse #3 AM, who was assigned to 8/21. She explained on ad pink areas to both heels drainage, reported this to the nurse, cleansed the areas essing. PM, an interview occurred was assigned to Resident #85 stated when he observed the dent #85's buttocks there icial openings. He recalled yound care nurse to the new insing, and applying a dry all and buttock pressure ed he notified the physician for the wound care but was there was no treatment for the sacral and buttock	F 6	86				
	She stated the forme	er wound care nurse failed to orders for treatments on the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 09/20/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP 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 PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	DATE	N	
F 686	Continued From page	e 45	F 6	586				
	MAR or TAR when the identified. The DON the nurse who identificated the nurse who identificated the nurse who identificated the nurse who identificated at 12:13 I occurred with the VO verified assessing Rewounds on 2/9/21. Swound was small in succer was described at time of her assessment the sacral wound, 20 wound and both areas the physician explair necrotic with moderar use an enzymatic oin with hopes of possible future. She wasn't sueschar or just leather clinical judgment to the leassessment. The phy was possible for necromount of time to Reclinical decline, poor shuffling his feet desponts in place. The service friction to the area created the same way the notice of the notice of the same way the notice of the same way the notice of the same way the notice of	further stated she expected fied the open area to obtain a flowing the facility's wound a physician. PM, a phone interview HRA wound physician. She esident #85's pressure he stated the right buttock size and the sacrum pressure as a cluster wound. At the ent there was 5% necrosis to 6% necrosis to the right heel is were Sharp's debrided. The definition of the drainage. She chose to the to debride the area by Sharp's debriding in the re if the necrotic areas were by skin and stated it was her of use a Sharp's fit heel on the day of the resician continued to say it resis to develop in a short sident #85's heels due to his nutrition and possible bette dressings and protective thuffling action causes the entire in the physician were many different types of all areas of necrosis were by At the time of her buttock wound did not need						
	The Medical Director	was interviewed via phone A and was familiar with						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _					20/2021
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
THE ODE	-NO AT DINEUUDOT DE	HAD O LIVING OFFITED		2	205 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		ı	PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 686	Continued From pag	e 46	F6	386	3			
	Resident #85. He red							
		\$5's heel wounds shortly						
		rved and was aware the						
	_	ner wound care nurse failed						
	_	care orders in a timely						
	manner. He could no	ot say if this directly resulted						
	in the deterioration of	f Resident #85's wounds and						
	stated Resident #85'							
		iickly due to his decline in						
		ne in mobility, poor appetite						
	and possible shuffling	g his feet when in bed.						
	wound care nurse or her employment at the was able to recall Referemembered the floor heel wounds and inside them on 1/28/21 becare orders were prewounds on 2/2/21 and dark areas present a drainage present. A cound she requested the wounds the following nurse recalled being when Resident #85 country treatment orderecalled assessing the remembered the area minimal drainage and	as conducted with the former in 9/15/21 at 2:00 PM who left the facility in March 2021. She esident #85 and stated she for nurse telling her about his structed the nurse how to still she could get there to look out failed to ensure wound esent. She assessed the heel and could not recall any large and there was minimal dry dressing was in place to be booties were on his feet the facility PA to assess the gray. The former wound care informed by the floor nurse developed breakdown to his 21 and stated she forgot to lers were in place. She he wounds on 2/8/21 and as to be small in size with definition of the same provider the following						
		M, a phone interview was PA who was able to recall						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _		0.0	C 9/20/2021		
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP (205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	5/20/2021		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 686	stated she was not nurse on 2/2/21 reg to both heels. She which had clean dr recalled his heels vareas, and small at no black areas, but other and was difficulties that different stated she could not pain, but it wouldn' Resident #85 to may have facial change wounds due to his added she had no Resident #85's stated and the stated on 1/28/2 both heels and reput care nurse. She wound care nurse areas and applied stated she didn't wfelt the former wourse areas and obtain orders and obtain orders and obtain orders and the facility. The Administrator and the facility's wound process.	e reviewed her notes and ified by the former wound care garding Resident #85's wounds assessed the areas on 2/3/21 y dressings in place. She were dark red in color, open mount of drainage. There were to one heel was darker than the cult to stage. The facility PA of recall any concerns with thave been uncommon for ake a noise, move around or s when she was assessing his dementia. The facility PA concerns for pain during	F	586				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 20/2021	
NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 007	20/2021	
				205	RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST RI	EHAB & LIVING CENTER		PIN	NEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From pa	ge 48	F 6	689				
F 689 SS=D	· ·	zards/Supervision/Devices	F 6	889			10/11/21	
	as free of accident In §483.25(d)(2)Each supervision and assaccidents. This REQUIREMENT by: Based on observative record review, the faintervention for a rewith the staff preser #5) of 3 residents refindings included: Resident #5 was accumulative diagnost Accident and right had Resident #5's quart dated 7/17/21 indication impairment and rejewas coded to exten with bed mobility, in one lower extremity fall with no injury. Resident #5 was cat on 5/27/21. Her can for an actual fall and bilateral grab bars fabed.	esident environment remains nazards as is possible; and resident receives adequate sistance devices to prevent of the prevent			Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; Resident #5 was reassessed by the Interdisciplinary Team on 9/20/21, regarding interventions related to a star assisted fall on 6/21/2021. It was determined that grab bars would not be appropriate for the resident at that time. The staff were following residents care plan regarding turning and repositioning by using 2 staff members. The incident at attaff responded appropriately. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice. Current facility residents that have sustained a fall have the potential to be affected. The Director of Nursing (DON) completed an audit on 9/22/2021 of current facility residents that has sustained a fall from July-September, to validate that an	ff g t and er ;		
	Review of Resident	#5's medical record indicated			investigation was completed and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 20/2021
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021
				2	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689		e 49 iisted fall on 6/21/21. There sing Assistant (NA #5 and	F 6	689	interventions were initiated. No residen were identified with missing intervention		
	provide incontinence continued rolling to the	nt #5 over in the bed to care and Resident #5 ne edge of the bed into NA o prevent the fall. NA #5 to the floor.			Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur; When an incident occurs, the licensed nurse will initially implement an		
	Review of Resident # (IDT) Post Fall Invest 6/21/21 read orders hilateral grab bars. T completed and signe Nursing (DON).			intervention to promote safety for the resident. The IDT will investigate the incident and validate that the intervention was initiated and remains appropriate. The MDS nurse or licensed nurse will update the care plan with the intervention that was initiated.			
	orders did not include and no side rail asse since admission (5/13 need for side rails as An observation of Re 9/14/21 at 12:50 PM. wheelchair having lui	sident #5 was conducted on She was sitting up in her nch. There were no observed . She was unable to recall			The Regional Clinical Director complete education on 9/21/2021, for the DON, ADON and unit manager regarding incident investigation and implementati of interventions. The DON, ADON and unit manager completed education on 10/07/2021 for the nursing staff regarding implementation of interventions following an incident. Indicate how the facility plans to monitored.	on r ng	
	on 9/15/21 at 1:50 PI assisting NA #7 with end of her shift. NA ibed to ease in her indistated that NA #7 roll her right side while sithe bed with her hand Resident #5 lifted her right side of the bed. fast that when she the side of the bed, it caused the side of	was conducted with NA #5 M. NA #5 stated she was her last rounds before the #5 stated NA #7 raised the continence care. NA #5 ed Resident #5 over onto he was on the other side of d on Resident #5. She stated r left leg and threw it over the She stated it happened so rew her left leg over the right used Resident #5's lower ed. NA #5 stated she			its performance to make sure that solutions are sustained; The Administrator will audit incident investigation and intervention implementation for residents with falls, weekly for 4 weeks then monthly for 2 months, to validate that an investigation was completed for each incident and interventions were implemented as recommended by the IDT team. The Administrator will review the audits monthly to identify patterns and trends and will adjust the plan as necessary to	n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 09/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	0.0	<u> </u>	STREET ADDRESS, CITY, S	STATE ZIP CODE	09/20/2021	
NAME OF T	TOVIDER OR GOLF EIER			, ,	•		
THE GREI	ENS AT PINEHURST RE	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 CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA' DEFICIENCY)		
F 689	Continued From paga attempted to prevent unable. NA #5 stated prevent Resident #5 or head on the floor. get Nurse #5 who as injuries. She stated a leave Resident #5's trolling her in prepara NA #5 stated she did was put in place for never seen grab bars would probably help repositioning. A telephone interview at 1:55 PM with NA # assigned Resident #8 She stated she was rwhen NA #5 came in with her last incontine ended. NA #7 stated pulled Resident #5 by then rolled her onto he #5 was on the other son Resident #5 when		F 6	maintain complia The Administrator during the monthl	nce. r will review the plan ly QAPI meeting and tlue at the discretion of t	ne	
	lower body sliding off #7 stated NA #5 had body and tried to stop to because of Resider #5 eased Resident # and she went and go Resident #5 for injuri She stated Resident help the staff by mak and repositioning. NA observed grab bars of	the bed onto the floor. NA hold of Resident #5's upper to the fall but she was unable ent #5's size. She stated NA 5's upper body to the floor					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		03/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 51	F 6	889		
	at 7:35 PM with Nurecalled Resident #because 2 staff me fell. She stated the verified the informa circumstances of the survey. Nurse #5 stidea, but she thoug would have been to An interview was completed, and meeting. She stated interventions are imwas completed, and An observation on Resident #5 sitting grab bars on the beat An interview was completed, and An observation on Resident #5 sitting grab bars on the beat An interview was completed, and An interview was completed, and An observation on Resident #5 sitting grab bars on the beat An interview was completed and with MDS Nursewere reviewed daily plan was revised at confirmed that the previous design and evaluation before were added to a beat the previous DON acare plan, but nobo	e fall as conveyed during the ated a grab bar was not a bad ht that other interventions ied first. Inducted on 9/15/21 at 2:25 strator. She stated the per position recently and that e for the fall investigations and of interventions. The did the IDT met daily and all falls ay were reviewed in the did it was at that time that new per position is at the investigation did the care plan revised. 19/15/21 at 2:55 PM, revealed up in the bed. There were no				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345177	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		03/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	PM with the Interim R She stated during the reviewed and discuss therapy needs identife therapy screening and Physician was contain The RM stated the nameded side rails or a RM stated the facility	nducted on 9/16/21 at 12:55 Rehabilitation Manager (RM). In IDT meetings, each fall was sed. If there were any fied, therapy first completed a number of the completed and if therapy was needed, the completed to obtain therapy orders. The complete who grab bars on admission. The condition of the complete of the comple	F6	689		
F 690 SS=D	Attempts to contact to unsuccessful. Messareturn call. An interview was comply with the Interim Estated it was their exinvestigated thorough intervention to preven off the bed would be Bowel/Bladder Incon CFR(s): 483.25(e)(1) §483.25(e) Incontine §483.25(e)(1) The faresident who is continual admission receives a maintain continence condition is or become not possible to maint §483.25(e)(2)For a reincontinence, based	int Resident #5 from rolling implemented. tinence, Catheter, UTI (-)-(3) ince. cility must ensure that nent of bladder and bowel on services and assistance to unless his or her clinical nes such that continence is tain.	Fθ	390		4/8/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING _		C 09/20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST F	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00/20/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		·		ECTION (X5) HOULD BE COMPLETION PROPRIATE DATE
F 690	indwelling catheter resident's clinical of catheterization was (ii) A resident who indwelling catheter is assessed for renas possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary tracontinence to the experience of the experi	enters the facility without an is not catheterized unless the ondition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder the treatment and services to extent possible. The resident with fecal don'the resident's esesment, the facility must ent who is incontinent of bowel the treatment and services to extent possible. The resident with fecal don'the resident's esesment, the facility must ent who is incontinent of bowel the treatment and services to formal bowel function as The resident with fecal don'the resident's esesment, the facility must ent who is incontinent of bowel the treatment and services to formal bowel function as The resident with fecal don'the facility must ent who is incontinent of bowel the treatment and services to formal bowel function as The resident with fecal don'the facility must ent who is incontinent of bowel the treatment and services to formal bowel function as	F 6	F 690 Address how corrective action w accomplished for those residents have been affected by the deficie practice; Resident # 40 has an order that written on 1/26/21 for PRN cathe every 8 hours if no voiding. Reshas not required continuous cathe Address how the facility will identerisidents having the potential to	s found to ent was erization ident #40 neter use.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING			1	20/2024
NAME OF DE	ROVIDER OR SUPPLIER	0.0		6.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	20/2021
	ENS AT PINEHURST REF	HAB & LIVING CENTER		20	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	assessment dated 1/indicated Resident #4 catheter. A nursing note dated #8 indicated Residen urinary catheter in plate The significant change assessment dated 1/indicated Residen urinary catheter in plate The significant change assessment dated 1/indicated Residen urinary catheter in plate The significant change assessment dated 1/indicated Indicated In	ng admission/readmission 7/21 completed by Nurse #8 40 had an indwelling urinary 1/7/21 completed by Nurse t #40 had an indwelling ace. Je Minimum Data Set (MDS) 13/21 indicated Resident severely impaired and she y catheter. Jence Care Area Assessment 1/13/21 significant change licated Resident #40 had an heter in place for urinary sident #40 was conducted M. She was observed with catheter in place. #40's medical record from the revealed no physician's an indwelling urinary	F	690	affected by the same deficient practice Current facility residents with indwelling urinary catheter are at risk of the allege deficient practice of failing to have a physicians order to support the use of a indwelling urinary catheter. The Director of Nursing (DON) and/or Assistant Director of Nursing/ADON completed an audit on 3/22/21, of currefacility residents with indwelling urinary catheter, to validate that there is a physicians order to support the use of the catheter. There were no other resident affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON and ADON completed education on 3/19/21, for the licensed nurses regarding obtaining orders and transcribing orders into the resident electronic medical record whenever a resident requires an indwelling urinary catheter. When a resident is admitted/readmitted has a change in condition that requires use of an indwelling urinary catheter, the nurse must obtain an order for the catheter and the order must be input in the electronic medical record that incluit the size of the catheter and balloon size the reason/diagnosis for use, when to change the catheter and care of catheter New admissions and physicians orders.	ged an ent he ss o tot	
	She was unable to re	removed. She reported that			will be reviewed daily at the clinical meeting.	· 	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345177	D. WING _			09/	20/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CDE	ENS AT PINEHURST REH	JAR & LIVING CENTER		2	05 RATTLESNAKE TRAIL		
IIIL GILL	INS AT FINEHOUST KEI	IAD & 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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	1						
F 690	Continued From page	e 55	F	690			
	she was certain urina	ry catheter care was			Newly hired licensed nurses will be		
	provided daily and as needed for Resident #40 when the urinary catheter was in use.				educated during new hire orientation.		
					Indicate how the facility plans to monitor	or	
	An interview was con	ducted with Nurse #6 on			its performance to make sure that		
		She indicated that she was			solutions are sustained;		
	regularly assigned to				The DON and/or the ADON will		
		nterview that Resident #40			audit/observe new		
		nary catheter when she was			admissions/readmissions and residents		
		ospital in January 2021, but e been removed. Nurse #6			identified with a change of condition 5 week for 4 weeks then weekly for 2	X.	
		indwelling urinary catheter			months to determine if the resident ha	c	
		e indicated she needed to			an indwelling urinary catheter and will	3	
		cord. Resident #40 's			validate that a physicians order has be	en	
		icluded no physician 's			obtained and input into the residents	011	
	orders for the use of t				electronic medical record.		
		atheter care/treatment			The DON and/or ADON will review the		
	orders, and no discor	ntinuation order for the			audits for patterns/trends and will adjust	st	
		reviewed with Nurse #6.			the plan as necessary to maintain		
	Nurse #6 confirmed to	here were no physician ' s			compliance.		
		ident #40 ' s indwelling			The DON and/or the ADON will review	the	
	•	she had when she was			plan during the monthly QAPI meeting		
		ospital on 1/7/21. Nurse #6			and the audits will continue at the		
		e there were no physician			discretion of the QAPI committee.		
		indwelling urinary catheter					
		I the exact date of when it ne stated that to the best of					
		dent #40 's indwelling			Indicate dates when corrective action v	will	
		removed sometime in			be completed; 4/8/21	VIII	
	January 2021. She w				be completed, 1/6/21		
		ng admission/readmission					
		ated this was normally done					
	by the nurse who con	-					
		on. Nurse #6 reported that					
		eter care was completed as					
	required even though	the physician 's orders					
	were not in the medic	cal record.					
	A phone interview wa	s attempted with Nurse #8					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SUR COMPLETE	
		345177	B. WING _			C 09/20/ 2	2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	_	(X5) OMPLETION DATE
F 690	Continued From page on 3/11/21 at 10:00 A reached.	e 56 .M. She was unable to be	F 6	390			
	Nursing (DON) on 3/2 indicated that Reside facility from the hospi indwelling urinary cat there were no physici #40 's medical recordurinary catheter. The reviewed Resident #4 based on the notes the was removed in the last she reported that the readmission (Nurse # physician 's orders for Resident #40 was removal should have orders. The DON state expectation for a physic for the use of a urinary care/treatment of the discontinuation of the Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care are The facility must ensure and tracheal succare, consistent with practice, the comprehend 483.65 of this sure	heter. She verified that an 's orders in Resident d related to this indwelling b DON reported that she to 's nursing notes and he indwelling urinary catheter atter half of January 2021. nurse who completed the to should have entered the or the urinary catheter when admitted on 1/7/21 and the ime of the urinary catheter 'et then discontinued these hat it was her sician 's order to be in place by catheter, for the urinary catheter, and for the urinary catheter. Stomy Care and Suctioning and tracheal suctioning. The that a resident who be, including tracheostomy catheters who be including tracheostomy catheters are including tracheostomy catheters. The that a resident who be including tracheostomy catheters are including tracheostomy catheters. The that a resident who be including tracheostomy catheters are including tracheostomy catheters. The that a resident who be including tracheostomy catheters are including tracheostomy catheters. The traches are including to the traches are including tracheostomy catheters are including tracheostomy catheters.	Fé	595		4/8	3/21

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING _			09/	20/2021
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE ODE	NO AT DINELLUDOT DEL	LAD & LIVING CENTED		20	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REI	AB & 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695		ns, staff and resident	F 6	695	F 695		
interviews and record review, the fa administer oxygen as ordered for 3 #69, Resident #43, and Resident #8 residents reviewed for respiratory c findings included		ordered for 3 (Resident and Resident #82) of 3 or respiratory care. The			Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; 1) On 3/10/21, the licensed nurse	I to	
	Resident #69 was admitted on 1/26/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Basident #60/s admission Minimum Data Cat.				adjusted the oxygen rate to 2 liters per minute according to the physicians order for Resident #69. 2) On 3/10/21, the licensed nurse		
	Resident #69's admission Minimum Data Set (MDS) dated 1/31/21 indicated cognitive status was not assessed and she exhibited no behaviors. She was coded for extensive assistance with bed mobility and non-ambulatory.				adjusted the oxygen rate to 2 liters per minute according to the physicians order for Resident # 43. 3) On 3/10/21, the licensed nurse obtained a physicians order for continu	er	
	Resident #69 was ca	re planned for altered e to COPD. There was			oxygen at 2 liters per minute for Reside # 82 and set the rate to 2 liters minute.	ent	
	Review of a nursing note dated 2/18/21 read Resident #69 was short of breath with an oxygen saturation of 78% on room air. Oxygen via nasal cannula (NC) at 3 liters was administered and increased to 4 liters to increase saturation. Once Resident #69 calmed down, the oxygen was decreased to 3 liters. The Physician was notified.				Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that receive oxygen is at risk for the alleged deficient practice of failing to administer oxygen as ordered. The DON, ADON and licensed nurses completed an audit on 3/22/21, of current		
	Resident #69 was ord NC continuously for 0 In an observation and was deemed alert and	d interview, Resident #69 d oriented. Her oxygen			facility residents with oxygen to validate that oxygen was administered accordin to the physician orders. All residents identified were receiving oxygen as ordered.		
	Resident #69 did not	ning a 3.5 liters via NC. appear short of breath and er oxygen should be running			Address what measures will be put into place or systemic changes made to)	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 09/20/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/20/2021	
				205 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 695	Continued From page	÷ 58	F 69	5		
	at 4 liters. She stated times.	she wore her oxygen at all		ensure that the deficient practice will recur; The DON and ADON completed	not	
		1 at 2:28 PM, revealed n concentrator was running		education on 3/19/21, for nursing staf regarding following physician orders f administration of oxygen. Newly hired nursing staff will be educated	or	
	Review of a nursing note dated 3/8/21 at 5:43 PM read Resident #69 was alert and oriented with oxygen running at 2 liters via NC.			during new hire orientation. When an order is obtained for oxygen licensed nurse will implement the order and will place a sticker on the	the	
	Review of a nursing note dated 3/9/21 at 6:37 Al read Resident #69 was alert and oriented and he oxygen was running continuously at 2 liters via NC.			concentrator to indicate the amount or oxygen flow for the resident. Indicate how the facility plans to moni		
	8:15 AM, Resident #6 was running at 3.5 lite her oxygen at all time oxygen saturation lev	l interview on 3/10/21 at 19's oxygen concentrator ers. She stated she required s and staff checked her els and she felt everything ey never adjusted her		its performance to make sure that solutions are sustained; The DON and/or ADON will observe 1 residents weekly for 4 weeks then 20 residents monthly to validate that oxy, is administered as ordered. The DON or the ADON will review the audits monthly to identify patterns/trer and will adjust the plan as necessary	gen ands	
	In an interview on 3/10/21 at 8:30 AM, Nurse #1 stated Resident #69 was very compliant and was not known to self-adjust her oxygen concentrator. In an interview on 3/10/21 at 11:00 AM, Unit Manager (UM) #1 stated Resident #69 was very			maintain compliance. The DON or the ADON will review the plan during the monthly QAPI and will continue the audits at the discretion o QAPI committee.		
	anxious at times and her oxygen. He stated	very complaint with wearing d Resident #69 had not been ng her oxygen concentrator.		Indicate dates when corrective action be completed; 4/8/21	will	
	Assistant (NA) #1 star	0/21 at 11:15 AM, Nursing ted does not refuse or She stated she had never 69 attempting to adjust her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	' ≣	3072072021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 695	Continued From pa	ge 59	F 6	95				
		n 3/10/21 at 11:45 AM, gen concentrator was running						
		n 3/10/21 at 1:34 PM, gen concentrator was running						
Resid		n 3/10/21 at 3:20 PM, gen concentrator was running						
	stated she had not attempting to adjus	observed Resident #69 ther oxygen concentrator and would because she was very						
		n 3/10/21 at 4:10 PM, gen concentrator was running						
	Director of Nursing expectation that Re	1/10/21 at 5:00 PM, the (DON) stated it was her sident #69's oxygen be dered at 2 liters continuously						
		as admitted on 12/12/18 with a ral Vascular Accident.						
	included an order d	#43's Physician orders ated 2/19/20 for oxygen at 2 nula (NC) continuously.						
		rterly Minimum Data Set 11 indicated she was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345177	B. WING _			09/20/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		5 RATTLESNAKE TRAIL	1 09/	20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 695	cognitively intact, ex behaviors and coded Resident #43's revis read she was at risk to sleep apnea. Oxy interventions. Review of a nursing Resident #43 was al continuous oxygen at 10:51 AM, Resident was running at 3 lite oxygen at all times. In an observation on Resident #43's oxyg at 3 liters. Resident sobserved staff adjus stated they checked consistently. In an interview on 3/ stated Resident #43 2 liters via NC and sher oxygen. In an interview on 3/ Manager (UM) #1 st	hibited rejection of care d for the use of oxygen. ed care plan dated 2/8/21 for respiratory distress due gen was not included in any note dated 2/17/21 read ert and oriented and on at 2 liters. d interview on 3/8/21 at #43's oxygen concentrator rs. She stated she wore her 3/10/21 at 8:20 AM, en concentrator was running #43 stated she had not ting her oxygen rate but	F	695	DEFICIENCY)			
	Assistant (NA) #1 sta adjust her oxygen co	10/21 at 11:15 AM, Nursing ated Resident #43 could not oncentrator. 10/21 at 11:50 AM, NA #1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	·	00/20/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 695	Continued From pa stated Resident #43 concentrator.	ge 61 3 could not adjust her oxygen	F 6	95				
		n 3/10/21 at 12:20 PM, gen concentrator was running						
		s/10/21 at 12:24 PM, NA #3 3 could not self-adjust her or.						
	In an observation on 3/10/21 at 2:30 PM, Resident #43's oxygen concentrator was running at 3 liters. In an interview on 3/10/21 at 5:00 PM, the Director of Nursing (DON) stated it was her expectation that Resident #43's oxygen be administered as ordered at 2 liters continuously via NC.							
		s admitted on 2/10/21 with a c Obstructive Pulmonary						
	included an order d	#82 Physician orders ated 2/10/21 for oxygen at 2 nula (NC) at bedtime for						
	Resident #82's admission Minimum data Set (MDS) dated 2/17/21 indicated he was cognitively intact and exhibited no behaviors. He was coded for oxygen.							
	2/24/21 for altered	evised care plan dated respiratory status due to s included oxygen via NC at 2						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING				20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	HAB & LIVING CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00	20/2021
(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 695	read Resident #82 woxygen running at 2 In an observation an AM, Resident #82 woxygen NC with his of at 5 liters. He stated his COPD. He stated oxygen was running. In an observation on #82's oxygen concert In an observation on Resident #82's oxygen at 2 liters per NC. He anyone adjusted his In an interview on 3/Manager (UM) #1 siphysically unable to concentrator. UM #1 medication cart on 3 Resident #82's oxygen stated someone mustated he also did not Resident #82 oxygen night. UM #1 stated experienced a rapid	note dated 3/4/21 at 1:41 PM as lying in bed with his liters via NC. d interview on 3/8/21 at 11:12 as lying in bed wearing his oxygen concentrator running he required oxygen due to I he was unsure what rate his 3/8/21 at 2:30 PM, Resident atrator was running at 5 liters. 3/10/21 at 8:50 AM, en concentrator was running at stated he did not notice if oxygen concentrator. 10/21 at 11:00 AM, Unit stated Resident #82 was self-adjust his oxygen confirmed he worked the /8/21 and did not notice en running at 5 liters. He at have adjusted it. He also of notice the order that in was only ordered for at	F	695			
	Director. In an interview on 3/	en orders with the Medical 10/21 at 11:15 AM, Nursing ated #82 Resident could not incentrator.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345177	B. WING			1	C 20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	stated Resident #82	e 63 0/21 at 11:50 AM, NA #2 could not adjust his oxygen	F	695			
	stated he spoke with	0/21 at 12:50 PM, UM #1 the Medical Director and esident #82 to wear his NC continuously.					
	- ,	OON) stated it was her dent #82's oxygen be					
F 756 SS=E	Drug Regimen Revie CFR(s): 483.45(c)(1)	w, Report Irregular, Act On (2)(4)(5)	F	756			4/8/21
		imen Review. ug regimen of each resident least once a month by a					
	§483.45(c)(2) This re of the resident's med	view must include a review ical chart.					
	irregularities to the at facility's medical direct and these reports mu (i) Irregularities includrug that meets the ce (d) of this section for (ii) Any irregularities induring this review museparate, written report attending physician and director and director of	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist list be documented on a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345177	B. WING		C 09/20/2021		
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/20/2021		
				205 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.		
F 756	(iii) The attending phy resident's medical rediregularity has been action has been taker be no change in the mphysician should doct the resident's medical. §483.45(c)(5) The fact maintain policies and drug regimen review to limited to, time frames the process and steps when he or she identifications are urgent action. This REQUIREMENT by: Based on record revisite type of the process and steps when he or she identifications are urgent action. This REQUIREMENT by: Based on record revisite type of the process and steps when he or she identifications are urgent action. This REQUIREMENT by: Based on record revisite type of the process and steps when he or she identifications are urgent action. This REQUIREMENT by: Based on record revisite type of the process are used to the process and steps when he or she identifications.	e pharmacist identified. Isician must document in the sord 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 record. It is include, but are not is for the different steps in its the pharmacist must take fies an irregularity that into protect the resident. It is not met as evidenced	F 7	,			
	assess residents on a abnormal involuntary (Residents #3, #18, # facility 's need to ider symptoms and to mor (Residents #18 and # ensure PRN (as need medications were time (Resident #40), and the evaluate residents on for gradual dose redu #43). In addition, the recommendations made Consultant (Residents	antipsychotic medication for movement disorders 29, #31, #41, and #43), the ntify target behavioral nitor those symptoms 43), the facility 's need to led) psychotropic e limited in duration ne facility 's need to psychotropic medications ctions (Residents #18 and facility failed to act upon		were not up to date and a total of 9 residents that did not have target behaviors identified at the time of survi For those residents found to have been affected by the deficient practice of not receiving drug regimen reviews/reports irregularities related to the Abnormal Involuntary Movement Scale (AIMS) and the Gradual Dose Reductions (GDR) were updated as follows: 1-Resident #29 s antipsychotic medication was discontinued on 2/27/2 so therefore an AIMS assessment is not required at this time. 2- a) The licensed nurse completed as	ey. n s of 21,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
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		345177	B. WING _		09	9/20/2021	
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 756	11/2/16 with multiple schizophrenia and codisturbance. An Abnormal Involution assessment was concessed as a movement sidentified. A physician 's order Seroquel (antipsychology) once daily for the quarterly Minimassessment dated 1 was rarely/never un	e diagnoses that included lementia without behavioral mtary Movement Scale (AIMS) mpleted on 12/1/19 for score of 0 (no involuntary ed). In dated 4/5/20 indicated otic medication) 50 milligrams Resident #29. In Data Set (MDS) 1/8/21 indicated Resident #29 derstood. She was assessed	F 7	· · ·	ued the 21. ved a liscontinue nt #40. iate a GDR ant at this ealth or was for signs vted an 1/21. The to include ne GDR at this		
	with no behavioral symptoms, but had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days. A physician 's order dated 1/15/21 indicated Resident #29 had a GDR of Seroquel decreasing the dose from 50 mg once daily to 25 mg once daily. The quarterly MDS assessment dated 2/16/21 indicated Resident #29 's cognition was severely impaired. She had no behavioral symptoms, but she had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days. A physician 's order dated 2/27/21 indicated Resident #29 's Seroquel was discontinued.			6- The licensed nurse receive from the physician on 3/25/21, thold for Sotalol when pulse rate than 50 for Resident #66. 7- a) The licensed nurse compalms for Resident #3 on 3/10/2 b) Sertraline and Hydroxyzine high diagnosis included with the origin for Resident #3 but was not pull the electronic medication adminates and the orders on 3/25/21 and diagnosis are showing on the Right management with the second Alms and the orders on 3/25/21 and diagnosis are showing on the Right management with the second Alms for Resident #31 on 3/10/4 Address how the facility will identification.	to include a e is less pleted an e.t. plad inal order lng over to histration urse and the desident pleted an e.t.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE ODE	NO AT DINEULIDET DE	HAD 9 I WING CENTED		2	05 RATTLESNAKE TRAIL		
INE GREE	ENS AI PINEHURSI RE	HAB & LIVING CENTER		Р	PINEHURST, NC 28374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 756	Continued From pag	e 66		756			
1 100	Continued From pag	0 00	'	1 30			
	A				residents having the potential to be		
		cation Administration			affected by the same deficient practice	,	
		m 12/2/19 through 2/27/21			AH 6 1174		
	indicated Resident #	_*			All facility residents have the potential t	.о	
	Seroquel daily as ord	dered.			be affected by the alleged deficient		
		150 1 1 1 1			practice of failure to assess residents of	'n	
		copy and Electronic Medical			antipsychotic medication for abnormal		
		1/1/20 through 3/8/21			involuntary movement disorders, identi	гу	
		ssessment or any other			target behaviors and monitor those		
	-	nt assessment had not been			symptoms, ensure PRN psychotropic		
	completed for Reside	ent #29 since 12/1/19.			medications are time limited in duration	1,	
	There was no syider	nce in Resident #29 ' s			evaluate residents on psychotropic		
		e Pharmacy Consultant			medications for gradual dose reduction and act upon pharmacy	1	
	identifying and addre				recommendations.		
		other involuntary movement			The Director of Nursing (DON) and		
		been completed for Resident			Assistant Director of Nursing (ADON)		
	#29 since 12/1/19.	been completed for resident			completed an audit on 3/10/21, of curre	≥nt	
	#20 3110C 12/1/10.				facility residents with orders for	,,,,,	
	An observation was	conducted of Resident #29			antipsychotic medications to validate th	nat	
	on 3/8/21 at 12:30 P				an AIMS had been completed within th		
	involuntary movemen				last 6 months. All AIMS were up to da		
					by 3/10/21. A total of 6 AIMS and 0 GR		
	An interview was cor	nducted with the Director of			were identified from the audits conduct		
		/10/21 at 1:20 PM. She			on 3/9/21 and 3/10/21.	-	
	l . T. ' '	y's normal process was to			On 3/21/21, the DON and ADON		
		ssments on admission and			completed updating behavior monitors	to	
		thereafter for residents on			include target behaviors for residents the		
		ation. The assessments were			receive psychoactive medications. 9		
		R under the assessment			residents were identified as not having		
		ed the AIMS assessments			target behaviors.		
		he admission nurse on			On 3/10/21, the DON and ADON		
		by the floor nurses every 6			completed an audit of PRN psychoactive	ve	
	months with coincidi	-			medications to assure there are stop		
		OON explained that the MDS			dates and reassessment of use. 3		
		#1 and MDS Nurse #2) put			residents were identified that did not ha	ave	
	,	S assessments that were			stop dates for orders.		
	due each month and	this was used to inform the			On 3/9/21, the pharmacist completed a	ın	
	floor nurses of when	an AIMS assessment was			audit of current facility residents that		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING			09/20/2021		
NAME OF PE	ROVIDER OR SUPPLIER	0.0	 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	20/2021	
NAME OF T	NOVIDEN ON SOIT LIEN							
THE GREE	NS AT PINEHURST R	EHAB & LIVING CENTER			05 RATTLESNAKE TRAIL			
				Р	PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 756	Continued From pa	ge 67	F7	756				
	due. The most rece	ent AIMS assessment for			receive psychotropic medications and			
		I 12/1/19 was reviewed with			made recommendations for 3 residents	s to		
		N confirmed there were no			have a gradual dose reduction.			
		completed after 12/1/19 for			On 3/25/21, the DON completed			
		revealed she was not aware			pharmacy recommendations that were			
		S assessments not being			received for February and March 2021			
		months. She indicated there			,,			
		with the facility 's protocol for						
		assessments as Resident			Address what measures will be put into)		
		ad 2 AIMS assessments			place or systemic changes made to			
	completed since 12	/1/19. The DON stated that			ensure that the deficient practice will no	ot		
	she would have exp	pected the Pharmacy			recur;			
	Consultant to identi	fy and address the need for			When a resident has a physician order	for		
	AIMS assessments	to be completed every 6			an antipsychotic medication, the licens	ed		
	months for residents on antipsychotic medication.				nurse will complete an AIMS assessme	ent.		
					The assessment will be updated at lea	st		
	A phone interview v	vas conducted with the			every 6 months and will be tracked and	t		
	Pharmacy Consulta	ant on 3/10/21 at 3:25 PM.			schedules by Minimum Data Set (MDS)		
		expectation for the completion			Nurse. The licensed nurse will impleme	ent		
		nts was on initiation of an			a behavior monitor in the electronic			
		cation and every 6 months			medical record to include resident			
		armacy Consultant explained			targeted behaviors and side effect			
		t to complete routine AIMS			monitoring every shift.			
		tipsychotic medications due to			When a PRN psychoactive medication			
		ffects of the medications.			ordered, the order will include a 14 day			
		ost recent AIMS completed on			time limit, and the physician will reasse	SS		
		ed with the Pharmacy			for continued use.			
		ent #29 's physician 's orders			The pharmacist will complete monthly			
		cated she received Seroquel			audits of resident medication and will			
	_	hrough 2/27/21 were reviewed			make recommendations to the physicia			
	•	Consultant. She revealed			regarding gradual dosage reduction. T			
		ed that an AIMS assessment			pharmacist will validate monthly if a GI			
	•	since 12/1/19 for Resident			was completed and if not, will follow up	1		
		y Consultant explained that			with the DON and physician to assure			
		with the facility in May of 2020			proper documentation is completed to			
		g remote reviews until January			support.	,		
		d that she thought the AIMS in the hard chart so she was			When the DON receives the Pharmacy recommendations monthly, she will	,		
		ould have reviewed the AIMS			provide copies to the physician and			
	unaware mar sile d	outu nave reviewed life Alivio			provide copies to the physician and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	NG		,	
		345177	B. WING _				20/2021
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE COE	ENG AT DINEULIDET	REHAB & LIVING CENTER		20	5 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST	REHAD & LIVING CENTER		PI	NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From p assessments whe monthly medication The Pharmacy Cobegan completing assessments for medications when facility in person in medication regimes she also had not cassessments during medication regimes Pharmacy Consultexpectation would assessment to be 6 months for Residuse of the antipsy. She also acknowles should have been assessment needs #29. 2a. Resident #41 to 10/31/18 with diag schizophrenia. A physician 's ord Aripiprazole (antip milligrams (mg) or	age 68 n completing her remote n regimen reviews in 2020. nsultant was asked if she had		756		ns. or ces w, rss, for st	
	assessment was of Resident #41 with The quarterly Minit assessment dated #41's cognition was assessed with had rejected care			Indicate how the facility plans to monitorits performance to make sure that solutions are sustained; The DON and/or the ADON will monitor x week for 4 weeks then weekly for 2 months, residents with new orders for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			1	C
NAME OF D	20//055 05 01/05/155	345177	D. WING _		ATREET APPREAD OUTV OTATE 7/D OODE	09	/20/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST I	REHAB & LIVING CENTER			05 RATTLESNAKE TRAIL		
				F	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC 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 756	Continued From page	age 69	F7	756			
	_	sident #41 was administered			psychoactive medications to assure Al	Ms	
		tic medication on 7 of 7 days.			has been completed when medication		
	' '	•			initiated , Behavior monitor with target		
	A review of Reside	ent #41 ' s current physician ' s			behavior and side effect monitoring		
	orders on 3/8/21 ir	ndicated the 4/10/19 order for			initiated, PRN psychoactive medication	1	
	Aripiprazole 15 mg	remained an active order.			has a stop date of 14 days.		
					The Administrator will audit completion		
		edication Administration			pharmacy recommendations monthly f	or 3	
		rom 1/29/20 through 3/8/21 t #41 was administered			months, to validate that pharmacy		
	Aripiprazole daily				recommendations, to include GDR□s have been completed within 30 days of		
	Anpiprazole dally a	as ordered.			receipt of recommendations.	1	
	A review of the ha	rd copy and Electronic Medical			The Administrator and DON will review	the	
		n 1/29/20 through 3/8/21			audits monthly to identify patterns/tren		
		assessment or any other			and will adjust the plan as necessary to		
	involuntary moven	nent assessment had not been			maintain compliance.		
	completed for Res	ident #41 since 1/28/20.			The Administrator and DON will review		
					plan during monthly QAPI and the aud		
		ence in Resident #41 ' s			will continue at the discretion of the QA	λPI	
		the Pharmacy Consultant			committee.		
		dressing that an AIMS other involuntary movement			Indicate dates when corrective action	azill	
		ot been completed for Resident			be completed; 4/8/21	VIII	
	#41 since 1/28/20.	•			so completed, 176721		
		s conducted on Resident #41					
		5 AM. There were no					
	involuntary moven	ienis observed.					
	An interview was o	conducted with the Director of					
		3/10/21 at 1:20 PM. She stated					
		normal process was to					
		sessments on admission and					
		hs thereafter for residents on					
		ication. The assessments were					
		MR under the assessment					
		ated the AIMS assessments					
		the admission nurse on					
	∣ admission and the	n by the floor nurses every 6					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING _				20/2021	
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,		
				20	05 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER			INEHURST, 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	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 756	Continued From page	e 70	F	756				
	Nurses (MDS Nurses out a calendar of MD due each month and floor nurses of when due. The most recent Resident #41 dated 1 the DON. The DON AIMS assessments of Resident #41. She record this issue of AIMS completed every 6 m may be a problem with completion of AIMS at #41 should have had completed since 1/28 she would have experience.	ON explained that the MDS #1 and MDS Nurse #2) put S assessments that were this was used to inform the an AIMS assessment was it AIMS assessment for /28/20 was reviewed with confirmed there were no ompleted after 1/28/20 for evealed she was not aware assessments not being onths. She indicated there the the facility 's protocol for issessments as Resident 2 AIMS assessments /20. The DON stated that ceted the Pharmacy and address the need for the be completed every 6						
	A phone interview was Pharmacy Consultant She stated that her expenses of AIMS assessments antipsychotic medical thereafter. The Pharmant it was important assessments for antip the potential side effect Resident #41's mos 1/28/20 was reviewed Consultant. Resident and MARs that indicate Aripiprazole daily from were reviewed with the She revealed she had	t on 3/10/21 at 3:25 PM. Expectation for the completion is was on initiation of an ition and every 6 months imacy Consultant explained ito complete routine AIMS cosychotic medications due to exts of the medications. It recent AIMS completed on its with the Pharmacy it #41 's physician 's orders						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 9/ 20/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		(3/20/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 756	explained that she b in May of 2020 and he reviews until January she thought the AIM hard chart so she was have reviewed the Acompleting her removering the reviews in 2 Consultant was asked completing a review residents on antipsystarted coming to the 2021 for her monthly reviews. She revealed completed a review her in person month reviews in 2021. The acknowledged that he been for an AIMS as minimum of every 6 to her extended use medication Aripipraze that a recommendation alert the facility the	Pharmacy Consultant egan working with the facility had been doing remote y 2021. She revealed that S assessments were in the as unaware that she could IMS assessments when the monthly medication 2020. The Pharmacy ed if she had begun for AIMS assessments for chotic medications when she es facility in person in January y medication regimen ed that she also had not for AIMS assessments during ly medication regimen e Pharmacy Consultant her expectation would have sessment to be completed a months for Resident #41 due	F 7	56				
	10/31/18 with multiple cerebral infarction w weakness on one side	s admitted to the facility on le diagnoses that included ith hemiparesis (muscle de of the body) and s on one side of the body)						
	9/25/19 indicated Ult	for Resident #41 dated rram (opioid pain medication) s needed for pain greater						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345177	B. WING			1	C 20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From pag	e 72	F	756			
	6/12/20 indicated Ult pain greater than 5 or for as need Ultram the for Resident #41 rem A pharmacy recommedated 12/2/20 completed Consultant indicated Administration Recorders for Ultram 50 instructions. The Pharmacy recommedated 12/2/20 completed the properties of the pharmacy recommedated 12/2/20 completed the properties of the pharmacy recommedated 12/2/20 completed the pharmacy recommedated 12/2/20 completed 12/2/20	d (MAR) showed 2 active mg with the same armacy Consultant wrote, plication, please discontinue rom her MAR". There was armacy recommendation sident #41 had been					
	#41's cognition was received PRN (as ne routine pain medicati frequently at a rating #41 was administere days. A pharmacy recomm dated 3/3/21 complete Consultant indicated from 12/2/20. The Pa duplicate order of Uthe MAR and she received iscontinued. There	14/21 indicated Resident moderately impaired. She eded) pain medications, no ons, and reported pain of 02 out of 10. Resident d opioid medication on 2 of 7 endation for Resident #41					
	A review of Resident	#41 's active physician 's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021		
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 007	20/2021	
				205 R	ATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			HURST, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From page	e 73	F 7	756				
	active orders for Ultra 50 milligrams (mg) Pl directions for adminis	d on 3/9/21 and revealed 2 am (opioid pain medication) RN (as needed) with same tration. One order was nd the other order was						
	Nursing (DON) on 3/2 stated that she received recommendations from by email. She indicated to nursing we during the morning me Monday through Fridated to and/or a reported that the recorresponded to and/or morning meeting and that same day. The proof of the form that same day. The proof of the form that same day is a	m the Pharmacy Consultant ted that recommendations are reviewed within the week seetings that were conducted any with herself, Unit and UM #2. The DON commendations were normally sected upon during the lor after the meeting during coharmacy recommendations and 12/2/20 and the repeat and 3/3/21 related to a stram 50 mg PRN were low. Resident #41 's active that revealed the duplicate and revealed the duplicate and revealed that she						
	PRN Ultram 50 mg non- She reported that Re- unit so she most likel person who was supp the Ultram 50 mg PR The DON stated that recommendation had reported that she exp	sident #41 was on UM #2's y would have been the cosed to discontinue one of N orders for Resident #41. the 3/3/21 pharmacy not yet been reviewed. She						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 9/20/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	312012021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 756	An interview was co 3/10/21 at 1:20 PM. recommendations for and the repeat recorrelated to a duplicate were reviewed with active physician 's of duplicate Ultram 50 place was reviewed that she could recall recommendations re PRN Ultram for Res A phone interview were physician to the indicated that she could recall recommendations to acted upon by the time regimen review. The recommendations for and the repeat recorrelated to a duplicate were reviewed with the She indicated that don 3/3/21 she realized recommendation from the repeat recorrelated that the she indicated that don 3/3/21 she realized recommendation from the she indicated that the she indicated that the she indicated that this was recommendation.	the Pharmacy Consultant 's ation regimen review. Inducted with UM #2 on The pharmacy or Resident #41 dated 12/2/20 mmendation dated 3/3/21 to order for Ultram 50 mg PRN UM #2. Resident #41 's orders that revealed the mg PRN order was still in with UM #2. UM #2 stated any pharmacy elated to a duplicate order for ident #41. Inducted with the matter of the matter of the responded to and/or me of her next monthly the pharmacy or Resident #41 dated 12/2/20 mmendation dated 3/3/21 to order for Ultram 50 mg PRN the Pharmacy Consultant. The previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20 to discontinue one orders for Ultram 50 mg PRN and the previous metal 12/2/20	F 7	756			
	11/14/19 and most r	admitted to the facility on ecently readmitted on 1/7/21 ses that included Alzheimer '					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE COMP	
		345177	B. WING			00/	20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CIT 205 RATTLESNAKE T PINEHURST, NC 2	RAIL	1 03/	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	s Disease. A physician 's order 1/8/21 indicated she care. A physician 's order 1/8/21 indicated Ativ 0.5 milligram (mg) ev (PRN). This PRN At no stop date. The significant changassessment dated 1, #40 's cognition was noted with a prognos was on hospice. Reantianxiety medication period. Pharmacy consultant dated 2/1/21 and 3/8 completed by the Phwere no recommend Resident #40 's PRI that was prescribed that was prescribed to The March 2021 action Resident #40 were revealed the 1/8/21 order continued to be A review of the Medi Records (MARs) from Resident #40 indicate administered.	for Resident #40 dated was admitted to hospice for Resident #40 dated an (antianxiety medication) very 1 hour as needed ivan physician 's order had ge Minimum Data Set (MDS) /13/21 indicated Resident severely impaired. She was sis of less than 6 months and sident #40 had received no on during the MDS review It medication regimen reviews st/21 for Resident #40 were armacy Consultant. There ations made related to N Ativan (initiated on 1/8/21) with no stop date. It we physician 's orders for eviewed on 3/9/21 and PRN Ativan physician 's eractive. Cation Administration m 1/8/21 through 3/9/21 for eed no PRN Ativan had been	F	756			
		as conducted with the 3/10/21 at 3:45 PM. He					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(×	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021	
NAME OF PR	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		00/20/2021	
THE GREE	ENS AT PINEHURST REI	AAR & LIVING CENTER		205 RATTLESNAKE TRAIL			
THE GILL	INS AT FINEHONST KEI	IAD & 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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 756	Continued From page stated he was aware PRN Ativan and other	that physician 's orders for	F 7	756			
	medications were req duration for all reside hospice. The PRN A	particularity payer of the limited in					
	reviewed with the Me	dical Director. He revealed cop date was an error. He					
	psychotropic medicat	ions were prescribed with a in accordance with the					
	She stated she was a orders for PRN Ativar psychotropic medicat time limited in duratio those on hospice. Torder dated 1/8/21 the Resident #40 was revenued at the dated 2/1/21 and 3/8/recommendations relevanced resident #40 were reconsultant. She revenued at the composition of t	t on 3/10/21 at 3:25 PM. aware that physician 's and other PRN ions were required to be on for all residents including he PRN Ativan physician 's at continued to be active for viewed with the Pharmacy lication regimen reviews					
	An interview was con Nursing (DON) on 3/2 stated she was aware required all PRN psyc time limited in duratio	for Resident #40 due to the date. ducted with the Director of 10/21 at 1:20 PM. The DON e of the regulation that chotropic medications to be on, but she had not realized d to residents on hospice.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345177	B. WING _			1	20/2021
NAME OF PI	ROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP (CODE	1 007	LO/2021
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 DEFICIENT	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 756	Continued From page	e 77	F 7	756			
	Consultant to identify	e expected the Pharmacy any issues such as this and dation to bring it the nursing attention.					
	4. Resident #18 was diagnosis of depressi	admitted on 4/2/18 with a on.					
	4/4/19 read Cymbalt	:18's Physician order dated a (antidepressant) delayed nilligrams every afternoon					
	4/15/19 read monitor	18's Physician order dated for behaviors and indicated s present please document every shift.					
	indicated she was co	num Data Set dated 1/15/21 gnitively intact and exhibited as coded for the use of an					
	read she was at risk thistory of depression	•					
	telehealth medication #18 indicated the followard followard for the followard for lab work the need for lab work	ndations ition completed regarding					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3372072021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 756	7/8/20-no recommenda //2020- recommenda //2020- recommenda //20-no recommenda //20-no recommenda //20-no recommenda //2020-no recommenda //2020-recommenda //2020-recommenda //2020-recommenda //2021- recommenda //2021- reco	of an anti-inflammatory endation completed regarding rk endation completed regarding rk endation endation endation dation for a gradual dose Melatonin (hormone) endation lation completed regarding the endation	F 7	56		
	notes indicated the 10/13/20-In good syreported a stable moncerns. No GDR decompensation. Be clinical indication for medications. 11/13/20-Conversational endorsed a starecommended due Benefits outweigh r	oirits, denies depression and ood. Staff reported no recommended due to risk of enefits outweigh risk and no r any GDR of psychiatric tional, appeared at baseline				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 9/20/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	3/20/2021	
(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 ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 756	2:17 PM, Resident # isolation unit for test She appeared in goreported no feelings boredom. She stated room but herself so In an interview on 3/ stated Resident #18 exhibited no signs of stated he had not obtained assumed it would be appetite or lack of all In an interview on 3/ Manager (UM) #1 st psychotropics should behaviors for the stated when the stated wellow in the stated of the state	ad interview on 03/08/21 at the talk was residing on the ing COVID-19 positive again. The positive again and spirits and engaging. She of sadness, isolation, or dishe enjoyed being in a spirit and she could have some privacy. 8/21 at 2:30 PM, Nurse #7 was in good spirits and fidepression. Nurse #7 poserved any evidence of the ving or worry. He stated the syes or no to her behaviors on the staff to look for but a crying, withdrawal, loss of the staff to personal hygiene.	F 7	756			
	Director of Nursing (Pharmacist complete	10/21 at 1:20 PM, the DON) stated the Consultant ed her medication reviews email her a pharmacy report					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	ODE	00.20.202	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 756	received the report printed a copy for address. There was Director at each not the Medical Direct times per week. How worden orders if new recommendations back in a folder for Medical Director dorecommendation, the recommendation, the recommendations regarding gradual missing targeted boursing recommendat	tions each month. Once she tand recommendations, she the Medical Director to is a folder for the Medical curse's station. The DON stated for came to the facility several event through the folder and eded and responded to the then put the recommendation filing. The DON stated if the id not agree with a he would write the rationale on on and put it back in the folder DN stated she expected the acist to make for the Medical Director dose reductions (GDRs) and ehaviors. She stated any idiations were addressed in the	F 7	756			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED
		345177	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 756	GDRs personally unantipsychotic. He stadifficult year because positive twice and ha Medical Director stata a GDR on her antide normalize. He stated behaviors to be iden behaviors to look for In an interview on 3/ stated it was her exp. Pharmacist identify t documentation and i recommendation reg. #18's antidepressant documented rational In a telephone intervithe Psychiatric Nursonot received any GD Consultant Pharmac prescribed Cymbalta informed her that the to address all recom there should be special GDR was contrained monitoring by the fact needed to be specificated. S. Resident #43 was cumulative diagnose Accident (CVA), Sch Disorder.	less the medication was an atted Resident #18 has had a se she tested COVID-19 as had to isolate twice. The led he would not recommend repressant until things he expected targeted tified so the staff knew what and document. 10/21 at 5:00 PM, the DON rectation that the Consultant he lack of targeted behavior dentify the need for a larding a GDR of Resident at unless contraindicated with the lack of targeted behavior dentify the need for a larding a GDR of Resident at unless contraindicated with the lack of targeted behavior dentify the need for a larding a GDR of Resident at unless contraindicated with the lack of targeted behavior dentify the practitioner stated she has a Recommendations from the list regarding Resident #18's and She stated the facility and Medical Director preferred mended GDRs. She stated cific documentation as to why dicated and the behaviors cility was too vague and	F	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245477	B WING			1	С
		345177	B. WING _			09/	/20/2021
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		205 R	ATTLESNAKE TRAIL		
0				PINE	HURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page	e 82	F 7	756			
	milligrams at bedtime Also included was an to monitor and indica occurred on every sh	for Paranoid Schizophrenia. order dated 2/5/20 for staff te yes or no if behaviors ift. If yes, please record narmacological interventions					
	(MDS) dated 1/18/21 cognitively intact and	erly Minimum Data Set indicated Resident #43 was exhibited rejection of care coded for the use of an					
	read she was at risk the use of antipsycho Schizophrenia and Bi included the completi Involuntary Movemen	polar Disorder. Interventions					
	Review of Resident # indicated the last AIM 1/29/20.						
	telehealth medication #43 indicated the follo 4/23/20-no recomment 5/12/20-no recomment	ndations ndations ed pain monitoring and igular dations dations dations ndations ndations ndations ndations					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 09/20/2021
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 756	notes indicated the 4/20/20-GDR not redecompensation. It clinical indication for medications. 6/3/20-Pleasant are thoughts, hallucing none. Current reges medication adjustro of decompensation or clinical indication medications. 9/11/20-Reported friends to talk toomaking symptoms emotions, gets uppercommendations. Benefits outweigh for any GDR of psy 10/9/20- Reported coping. GDR would decompensation. It is of decompensation in the deco	endations endations at #43's psychiatry telehealth e following: ecommended due to risk of Benefits outweigh risk and no or any GDR of psychiatric and friendly-no delusional ations, and mania. Staff report ime recommended. No ment recommended due to risk a. Benefits outweigh risk and on for any GDR of psychiatric and privacy, stressful, wanting reported isolation and lonely worse. Staff report occasional set easily-no new due to risk of decompensation. risk and no clinical indication ychiatric medications. improvements in mood and d result in risk of No GDR recommended due to ation. Benefits outweigh risk cation for any GDR of	F 7	756	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 09/20/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	09/20/2021
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 756	present indicated she ordered and no behaviors. In an observations and 10:51 AM, Resident # appeared pleasant, or There was no evidence reported her only conshowers. In an observation and 8:20 AM, Resident # 4 pleasant, cooperative no evidence of psychishower and had her had behaviors to document Resident # 43 exhibite and verbal behaviors. Unsure who complete assumed it was the M Managers (UM). In an interview on 3/1 Director of Nursing (D # 43 medical record dibehaviors. She stated electronic medical recorder for psychotropic actively working to fix.	43's medication (MARs) from 1/1/21 to received her Seroquel as viors exhibited. The MAR did ehaviors for staff were to dinterview on 3/8/21 at 43 was in bed. She coperative, and engaging. See of psychosis. She cern was regarding her dinterview on 3/10/21 at 3 was in bed. She appeared, and engaging. There was cosis She stated she got a mair washed yesterday. 10/21 at 8:30 AM, Nurse #1 of specify any target and the medical record but and agitation, short temper Nurse #1 stated she was defined the AIMS assessment but IDS Nurses or the Unit 10/21 at 11:53 AM, the 10/21 a	F7	56	
		s completed Resident #43's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/20/2021	
				205 RATTLESNAKE TRAIL			
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 756	Continued From page	÷ 85	F 7	756			
F 756	AIMS every 6 months MDS Nurse would give assessments due and needed to be completed MDS Nurse left some stated the current MD on the list. He stated record set up would be was due. UM #1 stated specify targeted behave regarding the use of a when an order for any into the electronic metemplate populated for UM #1 stated an AIM use of an antipsychot regarding the need to GDR unless it was continued in the consultant stated the Consultant	the stated the previous of the him a list of MDS of would indicate if an AIMS of the and that the previous time in December 2020. He are Solved Nurse's did not specify it the old electronic medical of the staff know when an AIMS of the medical record should viors for Resident #43 on antipsychotic. He stated of psychotropics was entered dical record, a generic or only yes or no responses. Solved, target behaviors for the ic and documentation evaluate the need for a contraindicated.	F 7	756			
	a pharmacy report an month. Once she recorrecommendations, she Medical Director to act for the Medical Director. The DON stated the Macility several times put through the folder and responded to the recorrecommendation back DON stated if the Mewith a recommendation rationale on the recorring the folder to be filled expected the Consult recommendations for	de printed a copy for the didress. There was a folder or at each nurse's station. Medical Director came to the per week and he went di wrote orders if needed and commendations then put the k in a folder for filing. The dical Director did not agree on, he would write the numendation and put it back did. The DON stated she ant Pharmacist to make					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			(С
		345177	B. WING			09/	20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	REHAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE S RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	AIMS assessment. recommendations meetings. The DOI on admission and the of MDS assessment floor completed the does not have any nurses that an AIM she was unaware that the Abeing done. The Deexpectation that the identified the need Resident #43, iden Seroquel been add #43 targeted behave antipsychotic. In an interview on 3 Nurse #2 stated she calendar with all of given to the UM's. In an interview on 3 Nurse #1 confirmed that indicated they AIMS assessments they gave to the UI information on what due.	chaviors and the need for an She stated any nursing were addressed in the morning N stated the AIMS protocol was every 6 months thereafter. e did the baseline AIMS on the MDS Nurses put out a list at due and the nurses on the AIMS. She said the system automatic prompt to alert the S was due. The DON stated that Resident #43's last AIMS completed on 1/29/20 and was IMS assessments were not ON stated it was her e Consultant Pharmacist for an AIMS assessment on tified the need for a GDR in Iressed and identified Resident viors for the use of an AIMS assessments was at the MDS assessments was and that the monthly calendar M's did not included any at AIMS assessments were	F	756			
		rview on 3/10/21 at 3:20 PM,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _		0	C 9/ 20/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		9/20/2021		
(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 C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 756	stated she did not revered for the need of was not aware where in the electronic med. Pharmacist stated she May 2020 and noted been addressed sinch had planned to addressed for targeted being April 2021. She staneed for targeted being psychotropics but known adverse side effects. In a telephone interviting the Medical Director of GDRs personally unleantipsychotic then he stated Resident #43 hallucinations and was and talk to people who Director stated he has recommendations regulated it was her expendication of special linear interview on 3/1 stated it was her expendication, identification of regulations and was and talk to people who in the proposed in an interview on 3/1 stated it was her expendication of special linear interview on 3/1 stated it was her expendication, identification regulation, identification of special linear interview on 3/1 stated it was her expendication, identification of special linear interview on 3/1 stated it was her expendication, identification regulations. She was a stated in the proposed for th	20. She stated the MS assessment on 6 months thereafter. She view Resident #43' medical f an AIMS assessment and the AIMS were documented ical record. The Consultant the started at the facility in no GDR on Seroquel had the 4/2019. She stated she these Resident #43's Seroquel that she was unaware of the the that it is the stated she that it is the stated she that is seroquel that the facility looked for and of the facility looked for and of the stated she that is seroquel that the she was unaware of the that is seroquel that the she was unaware of the that is seroquel that the facility looked for and the facility looked for and the facility looked for the stated he handled all the the sess the medication was an the differed to Psychiatry. He the experienced auditory, visual that shown to often yell out the oweren't there. The Medical do not received any the garding Resident #43's the property of the poon that the consultant the lack of targeted behavior	F 7	756				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345177	B. WING		0	C 9/ 20/2021
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		57207202 T
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 756	the Psychiatric Nur not received any G Consultant Pharma prescribed Seroque informed her that the to address all recon her understanding attempted due to F Schizophrenia. She Pharmacist should specific documenta contraindicated, the	rview on 3/11/21 at 1:40 PM, see Practitioner stated she has DR recommendations from the acist regarding Resident #43' el. She stated the facility ne Medical Director preferred mmended GDRs and it was that a GDR could not be desident #43's diagnosis of e stated the Consultant have identified the need for ation as to why a GDR was	F 7	56		
	6. Resident # 66 w 10/9/20 with multip Hypertension and a Resident # 66 had for Sotalol (used to 40 milligrams (mgs Review of Residen they were frequent	a doctor's order dated 2/21/21 treat heart rhythm problems) .) daily for atrial fibrillation. t #66's pulse rate revealed that ly below 50's. The following				
	were Resident #66 electronic vital sign 12/7/20 at 3:36 AM 12/24/20 at 12:06 A 1/25/21 at 2:36 PM 2/1/21 at 7:30 AM 2/3/21 at 7:30 AM - 49 per minute	's pulse rate recorded on the s and/or progress notes: - 46 per minute AM - 48 per minute - 48 per minute				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION		ATE SURVEY DMPLETED
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NAME OF PROVIDER OR SUPE		HAB & LIVING CENTER	'	:	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
PRÉFIX (EACH D	EFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROLEMENCY)	D BE	(X5) COMPLETION DATE
On 1/7/21, the conducted a con	M - 46 0 AM a PM - 4 Pharr lrug reg ecomn ings w le low s doctor a Reco ere reg ereadi 1:20 F terview nsultar w remo onsultar w remo onsultar w receiv em out doctor a weel ponded the do a weel ponded the do a receiv em out doctor a the do a weel ponded the do a receiv em out doctor a weel ponded the do a receiv em out doctor a the do a receiv em out doctor a the do a serview a	per minute and 7:48 PM - 45 per minute	F	756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			l	C 20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 RA	TADDRESS, CITY, STATE, ZIP CODE TTLESNAKE TRAIL URST, NC 28374	1 00,	20/2021
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	to the facility in Janua she expected the face recommendation with when she started cornot seen any of her resident's medical recommendation. On 3/10/21 at 3:45 Printerviewed. The Phypharmacist's recomming his stack at each in them up and address brought them back the them in the DON's of The Physician added the recommendations there were recommended with the Don's Pharmacy Consulton for Resident #66 to head of the Pharmacy Cons	nonthly drug regimen 020 and just started coming ary 2021. She indicated that ility to respond to her inin 30 days. She added that ning to the facility, she had ecommendations in the cords. M, the Physician was ysician stated that the hendation forms were placed urse's station. He picked ded them on Saturdays and e following week. He placed fice or Unit Manager's office. that he had responded to so that he had received and if indations that were not received them. M, a follow up interview was ON. The DON verified that litant had a recommendation ave hold order for the 21. She stated that she	F	756			
		s admitted to the facility on e diagnoses including					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345177	B. WING_			C 9/ 20/2021	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	(3/20/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	(MDS) assessment Resident #3 had seven he had received an assessment period. Resident #3 had a differ for Risperdal (an animilligrams (mgs.) by disorder and on 1/27 bedtime for schizoph Review of Resident revealed that the Ab Scale (AIMS) test or System Condensed not completed since psychotropic drug accompleted since psychotropic drug accompleted. On 3/10/21 at 1:20 F (DON) was interview she expected the Precommendation for completed. On 3/10/21 at 3:25 F was interviewed. The had been doing her reviews remotely into the facility in Januaresidents on antipsy test or DISCUS completed that AIMS thard copy chart so scompleted AIMS tester as a second pleted AIMS tester as a	quarterly Minimum data Set dated 2/25/21 indicated that vere cognitive impairment and antipsychotic drug during the octor's order dated 11/21/20 tipsychotic drug) 0.5 mouth daily for bipolar 7/21 for Risperdal 1 mgs at nerenia. #3's medical records normal Involuntary Movement Dyskinesia Identification User Scale (DISCUS) was admission to monitor for the diverse reaction. PM, the Director of Nursing yed. The DON indicated that narmacy Consultant to make the AIMS test to be PM, the Pharmacy Consultant the Consultant stated that she monthly drug regimen 2020 and just started coming lary 2021. She indicated that chotic drug should have AIMS	F 7	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING		09/20/2	N21
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY 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 COM	(X5) MPLETION DATE
F 756	different places and fithey were documented. The Consultant report reviewing for the need started coming to the to review them next in the Consultant report of the total review them next in the Consultant of the total review them next in the Consultant of the Cons	SCUS documented in for some reason she thought ed in the hard copy chart. It ted that she had not been dof AIMS test since she facility, but she would start month. M, a follow up interview was fon. The DON stated that chotic drug should have an Scompleted on admission on this. She verified that have an AIMS test nor on admission. She explained were supposed to notify the MS test was due and the se supposed to complete an	F 75	56		
	schizophrenia. The of (MDS) assessment of Resident #3 had seven he had received an atthe assessment period. Resident #3 had a dof for Sertraline 50 milling and on 11/20/20 for Hot by mouth every 6 hot. Resident #3's drug repharmacy Consultant.	quarterly Minimum data Set lated 2/25/21 indicated that ere cognitive impairment and intidepressant drug during od. Octor's order dated 11/21/20 grams (mgs) by mouth daily hydroxyzine 25 mgs 1 tablet urs as needed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION	\ , ,	TE SURVEY MPLETED
		345177	B. WING _		0	C 9/20/2021
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3/20/2021
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 756	revealed that the S did not have approximate of the Consult regimen review rerecommendations that once she printed them of folder for the doctor explained that the several times a we folder and responded placed the forms be nurse's station for during the COVID the doctor was not placed the folder in doctor or his Physithem up and brougafter. On 3/10/21 at 3:25 was interviewed. In the facility in Jar she expected the folder in the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the folder when she started to the facility in Jar she expected the facility in Jar she expect	lydroxyzine. It #3's medical records sertraline and the Hydroxyzine priate diagnosis for its use. It PM, the Director of Nursing ewed. She stated that the ant was completing the drug motely until this month (March Itant was sending the via email. The DON added ived the recommendations, ut and placed them in the or to address. The DON further doctor comes to the building ek and he went through the led to the recommendations. It to the recommendations, he ack in the folder at each filling. The DON reported that outbreak in December 2020, coming to the facility. She in the office at the lobby and the cian Assistant (PA) would pick ght them back off the week I PM, the Pharmacy Consultant The Consultant stated that she is monthly drug regimen in 2020 and just started coming muary 2021. She indicated that accility to respond to her vithin 30 days. She added that coming to the facility, she had it recommendations in the	F7	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 19/20/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO. 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		312012021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	interviewed. The Ph pharmacist's recomm in his stack at each r them up and address brought them back them in the DON's of The Physician added the recommendation there were recommended addressed, he never On 3/10/21 at 3:55 P conducted with the E the Pharmacy Consulter for Resident #3 to hat the Sertraline and the that she didn't know recommendation form not addressed. The was an issue, so she correction. She wou pharmacist recommendation for not addressed. The was an issue, so she correction. She wou pharmacist recommendation for and 1 copy foverify if the recommendation and 1 copy foverify if the recommendation. 8) Resident #31 was 5/22/20 with diagnost dementia with behave schizophrenia. An Abnormal Involunt assessment was con Resident #31. The quarterly Minimulassessment dated 1/#31's cognition was a service of the pharmacist recommendation for any service of the pharmacist recommendation and the pharmaci	M, the Physician was ysician stated that the nendation forms were placed aurse's station. He picked sed them on Saturdays and the following week. He placed ffice or Unit Manager's office. I that he had responded to so that he had received and if andations that were not received them. M, a follow up interview was nown a diagnosis for the use of the Hydroxyzine. She stated what happened to the m, but she verified that it was DON added that she knew it the already had a plan of a plan of the modation, a copy for the modation, a copy for the modations were addressed or admitted to the facility on the est that included vascular ior disturbance and the tary Movement Scale (AIMS) inpleted on 5/22/20 for	F 7	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING				20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 F	EET ADDRESS, CITY, STATE, ZIP CODE RATTLESNAKE TRAIL EHURST, NC 28374	1 00	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	A review of the curre indicated an order for antipsychotic medicate a day, had remained admission date of 5/2. A review of the hard record from 5/22/20 assessment or any cassessment had not #31 since 5/22/20. There was no evider record of the Pharma and addressing that other involuntary mobeen completed for ID During an interview of (DON) on 3/10/21 at facility's normal procental AIMS assessment of months for residents medications. She incompleted for ID assessment was cornurse at the time of a floor nurses every 6 of the MDS assessment the MDS Nurses put	nt physician orders on 3/9/21 r Risperidone Solution (an active) 2 milligrams (mg) twice active since Resident #31's 22/20. copy and electronic medical to 3/10/21 revealed an AIMS other involuntary movement been completed for Resident acy Consultant identifying an AIMS assessment or any electronic medical acy Consultant identifying an AIMS assessment or any electronic medical acy Consultant identifying an AIMS assessment or any electronic medical acy Consultant identifying an AIMS assessment or any electronic material since 5/22/20. With the Director of Nursing 1:20 PM, she stated the eless was to complete an admission and then every 6 on antipsychotic dicated the initial AIMS inpleted by the admitting admission and then by the months with coinciding dates tent. The DON further stated out a calendar of MDS ch month and this was used reses when an AIMS	F	756			
	Pharmacy Consultar stated her expectation	as completed with the at on 3/10/21 at 3:25 PM. She on for the completion of AIMS anitiation of an antipsychotic					

CENTER	3 FOR MEDICARE 8	CIVIEDICAID SERVICES				OIVID IV	<u> </u>
, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		345177	B. WING			09/	/20/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
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THE GIVE	LNO AT FINEHOROT RE	TIAD & LIVING CENTER		PI	INEHURST, NC 28374		
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IAG	THEODE THO THE	(Lee is Livin Fine in Gram then)	IAG		DEFICIENCY)	, <u>_</u>	
F 756	Continued From pag		F	756			
	I .	every 6 months. The					
	_	nt explained it was important					
	to complete routine	AIMS assessments for					
	antipsychotic medica	ations due to the potential					
	side effects the med	ication could cause. Resident					
	#31's most recent Al	IMS, completed on 5/22/20,					
	was reviewed with the	ne Pharmacy Consultant as					
	well as the physiciar	n's orders and MAR's from					
	5/22/20 through 3/9/	21 that indicated Resident					
	#31 received Risper	idone twice a day. She					
	confirmed she had n	not identified an AIMS					
	assessment had not	been completed since					
	I .	t #31. The Pharmacy					
	I .	tated she began working at					
		020 and had been doing					
	I .	January 2021. She thought					
		nts were in the hard chart so					
		ne could have reviewed the					
	I .	when completing her remote					
	_	regimen reviews in 2020.					
	1	sultant further revealed she					
	had not completed a						
		her in-person monthly					
	_	reviews in 2021 either. The					
	,	nt acknowledged her					
	· ·	ave been for an AIMS					
		ompleted a minimum of every ent #31 due to her use of the					
	1	ation Risperidone. She also should have initiated a					
	_	erting the facility an AIMS					
		eded for Resident #31.					
	0 0/40/6/ / / == =	na di Boni, di ci ci					
	I .	PM, the DON indicated she					
	I .	ent #31's hard copy and					
		ecord and confirmed there					
		sment completed since					
		expressed she was not aware					
	of the issue of AIMS	assessments not being					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C / 20/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		D BE	(X5) COMPLETION DATE	
F 756	she expected the Pha and address the need be completed every 6 antipsychotic medical	onths. She further stated armacy Consultant to identify d for AIMS assessments to 6 months for residents on tions.		756		4/0/04	
F 758 SS=E	CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(c)(3) A psyc affects brain activities processes and behave		F	758		4/8/21	
	resident, the facility in §483.45(e)(1) Reside psychotropic drugs a unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in and drugs; §483.45(e)(3) Reside psychotropic drugs punless that medication	ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic all dose reductions, and ons, unless clinically in effort to discontinue these					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	20/2021	
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THE OILE	ENO ATTINETIONOT NE	HAD & EIVING GENTER		PI	INEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Continued From pag in the clinical record;		F7	758				
	§483.45(e)(4) PRN of are limited to 14 days §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he rationale in the residindicate the duration §483.45(e)(5) PRN of drugs are limited to renewed unless the appropriateness. This REQUIREMENT by: Based on record revinterviews with staff, Medical Director, the residents on antipsydabnormal involuntary (Residents #3, #18, failed to identify target to monitor those sym#43), failed to evaluate medications for gradd (Resident #18), and needed) psychotropi limited in duration (Rof 9 residents whose The findings included 1. Resident #29 was 11/2/16 with multiple	arders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. Arders for anti-psychotic A days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced Ariew, observation, and Pharmacy Consultant, and facility failed to assess chotic medication for a movement disorders Ariey, #31, #41, and #43), et behavioral symptoms and aptoms (Residents #18 and the residents on psychotropic ual dose reductions failed to ensure PRN (as a medications were time esident #40). This was for 7 medications were reviewed. d: admitted to the facility on diagnoses that included			F 758 A total of 6 Abnormal Involuntary Movement Scales (AIMS) were not up date at the time of survey and a total or residents did not have target behaviors identified at the time of survey. Adjustments were made for those residents found to have been affected the deficient practice as follows; 1 Resident #29 s antipsychotic medicati was discontinued on 2/27/21, so theref an Abnormal Involuntary Movement Sc (AIMS) assessment is not required at ti time. 2- a) The licensed nurse completed a AIMS assessment for Resident #41 on 3/10/21. b) The licensed nurse discontinued the	f 9 by on ore ale his		
	disturbance.	ementia without behavioral			duplicate Ultram order on 3/10/21. 3- The licensed nurse received a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		9/20/2021	
				205 RATTLESNAKE TRAIL	_		
THE GREE	NS 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From pag	ne 99	F 7	58			
	An Abnormal Involunassessment was cor Resident #29 with a movements identified A physician 's order Seroquel (antipsychology) once daily for Four The quarterly Minimulassessment dated 1 was rarely/never und with no behavioral sycare on 1 to 3 days of period. Resident #29 antipsychotic medical A physician 's order Resident #29 had a fethe dose from 50 mg daily. The quarterly MDS a indicated Resident #	ntary Movement Scale (AIMS) impleted on 12/1/19 for score of 0 (no involuntary id). dated 4/5/20 indicated otic medication) 50 milligrams Resident #29. Jam Data Set (MDS) Jam Data Se		physician order on 3/10/21, to the Ativan order for Resident 3/4-The physician did not initiate Dose Reduction (GDR) of Residents antidepressant at this residents current health condibehavior monitor was updated to monitor for signs of depress The licensed nurse completed assessment for Resident #43. The Behavior monitor was updinclude target behaviors on 3/physician did not initiate a GD time, due to risks vs benefit reresidents diagnosis. 6- a) The licensed nurse con AIM assessment for Resident 3/10/21. b) Sertraline and Hydroxyzine diagnosis included with the orfor Resident #3 but was not put the EMAR. The licensed nurse the orders on 3/25/21 and the are showing on the Resident #8- The licensed nurse con the sident and the showing on the Resident and the showing on the Resident #8- The licensed nurse con the sident and the showing on the Resident #8- The licensed nurse con the sident #8-	#40. e a Gradual sident time, due to tion. The d on 3/19/21, sion. 5- d an AIMS on 3/10/21. dated to 21/21. The R at this elated to the mpleted an #3 on had iginal order ulling over to se updated diagnosis #3 □s EMAR. mpleted an		
	impaired. She had no behavioral symptoms, but she had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days.			AlMs assessment for Resider 3/10/21. Address how the facility will id	nt #31 on		
	A physician 's order Resident #29 's Ser A review of the Medi Records (MARs) from	dated 2/27/21 indicated oquel was discontinued. cation Administration m 12/2/19 through 2/27/21 i29 was administered dered.		residents having the potential affected by the same deficient Current facility residents have potential to be affected by the deficient practice of failure to residents on antipsychotic me abnormal involuntary movemed disorders, identify target behamonitor those symptoms, ens	to be t practice; the alleged assess dication for ent viors and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD		9/20/2021	
TO UNIC OF TH	TO VIDER OR GOLL EIER			205 RATTLESNAKE TRAIL	, <u> </u>		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	Continued From page	e 100	F 7	58			
1 750	A review of the hard Record (EMR) from a revealed an AIMS as involuntary movemer completed for Reside. An observation was con 3/8/21 at 12:30 Pl involuntary movemer. An interview was con Nursing (DON) on 3/ stated that the facility complete AIMS asset then every 6 months antipsychotic medical completed in the EMI section. She indicate were completed by the admission and then be months with coinciding assessments. The Discovery of MDS Nurse out a calendar of MD due each month and floor nurses of when due. The most recer Resident #29 dated at the DON. The DON AIMS assessments of Resident #29. She red finis issue of AIMS completed every 6 m may be a problem will completion of AIMS at #29 should have had	copy and Electronic Medical 1/1/20 through 3/8/21 sessment or any other at assessment had not been ent #29 since 12/1/19. conducted of Resident #29 M. There were no at observed. ducted with the Director of 10/21 at 1:20 PM. She at some and sission and thereafter for residents on tion. The assessments were R under the assessment end the AIMS assessments are admission nurse on by the floor nurses every 6 and dates of the MDS assessment was at AIMS assessment for 12/1/19 was reviewed with confirmed there were no completed after 12/1/19 for evealed she was not aware assessments as Resident 2 AIMS assessments.		psychotropic medications are in duration, evaluate resident psychotropic medications for reduction and act upon pharm recommendations. The Director of Nursing (DON Assistant Director of Nursing completed an audit on 3/10/2 facility residents with orders fantipsychotic medications to an AIMs had been completed last 6 months. All AIMs asse were up to date by 3/10/21. On 3/21/21, the DON and AD completed updating behavior include target behaviors for receive psychoactive medicaresidents were identified as not target behaviors. On 3/10/21 the DON and AD completed an audit of PRN pemedications to assure there and ates and reassessment of usersidents were identified as not stop dates. On 3/9/21, the pharmacist conduction audit of current facility resident receive psychotropic medicates and recommendations for 3 have gradual dose reductions. On 3/25/21, the DON complete pharmacy recommendations received for February and Market Address what measures will a Addre	gradual dose nacy N) and (ADON) 1, of current for validate that within the saments ON monitors to esidents that tions. 9 not having ON sychoactive are stop se. 3 not having mpleted an into that tions and a residents to s. ted that were arch 2021.		
	completed since 12/1 An interview was cor	r/19. Iducted with MDS Nurse #2		place or systemic changes m ensure that the deficient prac recur;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	343177	1		TREET ADDRESS, CITY, STATE, ZIP CODE	08)/20/2021
NAME OF PR	ROVIDER OR SUPPLIER						
THE GREE	NS AT PINEHURST REI	HAB & LIVING CENTER		2	05 RATTLESNAKE TRAIL		
				Р	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	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	e 101	F 7	758			
	on 3/10/21 at 2:28 PM	M. She was asked what			When a resident has a physician order	for	
		to let staff know when an			an antipsychotic medication, the licens		
		as due. She stated that she			nurse will complete an AIMs assessme		
		ompleted no tasks related to			Physicians orders and including new		
		its. She reported that each			admissions will be reviewed daily at		
	month a calendar wit				morning clinical meeting The assessm	ent	
		re due was given to Unit			will be updated at least every 6 months		
		: Manager #2. MDS Nurse			with Minimum Data Set (MDS) Nurse	,	
	•	calendar had not included			tracking and scheduling AIMS.		
		hat AIMS assessments were			and boriodaling / livio.		
	due.	nat, and acceptione were			The licensed nurse will implement a		
	ddo.				behavior monitor in the electronic med	cal	
	An interview was con	ducted with MDS Nurse #1			record to include resident targeted		
		M. She confirmed MDS			behaviors and side effect monitoring e	/erv	
		v that indicated they had no			shift.	,	
		AIMS assessments and that			When a PRN psychoactive medication	is	
	the monthly calendar				ordered, the order will include a 14 day		
		cluded any information on			time limit, and the physician will reasse		
	what AIMS assessme	<u>-</u>			for continued use.		
					The pharmacist will complete monthly		
	A phone interview wa	as conducted with the			audits of resident medication and will		
		t on 3/10/21 at 3:25 PM.			make recommendations to the physicia	an	
		xpectation for the completion			regarding gradual dosage reduction. T		
		s was on initiation of an			pharmacist will validate monthly if a GI		
	antipsychotic medica	tion and every 6 months			was completed and if not, will follow up		
		macy Consultant explained			with the DON and physician to assure		
		to complete routine AIMS			proper documentation is completed to		
		psychotic medications due to			support.		
		ects of the medications.			When the DON receives the Pharmacy	,	
					recommendations monthly, she will		
	During a follow up int	erview with the DON on			provide copies to the physician and		
	3/10/21 at 3:55 PM s	he revealed that the MDS			nurses for follow up of recommendation	ns.	
	Nurses were unaware	e that they were responsible			A copy of the recommendations will be		
	for notifying the floor	•			kept in a folder and the DON will monit		
	assessments were du	ue. She indicated it was her			and validate follow through of		
	expectation that AIMS	S assessments be			recommendations within 30 days of		
	completed for all resi	dents on antipsychotic			receipt of recommendations.		
		ssion and every 6 months			The Regional Director of Clinical Servi	ces	
	thereafter. She further				provided education to the DON on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			0:	C 9/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET AL	DDRESS, CITY, STATE, ZIP CODE	1	00	
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(X4) ID PREFIX TAG			ID PREFI) TAG			BE	(X5) COMPLETION DATE	
F 758	Continued From pag	e 102	F 7	58				
	nurses when the AIM	lurses to notify the floor IS assessments were due were then to complete an the EMR.		psych and s time l and p recor	/21, regarding drug regimen rev hoactive med monitoring, behav side effect monitoring, GDR prod limit for psychoactive medication process for pharmacy mmendation follow through. DON provided education to the	ior cess,		
	2. Resident #41 was 10/31/18 with diagnoschizophrenia.	admitted to the facility on oses that included		physi regim monit	ician on 3/25/21, regarding drug nen review, psychoactive med itoring, behavior and side effect itoring, and process/documentat			
	Aripiprazole (antipsy	physician 's order dated 4/10/19 for ripiprazole (antipsychotic medication) 15 nilligrams (mg) once daily in the morning.		regar psych psych	rding gradual dose reductions of hoactive medication and time lin hoactive medications. Pharmacy manager provided	:		
		ntary Movement Scale (AIMS) npleted on 1/28/20 for score of 1.0.		educa regar monit	ration on 3/24/21, for the pharma rding regulations related to AIM I itoring, GDR process and imentation requirements, time lin	s		
	#41 's cognition was was assessed with n had rejected care on	um Data Set (MDS) /14/21 indicated Resident s moderately impaired. She to behavioral symptoms, but 1 to 3 days during the MDS dent #41 was administered		PRN up fo	psychoactive medications and for recommendations that are give acility.	ollow		
		medication on 7 of 7 days.			ate how the facility plans to monerformance to make sure that	itor		
	orders on 3/8/21 indi	#41 's current physician 's icated the 4/10/19 order for emained an active order.		soluti The I x wee	ions are sustained; DON and/or the ADON will moni ek for 4 weeks then weekly for 2 ths, residents with new orders fo	!		
	Records (MARs) from	cation Administration m 1/29/20 through 3/8/21 41 was administered ordered.		psych has b initiat beha	hoactive medications to assure to be completed when medication ted, Behavior monitor with target wior and side effect monitoring ted, PRN psychoactive medications.	AIMs n et		
	Record (EMR) from	copy and Electronic Medical 1/29/20 through 3/8/21 ssessment or any other		has a	a stop date of 14 days. Administrator will audit completion macy recommendations monthly	on of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	C 20/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2021	
				2	05 RATTLESNAKE TRAIL			
THE GREI	ENS AT PINEHURST REF	1AB & LIVING CENTER			PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Continued From page	e 103	F 7	758				
	involuntary movemen completed for Reside	t assessment had not been nt #41 since 1/28/20.			months, to validate that pharmacy recommendations, to include GDR□s have been completed within 30 days o			
	An observation was on 3/10/21 at 11:45 A involuntary movemen				receipt of recommendations. The Administrator and DON will review audits to identify patterns/trends and wadjust the plan to maintain compliance	the		
	Nursing (DON) on 3/2 that the facility 's nor complete AIMS assess then every 6 months antipsychotic medical completed in the EMF section. She indicate were completed by the admission and then be months with coinciding assessments. The Discourses (MDS Nurses out a calendar of MDS)	ssments on admission and thereafter for residents on tion. The assessments were a under the assessment and the AIMS assessments are admission nurse on by the floor nurses every 6			The Administrator and DON will review plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action when be completed; 4/8/21	the		
	floor nurses of when a due. The most recent Resident #41 dated 1 the DON. The DON of AIMS assessments or Resident #41. She resofthis issue of AIMS completed every 6 may be a problem with completion of AIMS at #41 should have had completed since 1/28. An interview was conton 3/10/21 at 2:28 PM protocol they utilized.	an AIMS assessment was t AIMS assessment for /28/20 was reviewed with confirmed there were no ompleted after 1/28/20 for evealed she was not aware assessments not being onths. She indicated there the the facility 's protocol for ssessments as Resident 2 AIMS assessments						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING _				C 20/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 R	ET ADDRESS, CITY, STATE, ZIP CODE ATTLESNAKE TRAIL HURST, NC 28374	1 00	20/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 758	the AIMS assessme month a calendar with assessments that we manager #1 and Un #2 indicated that this any information on vidue. An interview was coon 3/10/21 at 2:30 P Nurse #2's intervier involvement with the the monthly calenda Managers had not in what AIMS assessments were unawa for notifying the floor assessments were expectation that AIM completed for all resemedications on admithereafter. She furth expected the MDS Nurses when the AIM and the floor nurses AIMS assessment in 3. Resident #40 was	completed no tasks related to ints. She reported that each th all of the MDS ere due was given to Unit it Manager #2. MDS Nurse is calendar had not included what AIMS assessments were inducted with MDS Nurse #1 PM. She confirmed MDS is with the tindicated they had no each AIMS assessments and that in they give to the Unit included any information on itents were due. Interview with the DON on the revealed that the MDS is that they were responsible in nurses when AIMS is assessments be idented in and every 6 months in indicated that she ind	F	758					
	s Disease.	ses that included Alzheimer ' for Resident #40 dated							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345177	B. WING _		0	C 9/20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST F	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758	A physician 's orda 1/8/21 indicated At 0.5 milligram (mg) (PRN). This PRN no stop date. This Electronic Medical The significant cha assessment dated #40 's cognition w noted with a progn was on hospice. Fantianxiety medical period. The March 2021 at Resident #40 were revealed the 1/8/2 order continued to A review of the Me Records (MARs) fr Resident #40 indicadministered. An interview was completed the 3/10/21 at 11:30 At Resident #40 initiat that was entered in reviewed. She was the regulations related that she was regulation related to the store of the	er for Resident #40 dated ivan (antianxiety medication) every 1 hour as needed Ativan physician 's order had order was entered into the Record (EMR) by Nurse #6. Inge Minimum Data Set (MDS) 1/13/21 indicated Resident as severely impaired. She was osis of less than 6 months and Resident #40 had received no tion during the MDS review ective physician 's orders for a reviewed on 3/9/21 and 1 PRN Ativan physician 's	F7	758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 19/20/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	, ,	W/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 758	Nursing (DON) on stated she was aw required all PRN p time limited in dura this regulation app She reported that i regulations to be for A phone interview Medical Director of stated he was awa PRN Ativan and ot medications were duration for all resi hospice. The PRN initiated on 1/8/21 reviewed with the I that not including a indicated he had b psychotropic medicates.	onducted with the Director of 3/10/21 at 1:20 PM. The DON are of the regulation that sychotropic medications to be tion, but she had not realized lied to residents on hospice. t was her expectation for the	F 75	58			
	diagnosis of depre Review of Resider 4/4/19 read Cymba release particles 3 for depression. Review of Resider 4/15/19 read monit yes or no. If behav in the medical reco	as admitted on 4/2/18 with a ssion. It #18's Physician order dated alta (antidepressant) delayed 0 milligrams every afternoon It #18's Physician order dated for for behaviors and indicated iors present, please document ord every shift. The order did geted behaviors for staff to be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45477	D WING				С	
		345177	B. WING _			09/	20/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
THE GREI	NS AT PINEHLIRST F	REHAB & LIVING CENTER		205 F	RATTLESNAKE TRAIL			
THE OILE	INO ALL INCLIONOTI	CEIAB & EIVING GENTER		PINE	HURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 758	Continued From pa	age 107	F	758				
	indicated she was no behaviors. She antidepressant. Resident #18's rev read she was at ris history of depressing plan dated 2/14/21 risk for adverse eff medication for dep Review of the Contelehealth medicati #18 indicated the full 4/23/20-no recomment the need for lab wo 6/10/20-recomment the continued use 7/8/20-no recomment he med for lab wo 9/1/20-no recomment need for lab wo 9/1/20	sultant Pharmacist monthly ion review notes for Resident collowing: nendations idation completed regarding ork idation completed regarding of an anti-inflammatory endation endation completed regarding ork endation endation nendation inendation idation for a gradual dose f Melatonin (hormone)						
	need for lab work 3/8/21-no recommon Review of Residen 1/1/21 to present d documentation of b	t 18's nursing notes from id not include any						
	Review of Residen	t #18's medication						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	345177	B. WING		C 09/20/2021
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB	& LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03/20/2021
PREFIX (EACH DEFICIENCY MU	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 758 Continued From page 108 administration records (M present indicated she recordered and no behaviors not list any targeted behamonitor. Review of Resident #18's notes indicated the follow 10/13/20-In good spirits, oreported a stable mood. Sconcerns. No GDR recordecompensation. Benefits clinical indication for any medications. 11/13/20-Conversational, and endorsed a stable morecommended due to risk Benefits outweigh risk and for any GDR of psychiatric. In an observation and inte 2:17 PM, Resident #18 as and engaging. She report sadness, isolation, or bordenjoyed being in a room behave some privacy. In an interview on 3/8/21 stated Resident #18 was exhibited no signs of deprenjoyed having a room to isolation. Nurse #7 stated any evidence of sadness He stated the nurses dood her behaviors on every shather was no specific behastaff to look for but assum withdrawal, loss of appetit	ARs) from 1/1/21 to elived her Cymbalta as exhibited. The MAR did viors for staff were to a psychiatric telehealth ing: denies depression and staff reported no enmended due to risk of soutweigh risk and no GDR of psychiatric appeared at baseline and decompensation. It is decompensation and clinical indication are medications. Berview on 03/08/21 at appeared in good spirits and red in good spirits and red in good spirits and resion. He stated she herself while in he had not observed such as crying or worry. In the county of the	F 75		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		90,20,202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Director of Nursing (#18's medical record behaviors. She state electronic medical record order for psychotrop actively working to finan interview on 3/ Manager (UM) #1 st psychotropics shoul behaviors for the stated electronic medical readd specific target behaviors. UM #1 st behaviors listed for knew what to look for has had a difficult 6	(10/21 at 11:53 AM, the (DON) confirmed Resident did not identify targeted ed it was an issue with the ecord when entering any ics and the facility was ix it.	F 7	,			
	stated she had beer COVID-19. In an interview on 3/stated the Consultar medication reviews a pharmacy report ereceived the report a printed a copy for thaddress. There was Director at each nur the Medical Director times per week. He wrote orders if need recommendations the control of the c	In in isolation twice for In 10/21 at 1:20 PM, the DON Int Pharmacist completed her Intermediate and would email her Intermediate and recommendations, she Intermediate and recommendations, she Intermediate and recommendation is se's station. The DON stated Intermediate and responded to the Intermediate and responded to the Intermediate and recommendation Intermediate and recommen					

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING (X3) A. BUILDING			X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	30/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	the recommendation to be filed. The DO facility identified the targeted behaviors recommendations of meetings. In an interview on 3 Nurse #2 stated shown completed no tasks assessments. She calendar with all the given to the UM's. In an interview on 3 Nurse #1 confirmed that indicated they AIMS assessments they gave to the UI information on what due. In a telephone intent the Consultant Phat the facility in May 2 during Resident #1 review that a GDR 2019 on Resident #1 she stated since she 2020 and due to Consultant Phat for an antidepressal in the first year and stated she was unabehaviors with the	le would write the rationale on and put it back in the folder. N stated she expected the eneed for a GDR and missing a She stated any nursing were addressed in the morning were addressed in the morning were addressed in the morning and MDS Nurse #1 are related to the AIMS reported that each month a en MDS assessments was and that the monthly calendar wis did not included any at AIMS assessments were and that the monthly calendar wis did not included any at AIMS assessments were and that the monthly calendar wis did not included any at AIMS assessments were and that the monthly calendar wis did not been done since April and the was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the facility in DVID-19, she planned to alta during her April 2021 visit. The was new to the need for targeted was of psychotropics but knew or adverse side effects.	F 7	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _		,	C 9/20/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1	3/23/2321	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 758	the Medical Director GDRs personally use antipsychotic. He statistically deficiently antipsychotic. He statistically deficiently antipsychotic. He statistically deficiently and medical Director states a GDR on her antipolar and medical Director states a GDR on her antipolar and personal deficiently defici	rview on 3/10/21 at 3:45 PM, or stated he handled all the inless the medication was an stated Resident #18 has had a se she tested COVID-19 has had to isolate twice. The ated he would not recommend depressant until things ed he expected targeted entified so the staff knew what or and document. 3/10/21 at 5:00 PM, the DON expectation that the facility of targeted behavior didentify the need for a segarding a GDR of Resident entities contraindicated with ale. 3/10/21 at 1:40 PM, rese Practitioner stated she has a separate of the facility informed her rector preferred to address all Rs. She stated there should be ation as to why a GDR was did the behaviors monitoring by vague and needed to be	F 7	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING _		C 09/20/2021
	ROVIDER OR SUPPLIER	IAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 03/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 758	included an order date Extended Release 24 bedtime for Paranoid included was an order monitor and indicate yoccurred on every shi behaviors and non-phin the medical record. Resident #43's quarte (MDS) dated 1/18/21 cognitively intact and behaviors. She was cantipsychotic. Resident #43's revise read she was at risk fithe use of antipsychotic Schizophrenia and Bi included the completion Involuntary Movement to be completed accook Review of Resident # indicated the last AIM 1/29/20. Review of the Consultate the follow 4/23/20-no recomments for the complete follow 4/23/20-no recomments.	ed 4/15/19 for Seroquel hour 50 milligrams at Schizophrenia. Also r dated 2/5/20 for staff to yes or no if behaviors ft. If yes, please record farmacological interventions erly Minimum Data Set indicated Resident #43 was exhibited rejection of care oded for the use of an d care plan dated 2/8/21 or adverse effects related to tic medications for polar Disorder. Interventions on of an Abnormal t Scale (AIMS) assessment rding to facility policy. 43's medical record S completed was on tant Pharmacist monthly review notes for Resident owing: ndations dations dations dations dations dations dations dations dations	F 7	58	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 09/20/2021
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 33/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR 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 758	notes indicated the 4/20/20-GDR not redecompensation. Eclinical indication for medications. 6/3/20-Pleasant are thoughts, hallucing none. Current reges medication adjustre of decompensation no clinical indication medications. 9/11/20-Reported of friends to talk too-making symptoms emotions, gets upper recommendations. Benefits outweigh for any GDR of psymprovements in more sult in risk of decrecommended due benefits outweigh for any GDR of psymprovements in more sult in risk of decrecommended due benefits outweigh for any GDR of psymprovements. In the sulting for any GDR of psymprovements in more sulting for any GDR of psymprovements in more sulting for any GDR of psymprovements. In the sulting for any GDR of psymprovements in the	mendations endations endations endations endations endations ent #43's psychiatry telehealth e following: ecommended due to risk of Benefits outweigh risk and no or any GDR of psychiatric and friendly-no delusional etions, and mania. Staff report ime recommended. No ment recommended due to risk a. Benefits outweigh risk and on for any GDR of psychiatric and privacy, stressful, wanting reported isolation and lonely worse. Staff report occasional set easily-no new due to risk of decompensation. risk and no clinical indication ychiatric medications. Reported mood and coping. GDR would compensation. No GDR e to risk of decompensation. risk and no clinical indication ychiatric medications. ecommended due to risk of Benefits outweigh risk and no	F 75	58	
	clinical indication for medications. Review of Resider 1/1/21 to present in regarding the refus	or any GDR of psychiatric of #43's nursing notes from noted nursing notes all to wear foot protectors on sal of lab work on 3/2/21.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION		LETED
		345177	B. WING _				20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 F	EET ADDRESS, CITY, STATE, ZIP CODE RATTLESNAKE TRAIL EHURST, NC 28374	, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From pag	e 114	F	758			
	present indicated sho ordered and no beha	#43's medication ds (MARs) from 1/1/21 to e received her Seroquel as aviors exhibited. The MAR did behaviors for staff were to					
	10:51 AM, Resident appeared pleasant, of There was no eviden	nd interview on 3/8/21 at #43 was in bed. She cooperative, and engaging. ace of psychosis. She neern was regarding her					
	8:20 AM, Resident # appeared pleasant, o There was no evider	d interview on 3/10/21 at 43 was again in bed. She cooperative, and engaging. ace of psychosis. She stated and reported no concerns.					
	stated the MAR did r behaviors to docume Resident #43 exhibit and verbal behaviors understanding that the	10/21 at 8:30 AM, Nurse #1 not specify any target ent in the medical record but ed agitation, short temper s. Nurse #1 stated it was her ne MDS Nurse or the Unit et the AIMs assessments.					
	Director of Nursing (#43 medical record of behaviors. She state electronic medical re	10/21 at 11:53 AM, the DON) confirmed Resident did not identify targeted d it was an issue with the cord when entering any ics and the facility was x it.					
		10/21 at 1:00 PM, UM #1 rses completed Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345177	B. WING _			09/2	20/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE,	ZIP CODE	1 00/2	10/2021
THE COE	ENS AT PINEHURST REI	JAP 8 I IVING CENTER		205 RATTLESNAKE TRAIL			
THE GREE	ENS AT FINEHUNST REI	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 PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 758	Continued From page #43's AIMS every 6 n previous MDS Nurse		F 7	758			
	MDS assessments do be completed and that left in December 2020	ue and if an AIMS needed to at the previous MDS Nurse J. He stated the current					
	stated the old electrowould let staff know v	specify it on the list. He nic medical record set up when an AIMS was due. UM					
	targeted behaviors fo the use of an antipsy	record should specify r Resident #43 to support chotic. He stated when an ropics was entered into the					
	electronic medical rec populates for only yes	cord, a generic template s or no responses. UM #1					
	antipsychotic and doo	et behaviors for the use of an cumentation regarding the need for a GDR unless it					
	Nurse #2 stated she a completed no tasks re	elated to the AIMS					
		eported that each month a MDS assessments was					
	Nurse #1 confirmed M that indicated they we AIMS assessments a they gave to the UM's	0/21 at 2:30 PM, MDS MDS Nurse #2's interview ere not involved with the nd that the monthly calendar is did not included any MMS assessments were					
	Pharmacist complete remotely and would e	0/21 at 1:20 PM, the DON) stated the Consultant d her medication reviews mail her a pharmacy report received the report and					

OLIVILIV	O T OTT MEDIO, ITE A	· · · · · · · · · · · · · · · · · · ·				CIVID ITC). 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				~ -		(С
		345177	B. WING			1	20/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		·
THE OBE	ENS AT PINEHURST REI	HAR & LIVING CENTER		2	05 RATTLESNAKE TRAIL		
INE GREE	ENS AI PINEHURSI REI	HAB & LIVING CENTER		F	PINEHURST, NC 28374		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG		,	1,10		DEFICIENCY)		
F 758	Continued From page	e 116	F	758			
	recommendations, sh	ne printed a copy for the					
	Medical Director to a	ddress. There was a folder					
	for the Medical Direct	tor at each nurse's station.					
	The DON stated the	Medical Director came to the					
		per week. He went through					
		orders if needed and					
	responded to the rec	ommendations then put the					
		k in a folder for filing. The					
		edical Director did not agree					
		on, he would write the					
		mmendation and put it back					
		d. The DON stated she					
		tant Pharmacist to make					
	· ·	r the Medical Director					
		se reductions (GDRs),					
		aviors and need for an					
	, ,	y nursing recommendations					
		e morning meetings. The					
		S protocol was on admission					
		thereafter. The admitted					
	nurse did the baselin	e AIMS on admission and					
	then the MDS Nurse	put out a list of MDS					
	assessments due and	d the nurses on the unit					
	completed the AIMS.	She said the system does					
	not have any automa	itic prompts to alert the					
	nurses that an AIMS	is due. The DON stated she					
	was unaware that Re	esident #43's last AIMS					
	assessment was con	npleted on 1/29/20 and was					
	unaware that the AIM	S were not being done. The					
		er expectation that the facility					
		r an AIMS assessment on					
	Resident #43, identifi	ied the need for a GDR in					
		essed and identified Resident					
	#43 targeted behavio						
	antipsychotic.						
		0/40/04 + 0.00 ====					
		iew on 3/10/21 at 3:20 PM,					
	_	nacist stated she started at					
	the facility in May 202	ZU. She stated the					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING		C 09/20/2	2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	•	STREET ADDRESS, CITY, STATE, ZI 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
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F 758	admission and ever stated she did not record for the need was not aware whe in the electronic me Pharmacist stated s May 2020 and note been addressed sin had planned to add in April 2021. She s need for targeted be psychotropics but k adverse side effects. In a telephone interthe Medical Directo GDRs personally urantipsychotic then histated Resident #43 hallucinations and wand talk to people with Director stated he recommendations for Resident #43's Serothe need for identifications. In an interview on 3 stated it was her exidentified the lack of documentation, ideal recommendation re#43's antipsychotic documented rational every 6 months. She	IMS assessment on y 6 months thereafter. She eview Resident #43' medical of an AIMS assessment and re the AIMS were documented dical record. The Consultant she started at the facility in d no GDR on Seroquel had note 4/2019. She stated she ress Resident #43's Seroquel tated she was unaware of the enaviors with the use of new the facility looked for stated he handled all the notes the medication was an net differed to Psychiatry. He is experienced auditory, visual was known to often yell out who weren't there. The Medical nad not received any rom the facility regarding or open the facility regarding the need for an AIMS or cation of specific targeted	F	758		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	E SURVEY IPLETED
		345177	B. WING			C
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP (205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	9/20/2021
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F 758	the Psychiatric Numot received any Gracility regarding R Seroquel. She stat the Medical Director recommended GD understanding that due to Resident #4 Schizophrenia. She identified the need to why a GDR was an AIMS assessme behavior monitorin and needed to be so 6. Resident #3 was 11/20/20 with multi schizophrenia. The (MDS) assessment Resident #3 had so he had received an assessment period Resident #3 had a for Risperdal (an amilligrams (mgs.) bedsime for schizophrenia for schizophrenia for Schizophrenia for Risperdal (an amilligrams (mgs.) bedsime for schizophrenia for schizophren	riview on 3/11/21 at 1:40 PM, see Practitioner stated she has DR recommendations from the esident #43' prescribed ed the facility informed her that or preferred to address all Rs and it was her a GDR could not be attempted 3's diagnosis of e stated the facility should have for specific documentation as contraindicated, the need for ent and identified that the g by the facility was too vague specific to Resident #43. As admitted to the facility on ple diagnoses including e quarterly Minimum data Set at dated 2/25/21 indicated that evere cognitive impairment and in antipsychotic drug during the second of the daily for bipolar 27/21 for Risperdal 1 mgs at obrenia. It #3's medical records boromal Involuntary Movement or Dyskinesia Identification and User Scale (DISCUS) was e admission to monitor for the	F	758		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 09/20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST REHAB & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	E TRAIL 28374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 758	antipsychotic drugs DISCUS completed 6 months. On 3/10/21 at 2:31 interviewed. She st not responsible for On 3/10/55 at 3:55 conducted with the residents on antipsy AIMS test or DISCU and then every 6 m Resident #3 did not DISCUS completed that the MDS Nurse floor nurses when A admission Nurse water AIMS test on admission Nurse water AIMS test on admission santipsychotic drug. 7) Resident #31 water 5/22/20 with diagnodementia with behas schizophrenia. An Abnormal Involutionassessment was concepted to the property of th	indicated that residents on should have AIMS test or on admission and then every PM, MDS Nurse #2 was tated that MDS Nurses were completing the AIMS test. PM, a follow up interview was DON. The DON stated that ychotic drug should have an IS completed on admission onths. She verified that have an AIMS test nor on admission. She explained as were supposed to notify the IMS test was due and the as supposed to complete an sion for residents on seadmitted to the facility on sees that included vascular vior disturbance and Intary Movement Scale (AIMS) impleted on 5/22/20 for num Data Set (MDS) I/9/21 indicated Resident	F 7:	,		
	#31's cognition was had received an and days during the MD A review of the curr indicated an order f	severely impaired, and she tipsychotic medication 7 of 7				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 09/20/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
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F 758	Continued From pag		F	758			
	A review of the hard record from 5/22/20 assessment or any cassessment had not #31 since 5/22/20. During an interview of (DON) on 3/10/21 at facility's normal proceedally in assessment of months for residents medications. She incassessment was connurse at the time of a floor nurses every 6 of the MDS assessments due eat to inform the floor nurses sessment was due completed in the eleunder the assessment was due completed in the eleunder the assessments but ear the MDS assessments as the MDS assessments as the manual manu	copy and electronic medical to 3/10/21 revealed an AIMS other involuntary movement been completed for Resident with the Director of Nursing 1:20 PM, she stated the ess was to complete an admission and then every 6 on antipsychotic dicated the initial AIMS appleted by the admitting admission and then by the months with coinciding dates tent. The DON further stated out a calendar of MDS and the month and this was used trees when an AIMS at The assessments were corronic medical record (EMR) and with MDS Nurse #2 on She stated she and MDS no tasks related to the AIMS on tasks related to the AIMS on tasks related use were given					
	calendar had not inc what AIMS assessm On 3/10/21 at 2:30 F conducted with MDS and MDS Nurse #2 h						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	IAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 03/2	0/2021
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F 758	any information on where due. A phone interview was Pharmacy Consultant stated it was her experience AIMS assessments of antipsychotic medicat months. The Pharmac was important to come assessments for antipthe potential side effectuse. On 3/10/21 at 4:56 PM had reviewed Resident electronic medical recompleted every 6 months assessment was no AIMS assessment was presponsible for notifying AIMS assessment was her expectation for completed on admissible receiving and the MDS Nurses to not an AIMS assessment was an AIMS assessment was residents receiving and the MDS Nurses to not an AIMS assessment was an AIMS assessment was an AIMS assessment was an AIMS assessment was an AIMS assessment.	lanagers had not included hen AIMS assessments s completed with the on 3/10/21 at 3:25 PM. She extation for the completion of in initiation of an ion and then every 6 by Consultant explained it plete routine AIMS by chotic medications due to cts the medication could M, the DON indicated she in #31's hard copy and bord and confirmed there in the completed since pressed she was not aware issessments not being onths. She further stated	F 75	58		
F 803 SS=D	CFR(s): 483.60(c)(1)-	t Nds/Prep in Adv/Followed (7) d nutritional adequacy.	F 80	03	4	1/8/21

PRINTED: 10/25/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

, ,	PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	345177	B. WING _			C 09/20/2021	
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB	& LIVING CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 5 RATTLESNAKE TRAIL NEHURST, NC 28374		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803 Continued From page 122 §483.60(c)(1) Meet the nuresidents in accordance wiguidelines.; §483.60(c)(2) Be prepared §483.60(c)(3) Be followed §483.60(c)(4) Reflect, bas reasonable efforts, the relethnic needs of the reside input received from reside groups; §483.60(c)(5) Be updated §483.60(c)(6) Be reviewed dietitian or other clinically professional for nutritional §483.60(c)(7) Nothing in the construed to limit the reside personal dietary choices. This REQUIREMENT is resident by: Based on review of facility and Registered Dietician (interview, the facility failed planned for 3 of 3 resident dining (Residents # 1, #10 also failed to consistently planned for 13 of 13 alert in attendance at the Residents #1, #2, #12, #139, #47, #50, #53, and #Findings included:	utritional needs of with established national d in advance; l; seed on a facility's igious, cultural and ent population, as well as ents and resident d by the facility's qualified nutrition adequacy; and this paragraph should be dent's right to make the not met as evidenced by's menu, observation (RD), resident and staff to serve the menu as ts observed during 0 & # 66). The facility serve the menu as and oriented residents dent Council meeting 13, #19, #23, #25, #38,	F &	303	F803 Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, #47, #50, #53, and #55 were identified as being affected by the deficient practice and voiced that the menu specified is not what is served. All residents have the potential to be affected by the deficient practice. On 3/17/21 Ellen Kindred, R.D. educate the Dietary Manager on food ordering, and all dietary personnel including the Dietary Manager on adhering to the posted menu. The Dietary Manager wil	ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021		
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 0011	20/2021	
				20	05 RATTLESNAKE TRAIL			
THE GREI	ENS AT PINEHURST R	EHAB & LIVING CENTER			INEHURST, NC 28374			
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F 803	Continued From pa	ge 123	F 8	303				
F 803	8/9/19 with multiple Hypertension. The (MDS) assessment Resident #1 had a desident #1 was into AM. He stated that of the time. Resident #1 was into AM. He stated that of the time. Resided dinner yesterday (3 breast, roasted red cabbage. He report coleslaw and looked Con 3/10/21 at 12:32 conducted. Reside instead of collard gramenu. 2. Resident 366 was 10/9/20 with multipl Hypertension. The (MDS) assessment Resident #66's coggin Resident #66 had a Review of the menu.	diagnoses including quarterly Minimum Data Set dated 2/18/21 indicated that oderate cognitive impairment. doctor's order for regular diet. doctor's order for regular diet. doctor's order for regular diet. for regular diet was enu for 3/9/21 (dinner) was st, roasted red potatoes and The menu for 3/10 (lunch) ack eyed peas, and collard derviewed on 3/10/21 at 10:55 menu was not followed 50% int #1 stated that the menu for /9/21) listed grilled chicken potatoes, and buttered ted what was served were dike "pot pie". PM, lunch observation was int #1 was served green beans reens that was listed on the sadmitted to the facility on e diagnoses including quarterly Minimum Data Set dated 2/4/21 indicated that		803	review daily the menu for the following and every Thursday for the weekend to insure that the menu items are availab. Should changes need to be made, the Dietary Manger will make sure that substitutions are of equal nutritional variance approved by the Registered Dietician a posted on the substitution list so that the residents are made aware of the change Dietary Manager will audit the meal trate to insure they are the same as the posimenu for 5x/week for 4 weeks, then 3x/week for 2 months. The Administrate will review audits weekly. The Dietary Manager will attend the Formal Committee Meetings monthly and will interview all resident council members plus 5 additional alert and oriented residents to insure the meal received with the meal specified on the menu. He will conduct these audits every month for 3 months. The Dietary Manager will providest trays 3x/week to Director of Nursing Services to review menu accuracy on a ongoing basis. The systemic change is the Dietary Manager will not be able to alter the menu without approval from the Registered Dietician. The Administrator will review the audits monthly to identify patterns/trends and adjust the plans necessary to maintain compliance. The Interdisciplinary Team will review the landing and the audits will continue at the discretion of the QAPI committee.	lue, and ae ges. ys ted or ood was ll svide ag an a a		
	Review of the menu conducted. The menu grilled chicken brea buttered cabbage. was glazed ham, bl greens. Resident #1 was int AM. He stated that of the time. Resided dinner yesterday (3 breast, roasted red cabbage. He report coleslaw and looked Con 3/10/21 at 12:34 conducted. Resided instead of collard gramenu. 2. Resident 366 was 10/9/20 with multipl Hypertension. The (MDS) assessment Resident #66 had a Review of the menu conducted. The menu grilled chicken brea	a for regular diet was enu for 3/9/21 (dinner) was st, roasted red potatoes and The menu for 3/10 (lunch) ack eyed peas, and collard derviewed on 3/10/21 at 10:55 menu was not followed 50% int #1 stated that the menu for /9/21) listed grilled chicken potatoes, and buttered ted what was served were dike "pot pie". A PM, lunch observation was int #1 was served green beans reens that was listed on the sadmitted to the facility on e diagnoses including quarterly Minimum Data Set dated 2/4/21 indicated that inition was intact.			substitutions are of equal nutritional value approved by the Registered Dietician aposted on the substitution list so that the residents are made aware of the change Dietary Manager will audit the meal tratto insure they are the same as the posimenu for 5x/week for 4 weeks, then 3x/week for 2 months. The Administrativill review audits weekly. The Dietary Manager will attend the Focommittee Meetings monthly and will interview all resident council members plus 5 additional alert and oriented residents to insure the meal received with the meal specified on the menu. He will conduct these audits every month for 3 months. The Dietary Manager will provitest trays 3x/week to Director of Nursin Services to review menu accuracy on a ongoing basis. The systemic change is the Dietary Manager will not be able to alter the menu without approval from the Registered Dietician The Administrator will review the audits monthly to identify patterns/trends and adjust the plans necessary to maintain compliance. The Interdisciplinary Team will review the plan during the monthly QAPI meeting and the audits will continue at the	and ne ges. ys ted or ood was II S vide ng an s ne		

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		345177	B. WING _			C 09/20/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	3/20/2021		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 803	greens. Resident #66 was int AM. He stated that in that was posted was On 3/8/21 at 12:25 Probserved during lunch beans instead of collection the menu. 3. Resident # 10 was 9/12/17 with multiple hypertension. The quantum (MDS) assessment of Resident #10's cognic Review of the menus conducted. The menus conducted. The menus filled chicken breast buttered cabbage. The was glazed ham, black greens. Resident #10 had a coarbohydrate diet. Resident #10 was int AM. She stated that was not the menu be this happened frequence. On 3/8/21 at 12:25 Probserved during lunch.	erviewed on 3/8/21 at 9:39 nost of the time, the menu not the menu being served. M, Resident #66 was h. He was served green ard greens that was listed on diagnoses including uarterly Minimum Data Set lated 12/21/20 indicated that tion was intact. for regular diet was au for 3/9/21 (dinner) was t, roasted red potatoes and he menu for 3/10 (lunch) ck eyed peas, and collard doctor's order for consistent erviewed on 3/8/21 at 9:42 the menu that was posted ing served. She added that	F8	303				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING_		09/20/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		9/20/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 803	interviewed. She repon the menu was not substitute it with som the menu for 3/10/21 be collard greens bushe had to substitute. On 3/10/21 at 4:10 Finterviewed. He stat menu was not being the 3/9/21 dinner me grilled chicken breas buttered cabbage. To potatoes and cabbaghad served coleslaw pot pie instead. On 3/10/21 at 4:35 F (DM) was interviewenew to the facility an manager (started in indicated that he was complained of menu reported that he was in ordering food supplies at least a witill ran out of items of had to substitute it. On 3/10/21 at 4:45 Finterviewed. She incomenu to be followed Administrator added dietary manager. She no previous experier signed up for the classifications.	M, Dietary Cook #1 was ported that at times the item to available, so she had to nething. Cook #1 verified that for lunch was supposed to to since it was not available, with the item that at times the planned followed. He verified that mu was supposed to be to, roasted red potatoes and the chicken breast, red ge were not available, so he (prepackaged) and chicken was new as a dietary January 2021). The DM is aware that residents had not being followed. He still trying to learn especially blies. He ordered food eek ahead but at times they on the menu so, the cook with the DM was new as new a	F8	03			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		03/20/2021	
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F 803	not been to the faci pandemic. She known DM and he was still to the facility today new DM. The RD reaware of resident's being followed. She sure to order enough regular, renal, and she expected at time not frequently. The might have ran out census and this impleted by the Resident Council 3/9/21. A gentled to this concerns related to this concerns related to this concerns related to this concerns related to the concerns related to followed. The grouper week the menumatched the food the luar regular diet. The glazed ham, black of the still to the still the still the second regular diet. The glazed ham, black of the still to the still the still the second residents of the second regular diet. The glazed ham, black of the still the second regular diet. The glazed ham, black of the still the second regular diet. The glazed ham, black of the second residents of the second regular diet. The glazed ham, black of the second residents of the second regular diet. The glazed ham, black of the second residents of the second regular diet. The glazed ham, black of the second residents of the second regular diet. The glazed ham, black of the second regular diet.	ed. She stated that she had lity since March 2020 due to sw that the facility had a new I learning. She started coming (3/11/21) and would train the exported that she was made concerns that menu was not e advised the DM to make the food on the menu for special diet. She added that the substitution happened but PRD stated that the facility of food due to the increase in proceed the ordering of food. Inducted of grievance forms esident Council from 1/1/21 the grievance dated 2/24/21 from stated on the menu. The the Dietary Manager (DM) poke with the residents ern on 2/24/21 and the do be resolved. I have been done on the menu of the me	F8				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021	
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 803	interviewed. She re on the menu was n substitute it with so the menu for 3/10/2 be collard greens be she had to substitute. On 3/10/21 at 4:10 interviewed. He starmenu was not being On 3/10/21 at 4:35. He stated that he was a dietary manager and this learn food supplies. He of week ahead but at on the menu so, the On 3/10/21 at 4:45 interviewed. She in menu to be followed. Administrator added dietary manager. So on previous experies signed up for the clother to the faci pandemic. She known as a dietary manager. So on 3/11/21 at 11:35 (RD) was interviewed.	PM, Dietary Cook #1 was eported that at times the item of available, so she had to mething. Cook #1 verified that the for lunch was supposed to ut since it was not available, the it with green beans. PM, Dietary Cook #2 was ated that at times the planned grollowed. PM, the DM was interviewed. The planned grollowed in January cated that he was aware that plained of the menu not being the drawn that he was still trying to be not process included ordering ordered food supplies at least a times they still ran out of items they still ran out of items they still ran out of items they are cook had to substitute it. PM, the Administrator was addicated that she expected the drawn as planned. The drawn the DM was new as the reported that the DM had bence as DM, but he was ass. SAM, the Registered Dietician the drawn as the stated that she had lity since March 2020 due to the ew that the facility had a new	F	303			
		l learning. She started coming (3/11/21) and would train the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _		09/2	20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 803 F 812 SS=D	new DM. The RD rep aware of resident's co not being followed. S sure to order enough regular, renal, and sp she expected that at happen but that it sho The RD stated that the of food due to the inci impacted the ordering Food Procurement, St	orted that she was made oncerns that the menu was she advised the DM to make food on the menu for ecial diets. She added that times a substitution would ould not happen frequently. He facility might have ran out rease in census and this g of food.	F 8			4/8/21
	state or local authoriti (i) This may include for from local producers, and local laws or regul (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on record revi Registered Dietician a facility failed to label a	re food from sources ed satisfactory by federal, ies. cood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility compliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and ince with professional rvice safety. is not met as evidenced		F812 During the facility annual survey, surveyor observed on 3/10/21, madietary staff without a hair net or be	ale	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ') MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 09/20/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				2	05 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REF	1AB & LIVING CENTER		P	PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 812	Continued From page	e 129	F 8	312				
	and beard restraints. kitchen observations.	ts, and failed to wear hair This is evident in 2 of 2			guard and food items without dates or labels. These food items were discarded No residents were identified as being affected by the deficient practice.	ed.		
	Findings included:				All residents have the potential to be affected by the deficient practices.			
	The facility's policy or				On 3/17/21 Registered Dietician educa	ted		
		viewed. The policy read in			all dietary personnel regarding the			
		in the refrigerator or freezer			requirement to wear hair nets and bea	rd		
		ed and dated (use by date).			guards when in the kitchen and on the	ı		
	within 7 days from pre	ed food items must be used			facility s policy and procedure for food	1		
					storage, labeling and dating. Beard guards/hair nets have been provided to	or		
		n dress code (undated) was			all dietary staff to be worn on duty.			
		read in part" all kitchen			The DON will observe that dietary staff			
		r hair and beard nets".			are donning hair nets and beard guard 5x/week for 4 weeks; then 3x/week for			
		AM, initial tour of the kitchen			weeks; then once weekly for 4 weeks.			
		Dietary Manager (DM) was			The Dietary Manager will audit the			
	observed to have a fu				refrigerator/freezer and nourishment			
		r beard guard while in the iewed, he stated that he			rooms for accurate storing, dating and	- 1		
		net and a beard guard			labeling of food to be done 5x/week for weeks; 3x/week for 4 weeks then once			
		He added that he was new			weekly for 4 weeks.			
		as DM, started in January			The Administrator will review the audits	:		
	2021 and was still lea	-			monthly to identify patterns/trends and	will		
	On 3/10/21 at 0⋅35 ΔI	M, a follow up kitchen			adjust the plan as necessary to mainta compliance.	11.1		
		ducted. The DM was again			The Interdisciplinary Team will review t	he		
		a beard guard. When			plan during the monthly QAPI meeting			
		d that he had been in and			and the audits will continue at the			
	out of the kitchen and beard guard.	I he forgot to put on his			discretion of the QAPI committee.			
	2. On 3/8/21 at 9:10 A							
	noted:	ducted. The following were						
		1/3 full, unlabeled, and DM identified it as pudding						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	C 20/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 5 RATTLESNAKE TRAIL NEHURST, NC 28374	1 03/	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	and stated that it sho opened. The DM ver and stated that it was opening. - A 4-quart container unlabeled. The DM indicated that it sho dated. The DM indicated for 7 days after -16 cartons of nutrition undated. DM stated to be dated. The inst "shelf life - 1 year from state. Once thawed, days". On 3/10/21 at 4:45 Printerviewed. The Adrifacility's policy on food dress code. She indicated to the facility and dress code. She new to the facility and	uld have been labeled when ified the pudding as expired good for 7 days after - 1/3 full - undated and dentified it as apple sauce. uld have been labeled and ated that opened food was opening. nal shakes-thawed and that the shakes did not need ruction on the carton read m production date in frozen refrigerate for up to 14 M, the Administrator was ministrator had provided the d storage and the facility's cated that she expected the ty's policy on food storage added that the DM was I new as DM. The DM had be as DM, but he was	F	3312			
F 842 SS=D	(RD) was interviewed not been to the facility the pandemic. She k new DM and he was coming to the facility train the new DM. Sh the facility's policy on code. Resident Records - Id	AM, the Registered Dietician I. She stated that she had y since March 2020 due to new that the facility had a still learning. She started today (March 11) and would e expected the DM to follow food storage and dress dentifiable Information 483.70(i)(1)-(5)	F	342			10/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 09/20/2021	
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	(i) A facility may no resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the extent to do so. §483.70(i) Medical §483.70(i)(1) In according the facility of the extent to do so. §483.70(i)(1) In according the facility of the extent to do so. §483.70(i)(1) In according the facility of the extent to do so. §483.70(i)(2) The fall information contregardless of the facility of the individual representative when (ii) To the individual representative when (ii) Required by Law (iii) For treatment, poperations, as permith 45 CFR 164.5 (iv) For public health neglect, or domesticativities, judicial at law enforcement pupurposes, research medical examiners a serious threat to	dent-identifiable information. It release information that is to the public. release information that is to to an agent only in contract under which the agent or disclose the information It the facility itself is permitted records. cordance with accepted ards and practices, the facility lical records on each resident amented; ible; and organized accility must keep confidential ained in the resident's records, orm or storage method of the en release is- , or their resident are permitted by applicable law; w; coayment, or health care mitted by and in compliance	F8	142			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345177		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED	
		345177	B. WING			09/20/2021	
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 842	Continued From pa	ge 132	F 8	42			
	record information a unauthorized use.	acility must safeguard medical against loss, destruction, or all records must be retained					
	for- (i) The period of tim (ii) Five years from there is no requiren	e required by State law; or the date of discharge when nent in State law; or ears after a resident reaches					
	(i) Sufficient information (ii) A record of the results of a and resident information.	nedical record must contain- ation to identify the resident; esident's assessments; sive plan of care and services ny preadmission screening evaluations and ducted by the State;					
	professional's progr (vi) Laboratory, radi services reports as	se's, and other licensed ress notes; and ology and other diagnostic required under §483.50. NT is not met as evidenced					
	facility failed to main	eview and staff interviews, the ntain accurate medical records reviewed for pressure ulcers		F 842 Address how corrective action accomplished for those reside have been affected by the def	ents found to		
	11/25/20 with multip	admitted to the facility on ble diagnoses that included illation, coronary artery		practice; Resident #85 was discharge the hospital on 2/11/2021 and did the facility Address how the facility will ideresidents having the potential affected by the same deficient	to the not return to dentify other to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 9/ 20/2021	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	•	5/20/2021	
THE GREENS AT PINEHURST REHAB & LIVING CENTER				205 RATTLESNAKE TRAIL	.002		
				PINEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE	
F 842	Continued From page	e 133	F 8	342			
F 842	Resident #85's physi order dated 11/25/20 assessments every M to 3:00 PM). The November 2020 Record (MAR) was reweekly skin assessment completed on 11/30/2 A review of Resident record revealed weekly completed and docur 11/30/20. The admission Minimassessment dated 12 #85 had severe cognized extensive as mobility and toileting, and bladder, and was The assessment furth pressure ulcers or other thanks of the December 2020 indicated a weekly skinitialed as completed 12/21/20 and 12/28/24. A review of the electrons weekly skinitialed as completed 12/21/20 and 12/28/24.	cian orders, revealed an for weekly skin Monday on day shift (7:00 AM Medication Administration eviewed and indicated a finent had been initialed as 20. #85's electronic medical kly skin assessments were mented on 11/25/20 and mum Data Set (MDS) 2/1/20 indicated Resident hitive impairment. He esistance from staff for bed and was incontinent of bowel as at risk for pressure ulcers. Their revealed he had no her skin conditions present. MAR was reviewed and kin assessment had been do on 12/7/20, 12/14/20,	F 8	The Director of Nursing an nurse completed an audit of current facility residents to weekly skin assessment won the Weekly Skin Assess the electronic medical recover identified as not having assessment documented. All residents have the pote affected by the deficient proposed and the proposed ensure that the deficient proposed ensure that the deficient proposed ensure that the deficient proposed education on 9/30 for the licensed nurses, recomment skin integrity on Skin Assessment form in the medical record. All new nureducated upon hire. Indicate how the facility platics performance to make support	on 9/30/21 of validate that a as documented sment form in ord. 9 residents on skin white skin skin shade to ractice. If the put into made to ractice will not exact will not sesistant bound Nurse 0/21-10/01/21 quiring them to the Weekly the electronic races will be and to monitor the track of the weekly the electronic race will be and to monitor the weekly for 4 the track of the weekly for 4 th		
	were completed and 12/28/20. The January 2021 M. indicated a weekly ski			weekly Skin Assessment in electronic medical record. The Wound Nurse will review monthly to identify patterns adjust the plan as necessal compliance. The Wound nurse or DON plan during the monthly QA and the audits will continued.	ew the audits s/trends and will rry to maintain will review the API meeting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _		,	C 09/20/2021	
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From pag	ge 134 #85's electronic medical	F 8	42 discretion of QAPI committee.			
	record revealed wee	ekly skin assessments were mented on 1/11/21 and					
	3/11/21 at 11:00 AM assessment had bee 12/21/20, 1/4/21 and completed the skin a failed to document to assessments in the	electronic medical record. conditions being present at					
F 908 SS=E	Nursing on 3/11/21 as he expected the nuskin assessment floor medical record when on the MAR.	rview with the Director of at 12:07 PM, she indicated ursing staff to complete the wsheet in the electronic in they sign off as completed t, Safe Operating Condition	F 9	08		4/8/21	
	§483.90(d)(2) Maint and patient care equ condition. This REQUIREMEN by: Based on record re interview, the facility dish-machine in safe evidenced by the hig	ain all mechanical, electrical, sipment in safe operating T is not met as evidenced view, observation and staff failed to maintain the experating condition as gh temperature dish-machine auge not working during the 2		F908 The facility failed to maintain th operating condition of the dishware residents were identified to be at the deficient practice. All dietal were educated on 3/17/21 that equipment is to be checked for working condition and that any malfunctions shall be reported	washer. No affected by ry staff all safe		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		(С
		345177	B. WING _			09/	20/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 908	9:05 AM, the staff we dishes using the high The dish-machine we reading "0" degrees wash cycle. The dish-machine (h March 2021 was revand rinse temperature 3/1/21 through 3/9/2 temperature recorde from 3/6/21 through On 3/8/21 at 9:07 AM interviewed. He stat gauge had not been (3/6/21). On 3/8/21 at 9:08 AM was interviewed. He that the wash tempe working since Sature the dietary aides wor and at times forgot to rinse temperature or A follow up kitchen of 3/10/21 at 9:35 AM, washing the dishes up dish-machine. The dietary aides wor and at times forgot to rinse temperature was reat the wash cycle. On 3/10/21 at 9:38 AM He stated that it was the Maintenance Director of the dishes and the stated that it was the Maintenance Director of the stated that it was the	r of the kitchen on 3/8/21 at ere observed washing the en temperature dish-machine. ash temperature gauge was Fahrenheit (F) during the sigh temperature) log for iewed. There was no wash res recorded for supper from 1. There was no wash d for breakfast and lunch 3/9/21. M, Dietary Aide (DA) #1 was seed that the wash temperature working since the weekend M, the Dietary Manager (DM) e stated that he was aware rature gauge was not day 3/6/21. He indicated that rking in the evening were new of document the wash and in the log.	FS	908	immediately to the Director of Maintenance. The Director of Maintenance verified on 3/10/21 that the water entering the kitchen is greater tha 160 degrees. Dietary Aides will verify the the final rinse temperature exceeds 180 degrees prior to use. If at any point sanitizing does not occur at 180 degreed dishwasher use will discontinue and manual dishwashing will occur with a chemical sanitizer until the dishwasher can be repaired. All residents have the potential to be affected by the deficient practice. The temperature log will be modified to include that manual dishwashing with u of a chemical sanitizer must be initiated should dishwasher rinse temperatures below 180 degrees. The Dietary Manag will audit all essential dietary equipment for proper working condition 5x/week for one month; 3x/week for one month and weekly for one month. Audits will be reviewed weekly by the Administrator a monthly to identify patterns/trends. The plan will be adjusted as necessary to maintain compliance. The IDT will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. All corrective action to be completed b April 8, 2021	an hat 0 es, use d fall ger ht or d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
345177		B. WING		0.0	C		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP		9/20/2021	
THE GREENS AT PINEHURST REHAB & LIVING CENTER				205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 908	Director this morning was supposed to com On 3/10/21 at 9:50 Al was interviewed. He informed him this mor dish-machine wash to working. He went to was reading 0 degree checked the water terbetween 160-165 degalready ordered the p On 3/10/21 at 4:45 Pl interviewed. She stat DM to inform the Mair immediately when the working. The Administration	(3/10/21) and somebody he to fix it. M, the Maintenance Director stated that the DM had rning (3/10/21) that the emperature gauge was not check it and the wash gauge his however when he emperature, it was reading grees F. He reported that he art and was coming today. M, the Administrator was hed that she expected the entenance Director he dish-machine was not estrator added that she was morning (3/10/21) that the	FS	908			