	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING			05/	26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	00 BLAKE BOULEVARD		
PINEHURS	SI HEALIHCARE & RE	EHABILITATION CENTER		Р	INEHURST, NC 28374		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
E 000	Initial Comments		E	000			
	was conducted 5/23	nsite recertification survey 3/2022 thru 5/26/2022. The compliance with the 3.73 Emergency					
F 000	INITIAL COMMENT	S	F	000			
		nsite recertification survey 8/2022 thru 5/26/2022. Event					
F 554 SS=D	Resident Self-Admir CFR(s): 483.10(c)(7	n Meds-Clinically Approp ′)	F	554			6/27/22
	medications if the in defined by §483.210 this practice is clinic	ight to self-administer iterdisciplinary team, as (b)(2)(ii), has determined that cally appropriate. IT is not met as evidenced					
	Based on observat interviews and reco assess and obtain F self-administration of	ions, staff and resident rd review, the facility failed to Physician orders for the of a topical cream for 1 residents reviewed for the			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will	do	
	The findings include	ed:			take the actions set forth in this plan of correction. The plan of correction		
	diagnosis of a Cere Review of Resident included an order da Original Cream 10 9	s admitted on 7/24/20 with a bral Vascular Accident (CVA). #99's active Physician orders ated 5/11/21 for Aspercreme % (a topical cream used to e applied to his bilateral knees ours for knee pain.			constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F 554 The facility failed to assess and obtain physician orders for the self-administration of a topical cream fo	r	
		, #99's care plan last revised			resident #99. 1. Corrective action for resident(s)		

Electronically Signed

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

06/18/2022

					OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIN
F 554	Continued From page	e 1	F 55	4	
	on 2/7/22 did not incl	ude a care plan for the his ordered topical cream.		affected by the alleged deficient For resident # 99 the medication	was
		erly Minimum Data Set dated as moderately cognitively		 removed from the bedside on 5/ and secured on the medication the assistant director of nurses. 2. Corrective action for residents 	cart. by
	record did not include for the self-administra	99's electronic medical any evidence of an order ation of his Aspercreme and		potential to be affected by the all deficient practice. On 6/17/2022 the Assistant Dire Nurses audited all resident roon	ctor of ns to
		administration assessment.		assure that no medications were bedside that had not been asser resident self -administration, 2 o	ssed for
		leted on 5/25/22 at 8:30 AM		resident sen administration. 2 c residents were identified with a found at bedside. On 6/17/2022	medication
	-	medication cart and put a the cream into a plastic		administration UDA's were com the 2 residents and orders obtai	
	applied the cream hir	e #2 stated Resident #99 nself. During the ident #99's medications, she		the physician for self- administrative kept at bedside. Medications we secured on med cart until proce	ere
		p with the Aspercreme on		administration completed. 3. Measures /Systemic changes	
		erviewed on 5/25/22 at 8:31 lication administration		prevent reoccurrence of alleged practice: On 6/16/2022 the Director of Nu	
	observation and reve	aled Nurse #2 always left a r him to apply himself but		Assistant Director of Nurses and Consultant began education of a Time, Part Time, PRN nurses, n	l Nurse all Full nedication
	she was unable to fin	ted on 5/25/22 at 2:41 PM, d any documented evidence administration for Resident		aides and agency nurses on fac related to medication safety that resident assessment for self -administration of medication pro- safely securing and storing med	included
		npleted with Nurse #2 on She stated she was not		Education will be completed by This information has been integ the standard orientation training	rated into
	aware that Aspercren order and a self-admi	ne required a Physician inistration assessment had to leaving any prescribed		all staff identified above and will reviewed by the Quality Assurar	urses for be

Facility ID: 923403

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					OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & RE	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 554	medication at the be An interview was co PM with the Adminis (DON). The DON st that Nurse #2 not lea	edside. nducted on 5/26/22 at 1:00 strator and Director of Nursing ated it was her expectation ave topical medications at side but rather it be applied by	F 554	 process to verify that the change been sustained. The facility speat in-service will be provided to all a Nurses and CNA's who give resi- care in the facility. Any nursing staff who does not re- scheduled in-service training will allowed to work until training has completed by June 26, 2022. 4. The monitoring procedure to e that the plan of correction is effect that specific deficiency cited rem corrected and/or in compliance w regulatory requirements: Quality assurance audits will be completed by the Director of Nur designee to assess that the med self- administration process is in compliance and that no other med bedside if the resident is not app for self-administration. Audits wi weekly for 2 weeks, then monthly months or until resolved for comp with facility policy on self- admini of medication process. Reports w presented to the weekly QA com the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be r and the ongoing auditing prograr reviewed at the weekly QA Meeti weekly QA Meeting is attended b Administrator, acting Residential Coordinator, Activity Director and Dietary Manager. Deficiencies th identified during the monitoring p 	cific agency dents eceive not be been nsure ctive and ains <i>v</i> ith the ses or ication ds are at ropriate II be done <i>y</i> for 3 bliance stration <i>v</i> ill be mittee by monitored n ng. The yy the Care I the at are

Event ID: YHE211

Facility ID: 923403

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTIO			ATE SURVEY DMPLETED
		345370	B. WING				05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRES	S, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOU	ILEVARD		
			PINEHURST, NC 28374		IC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 636 SS=D			F 6	36			6/27/22
	a comprehensive, ac reproducible assess functional capacity. §483.20(b) Compreh §483.20(b)(1) Resid A facility must make a assessment of a resid goals, life history and	duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, I preferences, using the					
	by CMS. The assess the following:	S.					
	 (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutrition (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatment (xvi) Discharge plann 	ell-being. hing and structural problems. s and health conditions. onal status. hts and procedures. hing.					
	regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The as						

Facility ID: 923403

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PRINTED: 06/30/2022

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		345370	B. WING		05/20	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER	300 BLAKE BOULEVARD			
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 636	Continued From page	o 1				
F 030	• • • • • • • • • • • • • • • • • • •		F 63	30		
		well as communication with				
	licensed and nonlicent members on all shifts	nsed direct care staff s.				
		no muine de Ouchie et to the				
		required. Subject to the ed in §413.343(b) of this				
		st conduct a comprehensive				
		dent in accordance with the				
		in paragraphs (b)(2)(i)				
		ection. The timeframes				
	prescribed in §413.34	43(b) of this chapter do not				
	apply to CAHs.					
		r days after admission,				
		ons in which there is no				
		the resident's physical or				
		or purposes of this section,				
		a return to the facility				
		y absence for hospitalization				
	or therapeutic leave. (iii)Not less than onc					
		T is not met as evidenced				
	by:	i is not met as evidenced				
		iew and staff interview the		F636 Comprehensive As	ssessment and	
		it an admission Minimum		Timing		
	-	in 14 days after admission.		The plan of correcting the s	pecific	
		lent #201) of 21 MDS		deficiency. The plan should	-	
		ed for completion. The		processes that lead to the c		
	findings included;			cited;		
				The facility failed to conduc		
	Resident #201 was a	admitted on 4/29/22.		comprehensive Minimum D	. ,	
				assessment within 14 days		
		ssion MDS assessment with		to the facility for resident #2		
	5/12/22 was still in pr	erence Date (ARD) of		Corrective Action for Affecte On date 05/25/22, the Minir		
	οπ <i>ει</i> εε was sum in μι	1091000 UT 0120122.		(MDS) Admission Assessm		
	An interview was cor	npleted on 5/26/22 at 12:10		Assessment Reference Dat		
		rse. She stated she realized		for resident (#201) was com	npleted by the	
		ed the MDS assessment this		facility Minimum Data Set N		
	morning. She stated	she had gotten behind and		submitted and accepted inte	o the state	

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PRINTED: 06/30/2022

			()(0) 1		OMB NO. 0938
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED
		345370	B. WING		05/26/202
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
PINEHUR	ST HEALTHCARE & REF	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMP E APPROPRIATE D
F 636	Continued From page	e 5	F 63	6	
	caught up and Resid assessment was not assessment should h 14th day after his adu An interview was con PM with the Administ expectation that all re	ple assisting her with getting ent #201's admission MDS completed. She stated the have been completed by the mission. npleted on 5/26/22 at 1:00 trator. She stated it was her esident MDS assessment be litted within the regulated		 data base on 5/26/22 in Bata Corrective action for residen potential to be affected by the deficient practice: All residents have the potent affected by the alleged deficient The Regional Minimum Data Consultant will complete a 11 all residents admitted to facil 05/16/22 – 06/16/22 in order that the Admission Minimum assessments were completed date. This audit will be con- later than 06/24/22. All residents identified as har Admission Minimum Data Se Assessment that is open and been completed yet will have assessments completed no 1 06/24/22. Any resident identi- having had an Admission assi completed as required will having assessment opened and cor- later than 06/24/22. This will by the facility Minimum Data Systemic Changes: On 06/20/22, the Regional M Set (MDS) Consultant compli- service training for the facility on how to conduct a compre- assessment, identifying and conditions that can affect the quality of life of residents wit 	ts with the e alleged ial to be ent practice. Set (MDS) 00% audit of ity from to validate Data Set d by the due opleted no ving an et d has not e these ater than tified as not sessment ave this opleted no be completed Set Nurse.

Event ID: YHE211

Facility ID: 923403

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		& MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & R	EHABILITATION CENTER		300 BLAKE BOULEVARD 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIO
F 636	Continued From pa	ge 6	F 636	Minimum Data Set assessment CMS and the importance of adh these timeframes. The monitoring procedure to en- the plan of correction is effective specific deficiency cited remains and/or in compliance with the re- requirements: The facility Director of Nursing of designated Nurse Manager will audits of up to five (5) residents admitted during the past 30 day ensure that Admission Minimum assessments were completed b required due date. This will be using a quality assurance (QA) Completion audit tool to ensure plan of correction is effective an specific deficiency cited remains and in compliance with the regu- requirements. This audit will be weekly for 4 weeks then monthl months or until sustained comp Reports will be presented to the Quality Assurance committee by Director of Nursing to ensure con action for trends or ongoing cor initiated as appropriate. The we Quality Assurance Meeting is af the Administrator, Director of Nu- Minimum Data Set Coordinator, Manager, Therapy, Health Infor Manager, Dietary Manager and Activity Director. The title of the person responsil implementing the acceptable pla- correction;	herence to asure that e and that s corrected egulatory or conduct who were ys to n Data Set by the completed Admission that the ad that s corrected latory e done ly for 2 liance met. e weekly y the corrective neerns is eekly ttended by ursing, Unit mation the ble for

Event ID: YHE211

Facility ID: 923403

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						NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	ATE SURVEY DMPLETED
		345370	B. WING			05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 637 SS=D	Comprehensive Asse CFR(s): 483.20(b)(2)	ssment After Signifcant Chg (ii)	F 63	37		6/27/22
	determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record revi facility failed to compl status Minimum Data within 14 days after th from the hospice prog reviewed for hospice The findings included Resident #41 was add 11/19/20 with diagnos dementia and a stroke A review of the medic revealed a physician's discontinue Hospice s	mental condition. (For n, a "significant change" le or improvement in the will not normally resolve hervention by staff or by rd disease-related clinical is an impact on more than ent's health status, and ary review or revision of the - is not met as evidenced iew and staff interviews, the lete a significant change in Set (MDS) assessment he resident was discharged gram for 1 of 2 residents (Resident #41). : mitted to the facility on ses that included vascular e. cal record for Resident #41 s order dated 3/16/22 to services. Data Set (MDS) 16/22 indicated Resident itive impairment and was not		F637 Comprehensive Assessme Significant Change For resident #41, a corrective ac initiated on 06/16/22. A Significant Change in Status M Data Set Assessment with an As Reference Date of 06/16/22 was on 06/16/22 and will be complete Resident #41 by the facility Minir Set Coordinator no later than the due date (14 days after the Asse Reference Date). Corrective action for residents wi potential to be affected by the all deficient practice. All residents have the potential to affected by the alleged deficient The Minimum Data Set Consulta complete a 100% audit of all resi who have been admitted to or dis from hospice care during the pass to ensure that Significant Change	tion was linimum sessment opened ed for num Data e required essment ith the eged practice . int will idents scharged st 90 days	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·
PINEHUR	ST HEALTHCARE & RE	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 COMPLÉTIO
F 637	On 5/26/22 at 12:09 completed with the I wasn't aware a Sign assessment should	ge 8 PM, an interview was MDS Nurse who stated she inficant Change in Status MDS have been completed within ent #41 was discharged from	F 637		en ospice and did nimum ignificant n Data vill be an Set n the f Minimum ents who ed from a equired if ders. essment d ent's n allow nt care. for the

Event ID: YHE211

Facility ID: 923403

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		X MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345370	B. WING	03/20/20		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & RE	EHABILITATION CENTER		00 BLAKE BOULEVARD INEHURST, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	
F 637	Continued From pag	ge 9	F 637	Date. This information has been integrated into the standard orientatio training for new Minimum Data Set Coordinators.	n	
				The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corr and/or in compliance with the regulate requirements; The Director of Nursing or designee of review 5 residents who have been eit admitted to or discharged from hospi services OR who have changed hosp providers during the past 30 days to ensure that a Significant Change in Status MDS Completed as required. This will be cusing the quality assurance tool entit "Significant Change in Status MDS Completion Audit Tool." This audit we done on weekly basis for 4 weeks the monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director Nursing to ensure corrective action for trends or ongoing concerns is initiate appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data S Coordinator, Unit Manager, Therapy, Dietary Manager and the Administrat The title of the person responsible for implementing the acceptable plan of correction;	that ected ory will ther ce bice Status been done led ill be en en en en en en en en en en en en en	
F 641 SS=D	, ,	ments	F 641	Administrator and /or Director of Nurs	6/27/22	

	-				FORM	D: 06/30/2022 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	
		345370	B. WING		05/	26/2022
NAME OF P	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345370 B. WING WE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IEHURST HEALTHCARE & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE IEHURST HEALTHCARE & REHABILITATION CENTER JOB BLAKE BOULEVARD PINEHURST, NC 28374 PINEHURST, NC 28374 K4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REFIX ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)					
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 641	Continued From page	10	F 641			
	The assessment mus resident's status. This REQUIREMENT by: Based on record revi interviews, the facility Data Set (MDS) asse- areas of bowel and bl #54), and medications for 2 of 21 residents m The findings included 1. Resident #54 was a diagnosis of Urinary F Review of Resident # orders included an on suprapubic catheter. Resident #54's quarter (MDS) dated 4/5/22 ir intact, coded for a urin occasional urinary inco An interview was com PM with the MDS Nur #54's MDS dated 4/5/ for occasional urinary an oversight.	t accurately reflect the is not met as evidenced ews, observations and staff failed to code the Minimum ssment accurately in the adder (Residents #44 and s (Resident #44). This was eviewed. admitted on 8/2/21 with a Retention. 54's cumulative Physician der dated 4/5/22 for her erly Minimum Data Set ndicated she was cognitively hary catheter and coded for ontinence. pleted on 5/26/22 at 12:10 se. She stated Resident 22 was coded inaccurately incontinence and that it was pleted on 5/26/22 at 1:00 ator. She stated it was her		 For resident #44, a corrective action obtained on 06/16/22. The specific deficiencies for resi #44 for Minimum Data Set with Assessment Reference Date of 03/2. were corrected on 06/16/22 by modifi the Minimum Data Set assessment in order to correct miscoding of question H0400 (Bowel Continence) and N04 (Anticoagulant). This correction was completed by the Regional Minimum Set Consultant. The corrected assessment was re-submitted and accepted by the state database on 06/16/22 in Batch #487. For resident #54, a corrective action obtained on 06/16/22. The specific deficiency for resider #54 for Minimum Data Set with Assessment Reference Date of 04/0 was corrected on 06/16/22 by modify the Minimum Data Set assessment in order to correct miscoding of question H0300 (Bladder Continence) . This correction was completed by the Reg Minimum Data Set Consultant. The corrected assessment was re-submitted and accepted by the state database on 06/16/22 by modify the Minimum Data Set assessment in order to correct miscoding of question H0300 (Bladder Continence) . This correction was completed by the Reg Minimum Data Set Consultant. The corrected assessment was re-submitted and accepted by the state database 	dent 2/22 ying n IOE Data Data was ent 5/22 ing n sjonal ted on	

Facility ID: 923403

		MEDICAID SERVICES			OMB NO. 0938	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	ſ
		345370	B. WING		05/26/202	22
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPL O THE APPROPRIATE DA	(5) LETIC ATE
F 641	Continued From page	e 11	F 64	11		
	with a diagnosis of er Review of Resident # orders included an or colostomy care every Resident #44's quarte (MDS) dated 3/22/20 had impaired vision a assistance with all ac Resident #44 had a c always incontinent of assessment period. An interview was com 12:22 PM with the MI Resident #44's MDS inaccurately for alway stated she should hav since the resident had stated it was an overs An interview was com PM with the Administ	erly Minimum Data Set 22 indicated the resident ind required extensive tivities of daily living. solostomy and was coded as bowel during the npleted on 5/26/2022 at OS Nurse. She stated dated 3/22/2022 was coded /s incontinent of bowel. She ve coded it as not rated d a colostomy. She further		 potential to be affected by deficient practice. All residents have the pot affected by the alleged d A 100% audit of the most completed Minimum Data assessment for all currer have a urinary catheter, are receiving anticoagula be conducted in order to H0300, H0400 and N041 accurately coded. This at completed by the Region Set Consultant and will be later than 06/24/22. All Minimum Data Set As are identified as having i of H0300, H0400 and/or modifications completed any necessary correction corrections will be completed by the completed and will be re-submitted database no later than 0 	tential to be eficient practice. t recently a Set nt residents who colostomy, and/or ant medication will determine if IOE were audit will be nal Minimum Data be completed no essessments that naccurate coding N0410E will have in order to make ns. These eted by the Set Consultant to the state	
	with a diagnosis of er Review of Resident # Administration Record revealed the resident	a admitted on 12/13/2021 ad stage renal disease. 44's Medication d (MAR) for March 2022 received heparin, 5000 cutaneously twice daily for		Systemic Changes On 06/20/22, the Region Set Consultant complete training for the facility Mi Coordinator that included of thoroughly reviewing t and conducting a physica	d an in-service nimum Data Set d the importance he medical record	
	(MDS) dated 3/22/202	erly Minimum Data Set 22 indicated the resident ants 5 out of 7 days, opioids		the resident prior to com Minimum Data Set Asses education emphasized th	ssment. This	

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	5 FUR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		00 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 641	Continued From page	e 12	F 641		
	assessment period. An interview was con 12:22 PM with the MI Resident #44's MDS inaccurately for antico received anticoagular period. She further st An interview was con PM with the Administ	no anticoagulants during the npleted on 5/26/2022 at DS Nurse. She stated dated 3/22/2022 was coded oagulants. The resident had nts during the assessment ated it was an oversight. npleted on 5/26/22 at 1:00 rator. She stated it was her esident MDS assessments		thorough assessment and review i to be able to accurately code H030 (bladder continence); H0400 (bow continence); and N0410E (anticoa This information has been integrat the standard orientation training fo Minimum Data Set Coordinators. The monitoring procedure to ensur the plan of correction is effective a specific deficiency cited remains or and/or in compliance with the regu requirements. The Director of Nursing or designe begin auditing the coding of MDS i H0300, H0400 and N0410E using quality assurance audit tool entitled "Accurate Minimum Data Set Codi Tool." This audit will be done weekly x 4 and then monthly x 2 months. Rep be presented to the weekly Quality Assurance committee by the Direct Nursing to ensure corrective action trends or ongoing concerns is initia appropriate. The weekly Quality Assurance Meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Un Manager, Support Nurse, Therapy Information Manager, Dietary Man and the Activity Director. The title of the person responsible implementing the acceptable plan correction;	200 el gulant). ed into r new re that nd that orrected latory ee will items the d ng Audit weeks orts will v tor of n for ated as the nit , Health ager for
F 656 SS=D	Develop/Implement (Comprehensive Care Plan	F 656	Administrator and /or Director of N	ursing. 6/27/22

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/30/2022 APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE	
		345370	B. WING				05/:	26/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CO	DE	-	
PINEHURS	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 656	implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Faci whether the resident's community was asses local contact agencies	ensive Care Plans ility must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and cludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must - re to be furnished to attain nt'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 ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. n the resident and the ive(s)- als for admission and ference and potential for lities must document a desire to return to the sed and any referrals to a and/or other appropriate	F	656				
	community was asses	ssed and any referrals to s and/or other appropriate						

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	OF DEFICIENCIES	MEDICAID SERVICES		רוסי ר	CONSTRUCTION		<u>O. 0938-03</u> e survey
	CORRECTION	IDENTIFICATION NUMBER:	, í				PLETED
		345370	B. WING _			05	5/26/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 14	É F	656			
		in the comprehensive care					
		in accordance with the					
		h in paragraph (c) of this					
	section.						
	This REQUIREMEN	Γ is not met as evidenced					
	by:						
		iews and staff interviews, the			F 656 Develop/Implement		
	-	op a comprehensive care			Comprehensive Care Plan		
		as needed psychotropic			Corrective Actions for Resident #61.		
		t #61) and the use of oxygen			A corrective action was taken in order		
	· · · ·	was for 2 of 21 residents			correct the care plan for Resident #61	on	
	reviewed.				05/26/22. This corrective action was	~	
	The findings included	4.			completed by the facility Minimum Dat Set Nurse.	а	
		1.			Corrective Actions for Resident #96.		
	1 Resident #61 was	admitted to the facility on			A corrective action was taken in order	to	
		ses that included anxiety			correct the care plan for Resident #96		
	disorder and seizure	-			05/26/22. This corrective action was		
					completed by the facility Minimum Dat	а	
	Resident #61's active	e physician orders revealed			Set Nurse.		
	an order dated 12/20	/21 for Lorazepam (an					
	antianxiety medicatio	on) 0.5 milligrams (mg) 1			Corrective action for residents with the	;	
	tablet by mouth every	y hour as needed for anxiety.			potential to be affected by the alleged deficient practice.		
	A review of the Marcl				All residents have the potential to be		
		d (MAR) revealed Resident			affected by the alleged deficient practic		
	#61 received Loraze	pam seven times.			A 100% audit of all current residents w	/ho	
	A				are currently receiving antianxiety		
	A quarterly Minimum	Data Set (MDS) 4/22 indicated Resident #61			medication and/or are receiving oxyge		
		t and received 3 out of 7			therapy was conducted in order to ens that their care plans accurately reflect	uie	
	days of an antianxiet				these services. This audit will be		
		y modioation.			completed by the Regional Minimum D	Data	
	Resident #61's active	e care plan, last reviewed			Set Consultant and will be completed i		
	4/15/22, made no ref				later than 06/24/22.		
		ons or the associated risks.			Any resident whose care plan is identit	fied	
					as not accurately reflecting antianxiety		
	A review of the April	2022 MAR revealed Resident			medication use and/or oxygen therapy	' will	
	#61 received Loraze	pam 11 times.			be revised by the Regional Minimum D		

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						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		OATE SURVEY
		345370	B. WING			05/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
PINEHURS	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIC DATE
F 656	Continued From page	e 15	F 65	6		
		PM, an interview occurred who indicated it was an		Set Consultant and will later than 06/24/22.	be completed no	
	oversight not to have care plan for the use psychotropic medicat			Systemic Changes On 06/20/22 the Regior Set Nurse Consultant p education to the facility	rovided in-service	
	Director of Nursing or	vith the Administrator and n 5/26/22 at 1:10 PM they expectation for Resident		Nurse on Comprehensi This education included ensuring that each resid	ve Care Plans. I the importance of dent's care plan	
		comprehensive and felt it to have included the use of ions for anxiety.		addressed actual proble resident strengths and p education emphasized must communicate the	preferences. The that the care plan resident's current	
	facility on 10/25/19.	originally admitted to the Her diagnoses included Ire (CHF) and hypertensive eart failure.		condition, needs, and p staff. Therefore, the ca ongoing revisions and u resident's condition cha education also included	re plan must have updates as the inges. The I the importance of	
	A physician order dat at 2 liters via nasal ca saturations below 90°			ensuring that resident c updated and accurately resident's current nutriti educational material inc the care plan is a tool u	reflect the ional status. The cluded the fact that	
	4/26/22 indicated Res	otes from 12/28/21 until sident #96 had oxygen in ıla when she was assessed		communicate resident's preferences, strengths, the interdisciplinary tea frontline staff, and that i the highest quality of ca	s condition, needs, special needs to m and primarily in order to provide	
	had severely impaired required extensive to	Data Set (MDS) 9/22 indicated Resident #96 d decision-making skill and total assistance with all ng. She was not coded for		ensure residents' needs plans must be person-c accurate and current re Emphasis was placed c the care plan accurately	s are met, the care centered and an flection of resident. on ensuring that y reflects the use	
		#96's active care plan, last /ealed no care plan in place		of any psychotropic me antianxiety agents as w therapy. This information has be	ell use of oxygen	

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TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345370	B. WING		05/26/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTIO	
F 656	Continued From page	e 16	F 656	5		
	indicated Resident #3 nasal cannula. On 5/23/22 at 10:40 / observed lying in bec nasal cannula. An interview with Me occurred on 5/25/22 had always known R continuously. On 5/26/22 at 12:09 / with the MDS Nurse #96's medical record explained she had al with oxygen in place not to have develope use. During an interview v on 5/26/22 at 1:10 Pl expectation for care p reflection of the resid would have expected	ways observed Resident #96 and felt it was an oversight d a care plan for oxygen with the Director of Nursing, M, she stated it was her olans to be an accurate ent. She further stated she I a care plan and place to address Resident		 Minimum Data Set Nurses. Monitoring Procedure to ensure that a plan of correction is effective and that specific deficiency cited remains correction in compliance with regulatory requirements. The Director of Nursing or designee we conduct audits to ensure that current residents have care plans that accurate reflect if they are receiving antianxiety medication and/or oxygen therapy. The Quality Assurance tool entitled "Comprehensive Care Plans QA Tool be completed weekly for 4 weeks the monthly for 2 months or until sustained compliance has been achieved. Rep will be presented to the weekly Quality Assurance committee by the Director Nursing to ensure corrective action initiated as appropriate. Compliance weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, There Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation of the acceptable plan 	t ected will ately y he " will n ed orts ty of will lity lity e apy,	
F 657			F 657	correction.	6/27/22	
SS=D	CFR(s): 483.21(b)(2)	(i)-(iii)				

Event ID: YHE211

Facility ID: 923403

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		D. 0938-03 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	COMPLETED	
		345370	B. WING		05/26/2022		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 657	Continued From page	e 17	F 65	57			
		prehensive care plan must					
	(i) Developed within 7	days after completion of					
	the comprehensive as	ssessment. terdisciplinary team, that					
	includes but is not lim						
	(A) The attending phy						
		e with responsibility for the					
	resident. (C) A nurse aide with	responsibility for the					
	resident.						
		and nutrition services staff.					
		ticable, the participation of					
		esident's representative(s). be included in a resident's					
	•	participation of the resident					
		resentative is determined					
	not practicable for the	e development of the					
	resident's care plan. (E) Other appropriate	staff or professionals in					
		ined by the resident's needs					
	or as requested by th	e resident.					
		ised by the interdisciplinary					
	comprehensive and c	ssment, including both the					
	assessments.						
		is not met as evidenced					
	by: Based on staff interv	iews and record review the		F657 Care Plan Timing and Re	vision		
		the comprehensive care		Corrective Action for Affected Re			
		nanagement (Resident #60),		Corrective Action for Resident #			
		pressure ulcer (Resident		care plan for resident #60 was r			
	, .	ssistance (Resident #74). esidents reviewed for care		order to add that the resident is restorative nursing services for l	-		
	plan revision. The find			upper extremities and left hand			
				This was completed by the Mini	mum Data		
		admitted 3/22/22 with a		Set Nurse Consultant on 06/16/			
	non-traumatic intercra	anial hemorrhade with left		Corrective Action for Resident #	3 The		

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 657	Continued From page	e 18	F 65	7	
	His admission Minima 4/4/22 indicated he h impairment, coded fo his activities of daily I impairment to his bila extremities. Review of a Restoratt form dated 5/2/22 indo receive passive range left upper extremities orthosis splint to his I for 3-4 hours for prev contracture. Review of Resident # plan 4/22/22 did not i contracture managem An interview was com PM with the MDS Nu #60's comprehensive revised to included R management for PRC An interview was com PM with the Administ expectation that Resi include the area of co 2. Resident #3 was o and osteoarthritis.	um Data Set (MDS) dated ad severe cognitive r total assistance with all of iving (ADLs) and coded for iteral upper and lower ive or Maintenance referral licated Resident #60 was to e of motion (PROM) to his and to wear a wrist-hand eft hand 3 times per weeks ention of a left hand 60's comprehensive care nclude a care plan for nent or restorative nursing. hpleted on 5/26/22 at 12:10 rse. She stated Resident care plan should have been esident #60's contracture		 the Minimum Data Set Nu on 06/16/22 in order to ad and related interventions fulcer to left lateral leg. Corrective Action for Resid care plan for resident #74 the Minimum Data Set Nu order to add that the resid staff assistance with eatin Corrective action for resid potential to be affected by deficient practice. All residents have the pote impacted by the alleged d A100% audit will be of current residents who are receiving restorative nursi order to determine if these accurately reflect on the c A 100% audit will be of current residents who curr pressure ulcer(s) in order the care plan reflects press A 100% audit will be of current residents who requires assistance with meals in of determine if this is accurat the care plan. This audit will be completed Minimum Data Set Nurse completed no later than 00 Any resident whose care plan as not accurately reflecting above audited items will b 	d focus, goal for pressure dent #74: The was revised by rse 05/26/22 in lent requires g meals. ents with the the alleged ential to be eficient practice. conducted on all currently ng services in e services are are plan. conducted on all rently have to determine if issure ulcer(s). conducted on all uire staff order to tely reflected on ed by the facility and will be 6/24/22. plan is identified g any of the
		ent #3 developed an open		order to ensure that the ca accurate and current refle resident's condition and n corrections will be comple	are plan is ction of eeds. All

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			OMPLETED
		345370	B. WING			05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PINEHUR	ST HEALTHCARE & REI	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 657	Continued From pag	e 19	F 65	7		
	Resident #3's left knd discontinued and new the treatment of her l ulcer. Review of Resident # plan last revised on 2 area with intervention ulcer. Resident #3's quarte dated 5/1/22 indicate impairment and was pressure ulcer. An interview was cor PM with the MDS Nu #3's comprehensive revised to included R with the onset date of An interview was cor PM with the Administ expectation that Res	w orders were received for left lower lateral pressure 43's comprehensive care 2/28/22 did not include a care ns for her stage 4 pressure rly Minimum Data Set (MDS) ed she had severe cognitive coded for one stage 4 mpleted on 5/26/22 at 12:10 urse. She stated Resident care plan should have been Resident #3's pressure ulcer f 11/25/21. mpleted on 5/26/22 at 1:00 trator. She stated it was her ident #3's revised care plan ulcer development to her left		facility Minimum Data Set Nu be completed no later than 06 Systemic Changes On 06/20/22, the Minimum Data Nurse Consultant in-serviced Minimum Data Set Nurse on importance of maintaining up plans that are reflective of the current status and needs. En placed on ensuring that care individualized for each reside needs. This includes ensurin care plan accurately reflects to of pressure ulcers, resident's staff assistance with feeding/ special services that they mat receiving including restorative services. Frontline staff who direct care to residents rely o plan in order to provide safe a care. Therefore, it is critical t addition to the routine quarter assessment and care plan re updates that are completed, t plans also be updated and re resident's condition changes. updates and revisions is an o	5/24/22. ata Set the facility the to date care e resident's nphasis was plans are nt's specific g that the he presence need for meals and y be e nursing provide n the care and effective hat in 'ly views and hat care vised as a Care plan	
	diagnoses that includ Resident #74's quart (MDS) dated 5/4/202 severely impaired co	admitted 1/15/2021 with ded dementia. erly Minimum Data Set 22 indicated the resident has gnition, required extensive ities of daily living and		process. The monitoring procedure to the plan of correction is effect specific deficiency cited rema and/or in compliance with the requirements; The Director of Nursing or de	ive and that ins corrected regulatory	

Event ID: YHE211

Facility ID: 923403

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		045070			
		345370	B. WING		05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		800 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO
F 657	Continued From page	e 20	F 657		
		and set up only for eating.		audit up to 5 current residents ir validate whether or not the care	
	Review of Resident #74's comprehensive care plan revised 1/26/2022 included a focus for nutritional problem related to weight loss. The resident's interventions stated the resident could feed herself after tray set up.			accurately reflects whether the r currently is currently receiving re nursing services, has a pressure requires staff assistance with feeding/meals. This will be done weekly basis x 4 weeks then mo	esident estorative e ulcer or e on
	by the former Directo progress note read; F Resident will eat if as intervention is to have	474's medical record note dated 3/30/2022 written r of Nursing (DON). The Resident has lost weight. sisted with meals. New e resident assisted with in for resident to be assisted		months. Reports will be present weekly Quality Assurance comm the Director of Nursing to ensure corrective action for trends or or concerns is initiated as appropri weekly QA Meeting is attended Director of Nursing, Wound Nur- Coordinator, Unit Manager, The	hittee by e ngoing ate. The by the se, MDS
	progress note dated Manager (DM) that re	al record also included a 3/30/2022 by the Dietary ead; put in recommendation with feedings and will er weight.		Health Information Manager, Die Manager and the Administrator. The title of the person responsit implementing the acceptable pla correction; Administrator and /or Director of	ble for an of
	conducted with the for intervention was disc interdisciplinary meet the resident required the resident's progres Minimum Data Set (M resident required ass MDS nurse should ha care plan. The forme add assistance with r	8 AM a phone interview was ormer DON. She stated the ussed in the morning ting and she did document assistance with feeding in ass notes. She made the MDS) nurse aware the istance with meals and the ave revised the resident's r DON stated she did not meals to the resident's care been the responsibility of			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345370	B. WING		05/26/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REF	IABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 657	Continued From page	21	F 65	7		
	March or being asked	rdisciplinary meeting in I to add feeding assistance sident #74's care plan				
	PM with the Administ	npleted on 5/26/22 at 1:00 rator. She stated it was her plan be revised to reflect				
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 65	8	6/27/22	
	as outlined by the con must- (i) Meet professional This REQUIREMENT	d or arranged by the facility, mprehensive care plan,				
	resident interviews, th correct route of medic 3 residents (Resident medication administra	ation.		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has t	d do ral aken	
	The findings included Resident #44 was ad diagnosis of end stag	mitted on 12/13/2021 with a		or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged	ion	
	(MDS) dated 3/22/20 had moderately impa extensive assistance	with all activities of daily eous endoscopic gastric tube), and received		 deficiencies cited have been or will be corrected by the dates indicated. F658 The facility failed to identify the correct route of medication administration for resident #44. 1. Corrective action for resident(s) affected by the alleged deficient pract On 06/17/2022 the Director of Nurses 	ot ice:	

Facility ID: 923403

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ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY	
d plan of	CORRECTION	IDENTIFICATION NUMBER:	. ,	i) ´co	COMPLETED	
		345370	B. WING)5/26/2022	
AME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	E		
INEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE	
F 658	Continued From page	e 22	F 65	8			
	updated 3/2/2022, con nutritional problem re- tube, and dialysis. Resident #44's Media (MAR) for May 2022 medications via oral nordered to be administ Resident #44's media physician orders for t be given through the Aspirin 81milligrams Fish oil 1000mg caps Fluoxetine 40mg table Melatonin 3mg, 2 tab Nephrovite 1mg table Probiotic capsule dai Metoprolol 25mg, hall Midodrine 10mg via F	elated to weight loss, feeding cation Administration Record revealed he received some route while others were stered via feeding tube. cal record revealed active he following medications to PEG tube; (mg) daily via PEG tube sule once daily via PEG tube e daily via PEG tube elets nightly via PEG tube et via PEG tube daily ly via PEG tube. If tablet via PEG 2 times daily PEG tube every 8 hours		 audited the medication routes #44 to assure they were appro- clarified with the physician that medications maybe taken ora 06/17/2022 all medication ord compliance. 2. Corrective action for resident the potential to be affected by deficient practice. On 6/17/2022 the Director of I nursing team audited resident feeding tubes to assure all me orders were ordered to be addres via the correct route of adminina Results: 4 of 4 residents with tubes were in compliance. A 2022 all residents were in com 3. Measures /Systemic char prevent reoccurrence of allego practice: Beginning on 6/15/2022 the D Nurses, Nurse Consultant and 	opriate and at all lly. As of ers were in dents with the alleged Nurses and ts with edication ministered istration. feeding s of 6/17/ npliance. nges to ed deficient		
	of Resident #44's me stated when he first of the orders were writte were never changed. #44 did not have any medications, the PEC supplemental feeding gave all his medication stated it was the nurs the route of administr had not noticed the ro			 Director of Nurses began in-see education to all full time, part if needed nurses and agency nu Topics included: Monitoring of the route of administration for residents wit tubes to assure the medication correct. Facility policy on clarification medication orders to include those with feeding tubes. The 6 rights of med pass. This information has been integet the standard orientation training 	time, and as urses ith feeding n route is tion of oute of e residents egrated into		

Facility ID: 923403

If continuation sheet Page 23 of 84

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SI	JRVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLE	
		345370	B. WING		05/20	6/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 658	On 5/25/2022 at 10:4 conducted with Nurse agency/contract nurs facility full time. She of Resident #44's medic crushed Resident #44 administration via PE entered the room, the did not take his medic been taking them ora Nurse #6 stated she following the orders of she made the unit maneeded clarification. An interview was con He stated all his medic administered orally. H difficulty with swallow medication via oral root An interview was con Administrator and the on 5/26/2022 at 1:00 stated it was her expla- be given via route oroot	9 AM an interview was e #6. She stated she was an e and did not work in the confirmed she administered cations. Nurse #6 stated she 4's medication for G tube. However, when she e resident informed her he cation via PEG and he had illy for several months. did not know; she was on the MAR. Nurse #6 stated anager aware the orders ducted with Resident #44. ication were being He further stated he had no ring and had been taking his oute for several months. ducted with the e Director of Nursing (DON) PM. The Administrator ectation that all medication	F 65	required in-service refresher all staff identified above and reviewed by the Quality Assu- process to verify that the cha- been sustained. Any of the in nursing staff who does not re- scheduled in-service training allowed to work until training completed by June 26, 2022 4. Monitoring Procedure to the plan of correction is effect specific deficiency cited rema- and/or in compliance with re- requirements. The Director of Nurs- designee will utilize the QA to to monitor compliance with of the route of administration of and that medications are bei administered via the clarified Director of Nurses and/or de monitor 3 residents with order tubes weekly x 2 and then m months for compliance. This direct observation of 3 reside various day and evening shift of the week to include weeke applicable). This tool will be	will be urance ange has dentified eceive will not be has been o ensure that ctive and that ains corrected gulatory ing and/or ool for F 658 clarification of f medications ng I route. The signee will ered feeding ionthly for 3 will include ents on fts and days ends if completed as	
	on 5/26/2022 at 1:00 stated it was her expo be given via route or Attempts to interview	PM. The Administrator ectation that all medication dered.		tubes weekly x 2 and then m months for compliance. This direct observation of 3 reside various day and evening shif of the week to include week	anonthly for 3 will include ents on fts and days ends if completed as ne that the ne need to audit (when it istained red). e to be DON will Committee.	

Event ID: YHE211

Facility ID: 923403

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		MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
INEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 658	Continued From page	≥ 24	F 658	3 Minimum Data Set Coordinator, The Manager, Health Information Manag Dietary Manager, Maintenance Director.	er,
F 677 SS=E		or Dependent Residents	F 677	7	6/27/22
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on record revi and staff interviews, t clean dependent resi #41, #78, #96 and #4	is not met as evidenced iews, observations, resident he facility failed to trim and dents' fingernails (Residents 4) for 4 of 4 residents s of Daily Living (ADL).		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has or will take the actions set forth in this plan of correction.	nd do eral taken is ction
	11/19/20 with a stroke side and vascular der A quarterly Minimum	Data Set (MDS)		constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will b corrected by the dates indicated. F677 The facility failed to provide na	be
	#41 had severe cogni behaviors or refusal c extensive assistance bathing tasks and wa	16/22 indicated Resident itive impairment and had no of care. He required with personal hygiene and s coded with limited range of upper extremity and both		 care. 1. Corrective action for resident(s) affected by the alleged deficient practices for resident #+41, on 06/17/2022 naticare was provided and documented the hall nurse. For resident #78, on 06/17/2022 natical was provided and documented by the second second	ctice: hil by care
	reviewed 4/7/22, inclu areas:	#41's active care plan, last uded the following focus nent to skin integrity. The		nurse. For resident # 96, on 06/17/2022 nai was provided and documented by th nurse.	il care

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					CONSTRUCTION		NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			· · ·	OATE SURVEY OMPLETED
		345370	B. WING _				05/26/2022
AME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 25	F	677			
	interventions include - ADL self-care perfo	d to keep fingernails short. rmance deficit, with an nail length, trim and clean			For resident # 44, on 06/17/2022 nail was provided and documented by the nurse.	hall	
	A review of Resident #41's nursing progress notes from 1/1/22 to 5/24/22 revealed no refusals of nail care documented.				 Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. Beginning on 6/16/2022, the 	ged	
	observed while lying	AM, Resident #41 was in bed watching TV. He was ngernails on both hands with der them.			nursing team began auditing all currer residents for the need of nail care. Thi audit will be completed by 06/26/2022 nail care will be provided to those residents identified in need of nail care	nt is : and	
	AM while lying in bed	pserved on 5/24/22 at 11:05 I watching TV. His nails on I unchanged from previous			The Minimum Data Set Nurse/Nursing Team will then task the requested shower schedule to Point C Care tasks to fire to the certified nursi	e Click ng	
	Resident #41, and as day. She explained r	4, who was familiar with ssigned to care for him that nail care would be completed			assistant's for documentation. This will completed by 06/ 17/2022 The nursing team obtained orders for diabetic nail by a nurse for each diabetic resident a 6/16/2022.	g care	
	Resident #41 "in a wi Resident #41's nails verified they were lor	d not rendered nail care to hile". An observation of occurred with NA #4 who ng with a dark substance ed, "well they do need nd some clippers."			3. Measures /Systemic changes to prevent reoccurrence of alleged defici practice: Beginning on 6/15/2022, the Director of Nurses, Assistant Director of Nurses a	of and	
	of Resident #41's har fingernails remained under them. Residen	M, an observation was made nds, which revealed long with a dark substance t shook his head "no" when offered to complete his nail			Nurse Consultant began education of full time, part time, and PRN Nurses a CNA's and Med Aides on the following • Nail care should be performed da with baths/showers and documented b the CNA in tasks in the electronic health	ınd g: iily	
		was made of Resident #41 M. He was lying in bed with			record. Refusal documentation for CNA's/Nurses. 		

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
F 677	Continued From page	e 26	F 67	7	
		nands resting on top of the		Diabetic nail care so	chedule and
		s on both hands were long		documentation by nurses	
	with a dark substance	-			
				This information has bee	en integrated into
	On 5/26/22 at 9:40 A	M, an interview occurred		the standard orientation	
	with NA #2 who was	assigned to care for		required in-service refres	sher courses for
	Resident #41 on 5/26	6/22. She stated "a group"		all staff identified above	and will be
		ide nail care to the residents,		reviewed by the Quality	
		nails if they were dirty. She		process to verify that the	
	denied providing rece	ent nail care to Resident #41.		been sustained. The fac	
				in-service will be provide	
		d with NA #6 on 5/25/22 at		Nurses and CNA's who	-
		she provided nail care when less the resident was a		care in the facility. Any r does not receive schedu	5
		ould let the nurse know. She		training will not be allowed	
		f she had provided nail care		training has been comple	
	to Resident #41.			2022.	
	On 5/25/22 at 2:25 P			4. Monitoring Procedu	
		5 and NA #8, who stated		the plan of correction is e	
		ned and trimmed on shower		specific deficiency cited	
	days or when there w			and/or in compliance wit	h regulatory
		d for by the nurse. They		requirements.	
		sident #41 refusing nail care		The Director of Nurses o	
		ot cared for him in a while.		monitor compliance utiliz Quality Assurance Tool v	-
	The Administrator and	d Director of Nursing (DON)		weeks then monthly x 3	
		5/26/22 at 1:10 PM and		resolved. Auditing will inc	
		pect nail care to be rendered		shifts and days of the we	
		or shower assistance. The		weekends. The Director	
	DON further added if			monitor nail care complia	-
	complete the task she	e would expect the nurse to		be presented to the wee	kly Quality
	be notified of the nee	d. The Administrator and		Assurance committee by	/ the Director of
		explain why nail care had		Nurses to ensure correct	
		dent #41 as there was no		initiated as appropriate.	
		bw this had or had not been		be monitored and the on	
	completed or attempt	ied.		program reviewed at the	
	0 Desident //70			Assurance Meeting or ur	
	∠. Resident #78 was	admitted to the facility on		necessary for complianc	e with ADL Care.

Facility ID: 923403

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		MEDICAID SERVICES	(X2) MI II TIPI I	ECONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		000 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLE
F 677	and seizure disorder. A quarterly Minimum assessment dated 4// #78 had moderately i no behaviors or refus extensive assistance bathing tasks. A review of Resident reviewed 5/20/22, ind self-care performance interventions was to p grooming and person A review of Resident notes from 1/19/22 to refusals of nail care of On 5/23/22 at 10:15 / with Resident #78 wh wheelchair in his roor long fingernails with a them. Resident #78 s that long and had bee cut. He added he woo have left them jagged Resident #78 was ob AM while lying in bed both hands remained observations. On 5/24/22 at 3:30 P completed with NA #4 Resident #78, and as	s that included osteoarthritis Data Set (MDS) 27/22 indicated Resident mpaired cognition and had al of care. He required with personal hygiene and #78's active care plan, last cluded a focus area for ADL e deficit. One of the provide assistance with hal hygiene. #78's nursing progress o 5/24/22 revealed no documented. AM, an interview occurred hile he was sitting in a m. He was noted to have a dark substance under stated he didn't like his nails en "a while" since they were uld bite them, but it would d. served on 5/24/22 at 11:07 I watching TV. His nails on I unchanged from previous	F 677	The weekly QA Meeting is attend Administrator, Director of Nursing Coordinator, Therapy Manager, F Information Manager, and the Die Manager. Date of Compliance: 06/27/2022	l, MDS lealth

Facility ID: 923403

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DEPARTMENT OF HEALTH AND HUMA CENTERS FOR MEDICARE & MEDICAI	-				FORM): 06/30/2022 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROV	IDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	-	(X3) DATE	
	345370	B. WING			05/2	26/2022
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PINEHURST HEALTHCARE & REHABILITAT	ON CENTER	-	000 BLAKE BOULEVARD PINEHURST, NC 28374	1		
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 F 677 Continued From page 28 to Resident #78 "in a while. An Resident #78's nails occurred is verified they were long with a counder them and stated she wood On 5/25/22 at 8:54 AM, an obsis of Resident #78's hands, which fingernails remained long with under them. Resident stated in to provide nail care to him this Another observation was made on 5/26/22 at 11:00 AM. He with wheelchair looking out his wind fingernails remained long with under them. On 5/26/22 at 9:40 AM, an interwith NA #2 who was assigned Resident #78 on 5/26/22. She came around to provide nail cat but she would clean nails if the denied providing recent nail cat but she would clean nails if the denied providing recent nail cat An interview was held with NA 11:00 AM and stated she provit there was a need, unless the in diabetic, then she would let the was unable to state if she had to Resident #78. On 5/25/22 at 2:25 PM, an inter completed with NA #5 and NA nails were to be cleaned and th days or when there was a need fingernails were cared for by th were unaware of Resident #78 in the past but had not cared for 	with NA #4 who lark substance uld care for them. ervation was made a cark substance o one had offered week. e of Resident #78 as sitting in the dow. His a dark substance rview occurred to care for stated "a group" re to the residents, y were dirty. She re to Resident #78. #6 on 5/25/22 at ded nail care when esident was a e nurse know. She provided nail care rview was #8, who stated immed on shower d. Diabetic le nurse. They refusing nail care	F 677				

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345370	B. WING		c	5/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 677	Continued From page	e 29	F 6	77		
		d Director of Nursing (DON)	10			
were interview stated they w		5/26/22 at 1:10 PM and				
		bect nail care to be rendered				
	DON further added if	or shower assistance. The				
	-	e would expect the nurse to				
	be notified of the nee	d. The Administrator and				
		explain why nail care had				
		dent #78 as there was no ow this had or had not been				
	completed or attempt					
		originally admitted to the				
		ith diagnoses that included e spasms and osteoporosis.				
	A quarterly Minimum					
		9/22 indicated Resident #96				
		d decision-making skills and efusal of care. She required				
		istance with all ADL and had				
	limited range of motic	on to all her extremities.				
	A review of Resident	#96's active care plan, last				
		cluded a focus area for				
	intervention to keep f	ent to skin integrity with an ingernails short.				
	A review of Resident notes from 1/19/22 to	#96's nursing progress 5/24/22 revealed no				
		locumented. The nursing				
	progress notes also in nod her head to yes/r	ndicated Resident #96 could no questions.				
		AM, Resident #96 was				
		l listening to music. She was ctures to her hands with her				
		t hand long and touching the				
		gernails on her left hand				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/30/2022 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		345370	B. WING				05/	26/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIF	P CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 677	Continued From page	30	F	677				
	were short in length. down observed.	There was no skin break						
	AM while lying in bed	served on 5/24/22 at 11:15 listening to the radio. Her hand remained unchanged ations.						
	5/24/22 at 3:05 PM. S aware of the facility's	l with Nurse Aide (NA) #7 on She indicated she was not policy on nail care and was re would be performed.						
	Resident #96, and as day. She explained n when needed but she to Resident #96 "in a Resident #96's nails t	M, an interview was J, who was familiar with signed to care for her that hail care would be completed had not rendered nail care while". An observation of o the right hand occurred rmed they needed attention.						
	of Resident #96's har fingernails to her right touching her palm. Re	M, an observation was made ds, which revealed t hand remained long and esident #96 shook her head yone offered to provide nail						
	on 5/26/22 at 9:34 AN listening to the radio. hand remained long a of her head that no or	was made of Resident #96 I who was lying in bed Her fingernails to the right and she indicated with a nod he had offered to trim them.						
	with NA #2 who was a Resident #96 on 5/26	M, an interview occurred assigned to care for /22. She stated "a group" de nail care to the residents,						

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	F DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · · ·	IPLETED
		345370	B. WING		0	5/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
PINEHURS	ST HEALTHCARE & REI	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From pag	e 31	F 67	77		
	but she would clean nails if they were dirty. She denied providing recent nail care to Resident #96. An interview was held with NA #6 on 5/25/22 at 11:00 AM and stated she provided nail care when					
1 tř d w to						
	diabetic, then she wo	nless the resident was a buld let the nurse know. She f she had provided nail care				
	to Resident #96.					
	On 5/25/22 at 2:25 P completed with NA #	M, an interview was 5 and NA #8, who stated				
	nails were to be clea	ned and trimmed on shower				
	days or when there v fingernails were care	ed for by the nurse. They				
	were unaware of Res	sident #96 refusing nail care ot cared for her in a while.				
		nd Director of Nursing (DON) 5/26/22 at 1:10 PM and				
	•	pect nail care to be rendered or shower assistance. The				
		f a NA was unable to e would expect the nurse to ed. The Administrator and				
	not occurred for Res	explain why nail care had ident #96 as there was no ow this had or had not been				
	completed or attemp					
	a diagnosis of end st	age renal disease.				
	(MDS) dated 3/22/20 had moderately impa	erly Minimum Data Set 022 indicated the resident aired vision and required				
	extensive assistance living.	with all activities of daily				

Facility ID: 923403

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 06/30/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		345370	B. WING		_	05/2	6/2022
NAME OF PI	ROVIDER OR SUPPLIER		- - [STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	focus for risk of inabili daily living and at risk to blindness and end On 5/23/2022 at 10:50 observed sitting in his were long with a black on both hands. Reside trim his nails when the stated he had asked t about trimming his fin- they would trim his na could not identify the with fingernail care. T aware his nails were I loss, he was not able On 5/24/2022 at 11:13 observed sitting in his were long and had a t nails on both hands. An interview was cond 5/24/2022 at 3:05 PM assigned to Resident him. NA #7 observed and stated the nails w stated the resident did stated she was an ag know the facility's poli the residents. An interview was cond 5/25/2022 at 11:01 AM all areas of the facility Resident#44. She stat	ty to perform activities of of self-care deficits related stage renal disease. D AM Resident #44 was wheelchair. His fingernails c substance under the nails ent #44 stated his family ey come to visit. He further he nurse assistants (NA) gernails and they stated ils when they had time. He NAs he had asked to assist he resident stated he was ong but due to his vision to see that they were dirty. B AM Resident #44 was wheelchair. His fingernails olack substance under the ducted with NA #7 on . She stated she was #44 and was familiar with Resident #44's fingernails vere long and dirty. She d need nail care. She further ency nurse and did not cy for nail care. She knew ibetic and some facility's do ide nail care to diabetic	F 67	7			

Facility ID: 923403

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
		345370	B. WING	B. WING		05/26/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 677	Continued From page	e 33	F 67	77			
	care on fingernails bu residents.	t not toenails for diabetic					
F 686 SS=E		event/Heal Pressure Ulcer (i)(ii)	F 68	36		6/27/22	
	resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, prev- new ulcers from deve This REQUIREMENT by: Based on record revi Wound Physician inte- ensure the alternating	hensive assessment of a hust ensure that- s care, consistent with ls of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent hadards of practice, to vent infection and prevent		The statements made on this p correction are not an admissior not constitute an agreement wi alleged deficiencies.	n to and do		
		7, #96, #3 and #30) for 4 of for pressure ulcers.		To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility's allegati	/ has taken in this correction		
	facility on 2/1/22 with	s originally admitted to the diagnoses that included a weakness to the dominant tes type 2.		compliance such that all allege deficiencies cited have been or corrected by the dates indicate F686	d will be		
		um Data Set (MDS) 18/22 indicated Resident ependence for daily decision		The facility failed to ensure the pressure reducing mattress wa according to the resident's weight	s set		

Facility ID: 923403

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345370 B. WING 05/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD **PINEHURST HEALTHCARE & REHABILITATION CENTER** PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 686 Continued From page 34 F 686 making. He was coded with moisture associated 1. Corrective action for resident(s) skin damage (MASD) and had a pressure affected by the alleged deficient practice: reducing device to the bed. On 06/16/2022 the nursing team verified the resident's weight and adjusted the Resident #17's active physician orders included alternating pressure reducing air mattress an order dated 3/16/22 for a low air loss mattress setting accordingly to assure each were to the bed. Check inflation of 75 to 150 per set correctly for resident # 17,# 96, # 3 manufacturer guideline. and # 30. 2. Corrective action for residents with A review of Resident #17's medical record the potential to be affected by the alleged revealed from 4/9/22 until 5/12/22 a foam deficient practice. dressing was applied to his sacrum due to On 06/16/2022 the nursing team audited redness every other day. all residents with ordered alternating pressure reducing air mattresses to Resident #17's weight on 5/13/22 was 153.4 assure that the mattress was at the pounds (lbs.). correct setting based on the resident's weight. Results: All residents with A review of Resident #17's active care plan, last alternating pressure reducing air reviewed 5/20/22, included a focus area for risk mattresses were in compliance. As of 06 for pressure ulcer development due to bowel and /26/2022 all residents with ordered bladder incontinence and decreased ability to alternating pressure reducing air assist with repositioning. One of the interventions mattresses were in compliance. included a pressure reducing mattress to the bed. On 06/20/2022 the Director of Nurses educated the wound nurse on the The May 2022 Treatment Administration Record expectation that alternating pressure (TAR) revealed nursing staff had been checking reducing mattresses will be set following the inflation of the low air loss mattress to the manufacturer recommends and the Resident #17's bed for the correct weight setting. resident's weight. On 5/23/22 at 10:35 AM, an observation was 3. Measures /Systemic changes to made of Resident #17. He was sitting up in a prevent reoccurrence of alleged deficient wheelchair at bedside. The alternating pressure practice: reducing mattress machine was set at 75 lbs. per weight setting. The machine had settings of 75 Beginning on 6/15/2022 the Director of lbs., 150 lbs., 175 lbs., 225 lbs., 300 lbs., 375 Nurses, Nurse Consultant and Assistant lbs., 450 lbs., and 500 lbs. and indicated to set Director of Nurses began in-service according to the resident's weight per pounds. education to all full time, part time, and as needed nurses and agency nurses. Resident #17 was observed lying in bed watching Topics included:

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923403

PRINTED: 06/30/2022

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		345370	B. WING				
		345370	B. WING		05/26/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHUR	ST HEALTHCARE & R	EHABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETIO	
F 686	Continued From pa	ge 35	F 68	86			
		:10 AM. The alternating	1.00	Alternating pressure reduc	ing		
		nattress machine was set at		mattresses and assuring they a			
	75 lbs.	natioss madille was set at		the appropriate setting and are			
				functioning condition.			
	An observation occ	urred of Resident #17 on		Reporting of concerns with	a mattress		
	5/25/22 at 9:15 AM	while he was lying in bed. The		to the Wound Nurse or Director			
		e reducing mattress machine		How to apply these princip	les to their		
	was set at 75 lbs.			daily practice.			
				This information has been integ			
		ed with Medication Aide (MA)		the standard orientation training	-		
		00 PM. She stated she		required in-service refresher co			
		nality of the pressure reducing		all staff identified above and wil			
		ure the connections were		reviewed by the Quality Assura			
		on, and the mattress was		process to verify that the chang			
	the machine.	aware of a weight setting on		been sustained. Any of the ide			
	the machine.			nursing staff who does not rece scheduled in-service training w			
	On 5/25/22 at 2:35	PM, an observation was made		allowed to work until training ha			
		Nurse of Resident #17's		completed by June 26, 2022.			
		e reducing mattress machine,					
		et at 75 lbs. The Treatment		4. Monitoring Procedure to er	nsure that		
	-	necked the functionality of the		the plan of correction is effectiv			
		uring her rounds to make sure		specific deficiency cited remain	s corrected		
		re secured, and the mattress		and/or in compliance with regul			
		dicated she checked the		requirements.			
		vell and was unable to explain		The Director of Nursing			
	•	mattress was set 75 lbs.		designee will utilize the QA tool			
	unless it had been	bumped by staff.		Alternating Pressure Ulcer Mat			
	The Mound Dhusis	on consultant was interviewed		monitor compliance that the ap			
	-	an consultant was interviewed PM and stated he expected		setting is in place for each matt Director of Nurses, and/or desig			
		sure reducing mattress		monitor three residents with alte	-		
		cked daily and set according		pressure ulcer mattresses weel	-		
		ight as stated on the machine.		weeks, then monthly for 3 monthly			
		bs between the resident's		accuracy of the mattress setting			
		ght on the machine would not		will be completed as stated abo	-		
	be a useful interver	-		such time that the QA Committee			
				determines the need to change			
	On 5/26/22 at 1:10	PM, an interview was held		frequency of the audit (when it			

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PRINTED: 06/30/2022 FORM APPROVED

	S FOR MEDICARE &					038-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SUR COMPLETE	
		345370	B. WING		05/26/2	022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHURS	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CO	(X5) MPLETIO DATE
F 686	Continued From page	∋ 36	F 686	5		
	who stated they experieducing mattress mattress mattress mattress mattress mattress mattress mattress in a constraint of the resident's weight of a constraint of the second of the seco	 physician orders included (21 for a low air loss Check proper inflation range ufacturer weight guidelines. Data Set (MDS) D/22 indicated Resident #96 d cognition and had a vice to the bed. t on 5/13/22 was 86.8 #96's active care plan, last luded a focus area for risk velopment due to history of er to the coccyx area and 		determined that sustained comp been achieved). Identified area concern are to be immediately a The DON will present the result QA Committee. The monthly Q is attended by the Administrator of Nursing, Minimum Data Set Coordinator, Therapy Manager, Information Manager, Dietary M Maintenance Director, Medical I	of addressed. s to the A Meeting , Director Health anager,	
	decreased ability to a of the interventions in mattress on the bed. inflated and functionin The May 2022 Treatm	Ensure the mattress is				
	the inflation of the low					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/30/2022 APPROVED . 0938-0391
STATEMENT OF DEFICIENT AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE	
		345370	B. WING			05/2	26/2022
NAME OF PROVIDER OR	SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PINEHURST HEALTH	ICARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
made of listening reducing per weigl 75 lbs., 1 lbs., 450 according Resident to the rad alternatir was set a An obser 5/25/22 a The alter machine An interv #1 on 5/2 checked mattress good, the inflated, I the mach On 5/25// with the alternatir confirmin Nurse sta air mattres the conn- was infla	to the radio. mattress ma ht setting. Th 50 lbs., 175 lbs., and 500 g to the resid #96 was obs dio on 5/24/2 ng pressure r at 200 lbs. vation occurred 25/22 at 2:00 the functiona ' making sure e light was or but was unaw nine. 22 at 2:35 Pl Treatment Nu ng pressure r ng it was set a ated she che ess' daily dur ections were ted. She indi ettings as we ident #96's m had been bu	6, while she was lying in bed The alternating pressure achine was set at 200 lbs. the machine had settings of lbs., 225 lbs., 300 lbs., 375 0 lbs. and indicated to set lent's weight per pounds. served lying in bed listening 2 at 11:15 AM. The educing mattress machine red of Resident #96 on hile she was lying in bed. ure reducing mattress	F 68	6			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345370	B. WING			05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 686	on 5/25/22 at 3:10 PM the alternating pressu machines to be check to the resident's weig He added large gaps weight and the weigh be a useful intervention On 5/26/22 at 1:10 Pf with the Administrator who stated they expe reducing mattress mat the resident's weight 3. Resident #30 was a stage 4 pressure ulce Resident #30's revise read she had a press present on admission included ensuring her and functioning prope The quarterly Minimu assessment dated 3/ #30 was cognitively in pressure ulcer, a press bed and for a weight Resident #30's active an order dated 4/6/22 to the bed. Check infl manufacturer guidelin A review of Resident electronic Treatment a revealed nursing staff that they had been ch	A and stated he expected ire reducing mattress ted daily and set according ht as stated on the machine. between the resident's t on the machine would not on. A, an interview was held and Director of Nursing, cted the alternating pressure ichine to be set according to as stated on the machine. admitted on 10/19/20 with a r. d care plan dated 5/25/21 ure ulcer to her sacrum 10/21/20. Interventions air mattress was inflated irly. m Data Set (MDS) 15/22 indicated Resident itact, coded for a stage 4 ssure reducing device to the of 248 pounds (lbs). physician orders included for a low air loss mattress ation of 225-300 per	F	586			

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PRINTED: 06/30/2022

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/30/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		345370	B. WING		_	05/	26/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		00 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Medical record dated An observation was c PM. Resident #30's a mattress machine we 175-225 lbs.	ting on all three shifts. cord weight in her electronic 5/13/2022 was 271.4 lbs. ompleted on 5/23/22 at 3:40 Iternating pressure reducing ight setting was between	F 686				
	11:30 AM. Resident # reducing mattress ma between 175-225 lbs.						
	(MA) #1 on 5/25/22 at checked the functiona mattress' making sure good, the light was or	pleted with Medication Aide t 2:00 PM. She stated she ality of the pressure reducing the connections were a, and the mattress was vare of a weight setting on					
	5/25/22 at 2:45 PM. S (TN) #1 ensured the a reducing mattress ma correct on first shift ar responsible to check of	pleted with Nurse #2 on she stated Treatment Nurse alternating pressure schine weight setting were ad the floor nurses were on all other shifts. She ed her observations on the					
	PM. Resident #30's a	ompleted on 5/25/22 at 4:30 Iternating pressure reducing ight setting was between					
	On 5/25/22 at 4:40 PM	I, an observation was made					

Facility ID: 923403

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/30/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE	
		345370	B. WING				05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 686	reducing mattress ma between 175-225 lbs. the functionality of the her rounds to make si secured, and the mat indicated she checker and was unable to ex mattress was set betw had been bumped by documented her obse shift. The Wound Physiciar on 5/25/22 at 3:10 PM the alternating pressu machines to be check to the resident's weigh He added large gaps weight and the weight be a useful intervention An interview was com Administrator and the on 5/26/22 at 1:00 PM expected the alternation mattress machine to b resident's weight as si 4. Resident #3 was an Dementia and Osteoa Resident #3's quarter 5/1/22 indicated she f impairment, coded for	At #30's alternating pressure ichine, confirming it was set TN #1 stated she checked a air mattress daily during ure the connections were tress was inflated. She d the weight settings as well plain why Resident #30's ween 175-225 lbs unless it staff. She stated she ervations on the TAR for first a consultant was interviewed A and stated he expected ire reducing mattress ted daily and set according int as stated on the machine. between the resident's to on the machine would not on. upleted with the Director of Nursing (DON A. The DON stated she ing pressure reducing be set according to the tated on the machine. dmitted on 4/1/8/20 with arthritis. Ny Minimum Data Set dated had severe cognitive one stage 4 pressure ssure reducing device to the as 127 pounds (lbs).	F	686				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/30/2022 APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE	
		345370	B. WING				05/	26/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
PINEHURS	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD NEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 686	stage 4 pressure ulce Resident #3's active p order dated 10/27/21 the bed. Check inflation manufacturer guidelin Resident #3's last recomedical record was dated A review of Resident a electronic Treatment A revealed nursing staff that they had been cho low air loss mattress the correct weight setting An observation was continued and the setween 150-175 lbs. An observation was continued and the petween 150-175 lbs.	ot include a care plan for her r. obysician orders included an for a low air loss mattress to on of 75-150 per les every shift. ord weight in her electronic ated 5/11/22 was 127.2 lbs. #3's April and May 2022 Administration Record (TAR) had documented evidence lecking the inflation of the to Resident #3's bed for the on all three shifts. ompleted on 5/23/22 at 3's alternating pressure ichine weight setting was	F	686				
	(MA) #1 on 5/25/22 at checked the functional	pleted with Medication Aide t 2:00 PM. She stated she ality of the pressure reducing the connections were						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345370	B. WING			05/	26/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 686	good, the light was or inflated, but was unaw the machine. An interview was com 5/25/22 at 2:45 PM. St the alternating pressue machine weight settin and on the other shifts responsible to check. documented her obset On 5/25/22 at 4:40 PP with Treatment Nurse alternating pressure r confirming it was set I stated she checked th mattress' daily during the connections were was inflated. She indi weight settings as we why Resident #3's ma 150-175 lbs unless it She stated she docur the TAR for first shift. The Wound Physiciar on 5/25/22 at 3:10 PM the alternating pressue machines to be check to the resident's weigh He added large gaps weight and the weight be a useful intervention An interview was com	n, and the mattress was vare of a weight setting on appleted with Nurse #2 on She stated TN #1 ensures are reducing mattress og were correct on first shift is the floor nurses were She stated she ervations on the TAR. M, an observation was made (TN) #1 of Resident #3's educing mattress machine, between 150-175 lbs. TN #1 he functionality of the air her rounds to make sure secured, and the mattress cated she checked the II and was unable to explain attress was set between had been bumped by staff. nented her observations on in consultant was interviewed A and stated he expected are reducing mattress ted daily and set according th as stated on the machine. between the resident's t on the machine would not on.	F	686			

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PRINTED: 06/30/2022

			()(0)		OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO
F 686	Continued From page	e 43	F 686	5	
		be set according to the stated on the machine.			
F 689 SS=G	-	ards/Supervision/Devices	F 689		6/27/22
	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio Medical Director (MD failed to provide wour that resulted in a resi Resident #54 fell duri sustained a distal fen facility failed to comp Resident #54's fall. T non-ambulatory resid lift according to the m resulting in a distal fe This was for 2 of 3 re accidents. The finding 1. Resident #54 was Congestive Heart Fai knee arthroplasty (kn readmitted on 3/31/22 fracture to her left leg	sident environment remains azards as is possible; and esident receives adequate stance devices to prevent is not met as evidenced ins, resident, staff and i) interviews, the facility nd care in a safe manner dent fall with injury. Ing wound care and hur fracture. In addition, the lete an investigation for he facility also failed to lift a ent with a mechanical sling hanufacturer instructions mur fracture (Resident #3). sidents reviewed for gs included: admitted on 8/2/21 with lure and a history of a left ee replacement). She was 2 with a closed distal femur after a fall.		The statements made on this plan o correction are not an admission to ar not constitute an agreement with the alleged deficiencies. To remain in compliance with all fede and state regulations the facility has or will take the actions set forth in thi plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will b corrected by the dates indicated. F689 The facility failed to provide w care in a safe manner that resulted in fall with injury for resident #54 and fa to complete an investigation for a fall to lift a non ambulatory resident with mechanical lift according to manufac instructions for resident #3. 1. Corrective action for resident(s) affected by the alleged deficient prace Resident #54 had an ordered x-ray of	nd do eral taken s stion e round n a illed and a turer

Event ID: YHE211

Facility ID: 923403

If continuation sheet Page 44 of 84

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · · · · · · · · · · · · · · · · ·	TE SURVEY MPLETED
		345370	B. WING		0	5/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
PINEHUR	ST HEALTHCARE & REH	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES ID ICIENCY MUST BE PRECEDED BY FULL PREFIX RY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From pag	e 44	F 68	39		
	persons with transfer		1 00	indication of a possible of	distal femur	
		.		fracture of left knee. The		
	Resident #54's incide	ent report dated 3/20/22 at		referred to an orthopedia		
		by Nurse #5 read Treatment		On 3/24 she was seen i		
		roviding care to the resident		a diagnosis of a peripros		
		ist her to the floor. There		fracture was found on x-		
	-	aints of pain but later stated		was to the hospital for fo	-	
		nful. The MD was notified on 3/21/22. The follow up		Resident #3 was sent to on 11/09/2021 for follow	•	
	note dated 3/21/22 re	-		complaints of left knee p		
		clinical meeting. Resident		apparent injury during u		
		ound care and lowered to the		mechanical lift for transf		
		intervention was to educate		that occurred on 10/26/2		
	-	und care while the resident		resident was ordered to	-	
	was in the bed.			knee immobilizer with a	-	
	A nursing note dated	3/20/22 at 7:03 PM		closed fracture distal en The x-ray that was order		
	-	#5 read TN #2 was providing		and obtained on 10/26/2	-	
		ent #54 and assisted her to		there was no evidence of		
	the floor. There were	no noted abnormalities and		there was soft tissue sw	elling to the	
	the note did not have	•		medial aspect of the left	knee.	
		VD was notified and ordered				
	an x-ray to her left kr (Monday 3/21/22).	nee on the following morning		2. Corrective action fo the potential to be affect deficient practice.		
				All residents and those r	equiring use of a	
	Resident #54's fall ca	are plan last revised 3/21/22		mechanical lift for transf		
		in actual fall with the new		the alleged deficient pra		
		ting TN #2 to provide wound		On 6/17/2022 the Direct		
	care with resident in	the bed.		Nursing Team and Minin		
	The x rev require det	ad 3/21/22 indicated a		Nurse audited change ir identified through the Da		
		ed 3/21/22 indicated a fracture of the left knee.		Meeting for indicators of	•	
				current residents with id	-	
	A nursing note dated	3/21/22 at 4:30 PM read the		past week (6-10 to 6/16/		
	-	an orthopedic consult was		that the incident report p		
		was scheduled to see the		place and all intervention	ns identified by the	
	orthopedist on 3/25/2	22.		Interdisciplinary team we	ere in place on the	
	1		1	care plan/kardex.		1

Event ID: YHE211

Facility ID: 923403

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
		345370	B. WING		0	5/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETIC
F 689	Continued From page	e 45	F 68	9		
	A nursing note dated	3/24/22 at 12:07 AM		Results:7 of 7 residents were	in	
		nt out to the vascular clinic		compliance with the incident		
	on 3/24/22 for a left lo			report/investigation process.	As of	
		t #54 was admitted to the		6/26/2022 all care plans will b		
	hospital at this time.			compliance for moderate and		
				risk care plans and intervention	-	
	Resident #54's hospit	tal history and physical dated		On 06/16-17/2022 the nursing		
	3/24/22 read she pres	sented to the hospital for an		team and therapy manager re	eviewed all	
	elective aortogram to	her left lower extremity		residents care plans/kardex f	or	
	when her left knee wa	as noted swollen and painful.		appropriate transfer status. A	s of 06/17	
		eriprosthetic distal femur		/2022 all care plans/kardex re		
		mitted to the hospital and		appropriate transfer status ar		
	orthopedic surgery wa	as consulted.		assistance for transfers for fa 6/10-6/6/2022	ll between	
	-	tal discharge summary		3. Measures /Systemic cha	-	
		nonoperative strategy was		prevent reoccurrence of alleg	ed deficient	
		ire and she was fitted with a		practice:		
		follow up at orthopedic		On 06/16/2022 the Nurse Co		
		charged back to the facility		began education with the Dire		
		-weight bearing to her left		Nurses and Assistant Directo		
	lower extremity and a	i knee immobilizer.		and Minimum Data Set Nurse		
				incident report/post fall proce		
		54's active Physician orders		accessing the kardex/care pla		
		ed 3/31/21 for her to be		transfer status and the post fa	aii/incident	
		echanical sling lift and		report process.	lursos and	
	while wearing a leg b	her left lower extremity		On 06/16/22 the Director of N Assistant Director of Nurses I		
	white weating a leg pl			education of all full time, part		
	Resident #54 was inte	erviewed on 5/23/22 at 1:48		needed nurses, certified nurs		
	PM. Resident #54 sta			assistants, medication aides	-	
		to the fall and was being		on the following topics:	and agonoy	
		sit-to-stand lift. She stated		Definition of a fall		
	-	the dressing to her sacral		Incident Report Process		
		ned over the side of the bed		Post Fall Process		
		out. Resident #54 stated		Notifications post fall		
		sit-to-stand lift but rather		How/when to access kar	dex to view	
		lder to the standing position.		care required to include		
	-	TN #2 was the only nurse		transfer/ambulation status an	d use of a	
		acral wound care that way		mechanical lift		

Facility ID: 923403

			0.00			NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		345370	B. WING _			05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 689	Continued From pag	e 46	F 6	89		
		he stated had a history of a		Resident safety when pr	ovidina	
		t in the past and her knee		wound care- wound care sho	-	
		htly painful prior to being		provided while the resident is		
		tal on 3/24/22. Resident #54		Safe resident transfer with the second		
		istance then she and an		mechanical lift and use of 2 p	ersons for all	
	aides assisted her ba	ack to bed using the		mechanical lift transfers.		
	mechanical sling lift.			This information has been in	egrated into	
				the standard orientation train	•	
		npleted on 5/25/22 at 2:35		required in-service refresher		
		stated she was assigned		all staff identified above and		
		day 3/20/22 at the time of		reviewed by the Quality Assu		
		she went into the room and		process to verify that the cha	-	
	-	n placed in bed. She stated		been sustained. Any staff w		
	-	ained of pain at the time of		receive scheduled in-service		
		e and an x-ray was ordered. #54 was unable to stand		not be allowed to work until to been completed by June 26,	-	
		e was transferred using the		been completed by Julie 20,	2022.	
		o the fall. NA #5 stated TN		4. Monitoring Procedure to	onsuro that	
		sistance with using the		the plan of correction is effect		
		ist Resident #54 to bed for		specific deficiency cited rema		
		ather was attempting to		and/or in compliance with reg		
		care while Resident #54 was		requirements.	, ,	
		nt while leaning against her		The Director of Nursing or de	signee will	
		e the fall, Resident #54 had		monitor compliance utilizing		
	to be transferred usir	ng a mechanical sling lift. NA		Quality Assurance Tools wee	kly x 2 weeks	
		54's electronic Kardex		then monthly x 3 months. The		
		sit-to-stand for transfers at		Nursing will monitor to ensur		
		d TN #2 did not ask her for		fall/incident process is in com		
	-	nsfer Resident #54 to her		by direct observation that the		
	bed for wound care.			lift transfer process is being s	•	
	An intonvious unos	photod on $E/2E/22$ of $2:40$		performed. Reports will be p		
		npleted on 5/25/22 at 2:49		the weekly Quality Assurance by the Director of Nurses to e		
		stated TN #2 stepped out of vay and stated she needed		corrective action is initiated a		
		stated when she entered the		appropriate. Compliance will		
		vas on both knees beside her		and the ongoing auditing pro		
		#2 stated Resident #54 did		reviewed at the weekly Quali		
		ted to the floor. NA #1 stated		Meeting. The weekly QA Mee	-	
		er Resident #54 to bed for		attended by the Administrato		

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		MEDICAID SERVICES					O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			· · ·	E SURVEY IPLETED
		345370	B. WING			0	5/26/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER			0 BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 47	F 68	39			
	her wound care but ra wheelchair and had F her bed while she con sacrum. NA #1 stated	ather stood her up from her Resident #54 lean up against mpleted wound care to her d prior to her fall, she was a			Nursing, MDS Coordinator, Therapy Manager, Health Information Manage and the Dietary Manager. Date of Compliance: 06/27/2022	er,	
	sit-to-stand lift and now was a mechanical sling lift transfer. NA #1 stated Resident #54's electronic Kardex indicated she was a sit-to-stand for transfers at the time of the fall and TN #2 did not ask her for any assistance to transfer Resident #54 to her bed for wound care.						
	PM with Unit Manage was doing Resident sacrum while having brace herself against when her knees gave to the floor. UM #1 s						
	AM with the MD. He s the circumstances inv but he ordered an x-r since she was not co nurse said there was stated Resident #54's prevented if TN #2 has	npleted on 5/25/22 at 11:35 stated he was not aware of volving Resident #54's fall ray for the following morning mplaining of pain and the no obvious injuries. The MD s fall could have been ad used the sit-to-stand lift to ompleted her wound care.					
	· ·	the Nurse #5 assigned)/22 were unsuccessful.					
	at 11:34 AM with the #2 informed her that	/ was completed on 5/26/22 former DON. She stated TN Resident #54 did not have a to the floor onto her knees.					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /	IG	· · · ·	LETED
		345370	B. WING		05/2	26/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	e 48	F 6	89		
	The former DON stat	ed Resident #54 was				
	supposed to be trans	ferred using the sit-to-stand				
		e was not aware that TN #2				
	•	ift at the time of the fall. She mplete an investigation				
		onsidered a fall according to				
	TN #2.					
	A telephone interview	/ was completed on 5/26/22				
	· ·	#2. She stated she stood				
		her wheelchair by lifting her				
		aned her against the side of				
		d she always completed				
		I dressing changes that way I #2 stated Resident #54				
	preferred to have her					
	completed while stan					
		sed to transfer her back to				
		re, the staff would not get				
		tated she did not use the r Resident #54 back to bed				
	or did she ask for and					
		ed to complete her wound				
		esident #54's legs gave out				
		to floor onto her knees but				
		not a fall. She stated she				
		DON and she didn't ask her rcumstances since she did				
	not consider it a fall.					
	An interview was con	ducted on 5/26/22 at 1:00				
		rator and DON. The DON				
		dent was assisted to the				
	floor, it was considered					
		ing an assisted fall should be ed to ensure the staff did not				
	do something wrong					
	2. Review of the man					

Facility ID: 923403

If continuation sheet Page 49 of 84

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/30/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		345370	B. WING				05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			000 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	follows on page #25: ' bar, ensure that the re- well clear of moving n Resident #3 was adm Dementia and Osteoa Resident #3's quarter 7/22/21 indicated sev non-ambulatory and t with transfers. Resident #3's revised falls dated 8/5/21 read sling transfer with the Review of an undated Resident #3 was a ful transfers. Reviews of Resident a a note dated 10/26/21 were using the mecha when she complained was no redness or sw Tylenol and the Medic knee x-ray. Resident #3's left kne 10/26/21 read there w but soft tissue swelling left knee. Review of a nursing m PM read Resident #3 pain to her left knee.	In the spreader spreader spident's legs and feet were nast to avoid injuries. In the on 4/1/8/20 with arthritis. In the one of a set dated are cognitive impairment, otal staff assistance of 2 In the one of a risk of a sist of a sist and a spistance of 2 staff. In the one of a staff. In the one of a staff are and a sist and a signal with a set of a	F	689				

Facility ID: 923403

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE	
		345370	B. WING		_	05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	L		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	9 50	F 689				
	11/9/21 read Residen being transferred from been painful since. Ac left periprosthetic dist to return to the orthop Review of a nursing m PM read Resident #3 orthopedic consult an femur fracture treated Review of an undated completed by the form (DON) read Resident wheelchair at 2:30 PM used the mechanical #3 back to bed. She c after being laid down. an x-ray was ordered with root cause analy occurred due to osted and a total left knee re referred to orthopedic Investigation Guide w all written on 11/10/21 Review of the written was completed by ag #9 read she and ager Resident #3 back to b sling lift and while doi each side of the lift m battery pack part of a bar). The statement re back and her legs mo	aote dated 11/9/21 at 6:07 returned from the d was noted to have a left with a knee immobilizer. I Investigation Guide mer Director of Nursing #3 was sitting in her A on 10/26/21. The aides sling lift to transfer Resident complained of knee pain The MD was notified and . Review of the conclusions sis read the incident parthritis, hypothyroidism eplacement. She was is. Attached to the rere staff written statements					

Facility ID: 923403

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/30/2022 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345370	B. WING				05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
				3	00 BLAKE BOULEVARD			
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		Р	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 689	her to assist her with the back to bed using the indicated NA #9 hook began to lift her up where side of the lift mast. No back so the mast would and then placed her of of pain once in bed. Review of the written completed by Nurse # to be put to bed after #10 used the mechan to the bed when she yon redness or swelling with orders for an x-rate Tylenol. An observation was contained a sing was immediately pain was only one staff me she didn't think NA #9 An interview was com AM with the MD. He is the circumstances invites the consult. The evidence of a fall invo 10/26/21. An interview was com	ated dated 11/10/21 NA #10 read NA #9 asked transferring Resident #3 mechanical sling lift. She ed sling to the lift bar and hile her legs were on each A #9 pulled Resident #3 Id not be between her legs in the bed. She complained statement dated 11/10/21 f1 read Resident #3 asked lunch and NA #9 and NA ical sling lift to transfer her velled out in pain. There was g and the MD was notified bys and her as needed ompleted on 5/23/22 at #3. She was lying in bed he recalled an incident g her to bed using the lift ap. She said her left knee ful. Resident #3 stated there mber transferring her and thew what she was doing. pleted on 5/25/22 at 11:35 tated he was not aware of olving Resident #3's left ered an x-ray and an he MD stated there was no lving Resident #3 on	F	689				
	orthopedic consult. Thevidence of a fall invo 10/26/21.	ne MD stated there was no lving Resident #3 on pleted on 5/25/22 at 3:46						

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/30/2022 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345370	B. WING			05	/26/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHURS	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	aides that no longer w began to complain of orthopedic evaluation Attempts to interview Resident #54 on 3/20. A telephone interview at 9:06 AM with Nurse the nursing note dated aides were changing complained of left kne complained. She state received orders for the #3 stated she was aw orthopedic hardware it that something happe transfer. She said it w were in-serviced on the mechanical sling lift. An observation was c mechanical sling lift w 10:20 AM with NA #1. had to be 2 staff mem lift. She demonstrated to the sling bar and liff pump on the lift mast. performing a mechani must be facing the pe #1 stated the reason f person operating the lift also to prevent any in lift mast. A telephone interview	g transferred by 2 agency vorked at the facility. She pain and was sent for an the Nurse #1 assigned /22 were unsuccessful. was completed on 5/26/22 e #3. She recalled writing d 11/5/21. She stated the her on when she ee pain and she never ed she notified the MD and e orthopedic consult. Nurse rare that Resident #3 had in her left knee and heard oned to her leg during a lift rasn't long after that they he proper use of the ompleted of the facility's ras completed on 5/26/22 at . She stated there always her present while using the d how a lift pad was attached ted using the hydraulic NA #1 stated anytime ical sling lift, the resident rson operating the lift. NA the resident must face the lift was to ensure the g the transfer safely and juries related to striking the was completed on 5/26/22	F	689			
	-	was completed on 5/26/22 #10. She stated she was					

		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345370	B. WING _			05/	26/2022
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER) BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	only the spotter during questioned about her stated she did not rec were on either side of lifted. NA #10 stated s proper use of the faci until after the incident Multiple telephone me to return call to discus involving Resident #3 A telephone interview at 11:34 AM with the completing the invest and it was determined knee on the side of the the staff were in-server	g the lift transfer. When written statement, she sall if Resident #3's legs the mast before she was she was not trained on the lity's mechanical sling lift involving Resident #3. essages were left for NA #9 as the circumstances 's injury were unsuccessful. was completed on 5/26/22 former DON. She recalled igation involving Resident #3 d that the aides hit her left e lift mast. She stated all ed on the correct use of the ut there was no ongoing t observations for the	F	689			
F 692 SS=D	PM with the Administr Administrator provide mechanical sling lift for 11/11/21 after the inci- stated she expected a mechanical sling lift p injuries. Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous er	d evidence of training on the or NA #9 and NA #10 dated dent. The Administrator all the nursing staff use the roperly to prevent resident atus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and popic jejunostomy, and	F6	592			6/27/22

Facility ID: 923403

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PRINTED: 06/30/2022

		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 06/30/2022 FORM APPROVED 18 NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		345370	B. WING				05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				300	BLAKE BOULEVARD		
PINEHUR	SI HEALIHCARE & REP	ABILITATION CENTER		PIN	IEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	Continued From page	o 54	Ге				
1 032			F 6	92			
	ensure that a residen	ssment, the facility must it-					
		ins acceptable parameters					
		such as usual body weight or					
	, ,	it range and electrolyte esident's clinical condition					
		is is not possible or resident					
	preferences indicate	•					
	§483.25(g)(2) Is offer maintain proper hydra	red sufficient fluid intake to ation and health;					
		red a therapeutic diet when					
		problem and the health care					
	provider orders a the This REQUIREMENT	rapeutic diet. Γ is not met as evidenced					
	by:						
		iew, observations, and			The statements made on this plan		
	-	tered Dietician (RD), family,			correction are not an admission to a		
	· · · · ·	failed to implement new			not constitute an agreement with the	e	
		ident identified with weight ents reviewed for nutrition			alleged deficiencies. To remain in compliance with all fed	oral	
	(Resident #74).				and state regulations the facility has or will take the actions set forth in th	s taken	ı
	The findings included	l:			plan of correction. The plan of corre constitutes the facility's allegation of	ction	
	Resident #74 was ad	mitted 1/15/2021 with			compliance such that all alleged		
	diagnoses that includ				deficiencies cited have been or will corrected by the dates indicated.	be	
	Resident #74's quarte	erly Minimum Data Set			F692		
		2 indicated the resident has			1. For clinical services, a correctiv	/e	
	severely impaired co	gnition, required extensive			action was obtained on 5/23/2022.		
		ties of daily living and					
	required supervision	and set up only for eating.			Based on staff interviews, observati and record review the facility failed to		
	Review of Resident #	74's comprehensive care			implement interventions to maintain		
		22 included a focus for			nutrition and hydration status for 1 c		
	nutritional problem re	elated to weight loss. The			reviewed residents. For Resident #7	74	

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PRINTED: 06/30/2022

•=	STOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE
F 692	Continued From page	e 55	F 69	2	
	resident's interventior feed herself after tray Review of Resident #	ns stated the resident could set up.		assistance at meals was not orders and resident experien significant weight loss. Resid passed away 6/2/2022.	ced
	by the former Director progress note read; F Resident will eat if as intervention is to have	r of Nursing (DON). The Resident has lost weight. sisted with meals. New e resident assisted with		2. Corrective action for rest the potential to be affected by deficient practice.	y the alleged
	with each meal.	in for resident to be assisted al record also included a		All residents have the potenti affected by the alleged defici On 6/15/2022 in-service was nursing, nursing assistants, a	ent practice. initiated with
	progress note dated 3	3/30/2022 by the Dietary ad; put in recommendation		department heads. On 6/20/2 resident orders were reviewe comprehensive list of resider	2022 all ed to create a
	Dietician (RD) on 3/3	conducted by the Registered		require assistance at meals a available to staff via commun MAR/Care tasks were review updated on 6/20/2022 to refle	nication book. /ed and
		ne RD documented feeding		meal assistance needs. Mea also altered to highlight meal requirements.	I tickets were
		AM Resident #74 was meal tray. The resident was nce with her meal.		3. Systemic changes	
	observed sitting in he	5 PM Resident #74 was r wheelchair being assisted y a family member. The		Beginning on 6/15/2022 In-se education was provided to al part time, and as needed – C Nursing Assistants, Medicatio	l full time, Certified
	family member stated assistance with meals The family member fu	I the facility staff provided s when she was not there. urther stated she had some was not being provided with		nurses to include agency by of Nurses/Assistant Director Nurses/Nurse Consultant. To included:	the Director of
	meals.			ADL's Eating Presentation	on
	observed sitting in he	AM Resident #74 was r wheelchair with a meal tray The resident was not		Tray Delivery and Set-up Nursing/CNA Training Nursing and Nursing Ass	p for

Facility ID: 923403

If continuation sheet Page 56 of 84

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
PINEHUR	ST HEALTHCARE & RE	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLI THE APPROPRIATE DAT
F 692	Continued From pag	je 56	F 69	02	
	receiving assistance An interview was co	with her meal. nducted with Nurse Assistant		 Procedures Nutrition and Hydratic Any nursing staff who doe scheduled inservice trainir 	s not receive
	(NA) #7 on 5/26/2022 at 10:30 AM. She stated she was assigned to Resident #74. She stated the resident did not get assistance with every meal. The resident's care tasks indicated she was independent with meals but if she noticed the			allowed to work until the tr completed by June 26, 20 This information has been the standard orientation tr	22. integrated into
	resident was not eat her.	ing, she would try to assist		required in-service refresh all staff and will be reviewe Assurance process to veri	er courses for ed by the Quality fy that the
	conducted with the F #74's weight loss wa	8 AM a phone interview was RD. She stated Resident as discussed in a eting in March. She further		 change has been sustaine staff will be completed by 4. Quality Assurance model 	6/26/2022.
	stated the former DC meeting and stated s	ON was present at the		procedure.	
	with each meal.			The Director of Nursing or monitor meal service 5 tim weeks, then weekly x 2 m	nes weekly x 4 nonths, and then
	conducted with the f	38 AM a phone interview was former DON. She stated the		monthly x 3 months using Assurance Audit tool. Mon include ensuring staff are	itoring will
	intervention was discussed in the morning interdisciplinary meeting and she did document the resident required assistance with feeding in the resident's progress notes. She made the			channels to review which require assistance at mea assistance with meals, and	residents Is, providing
	resident required as	MDS) nurse aware the sistance with meals and the ave revised the resident's		multiple channels to provid information regarding assi meals. The Clinical Team	stance at
	add assistance with	er DON stated she did not meals to the resident's care e been the responsibility of		significant weight changes properly and timely to mai and hydration status. Rep presented to the weekly Q	ntain nutrition orts will be Juality
	conducted with the N did not recall the inte March or being aske	25 PM an interview was MDS nurse. She stated she erdisciplinary meeting in ed to add feeding assistance esident #74's care plan		Assurance committee by t to ensure corrective action appropriate. Compliance v and ongoing auditing prog the weekly Quality Assura The weekly QA Meeting is	n initiated as vill be monitored ram reviewed at nce Meeting.

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		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIC
F 692	Continued From page	e 57	F 692	2	
	interventions or care			Administrator, Director of Nursing, M Coordinator, Therapy, Health Inform Manager, and the Dietary Manager	
F 695 SS=D	Respiratory/Tracheos CFR(s): 483.25(i)	stomy Care and Suctioning	F 69		6/27/22
	needs respiratory car care and tracheal suc care, consistent with practice, the compret care plan, the resider and 483.65 of this su This REQUIREMENT by:	ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart. Γ is not met as evidenced iews, observations, Medical		The statements made on this plan o	f
	Director and staff inte clarify an physician's administer oxygen as reviewed for respirate	erviews, the facility failed to order for oxygen and s ordered for 1 of 1 resident ory care (Resident #96).		 correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all federate and state regulations the facility has 	nd do eral taken
	on 10/25/19 with diag	iginally admitted to the facility gnoses that included ire (CHF) and hypertensive		or will take the actions set forth in thi plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will b corrected by the dates indicated. F695	ction
	order dated 6/28/21 f nasal cannula as nee below 90% and an or	physician orders revealed an for oxygen at 2 liters via eded for oxygen saturations order dated 10/15/21 if oxygen er than 92% may discontinue		 The facility failed to clarify a physic of for oxygen and administer oxygen as ordered. 1. Corrective action for resident(s) affected by the alleged deficient practice for resident #96, the oxygen orders confirmed with the physician by the nursing team on 06/16/2022 and statistical stati	s ctice: were

Facility ID: 923403

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 09	PROVE 38-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURV COMPLETE	
		345370	B. WING		05/26/2	022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
PINEHUR	ST HEALTHCARE & REI	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) MPLETIOI DATE
F 695	Continued From pag	e 58	F 6	95		
F 695	Resident #96 smiles asked a question but was on via nasal car using at 2 liters as or A quarterly Minimum assessment dated 5/ has severely impaire received extensive to for her Activities of D not coded for oxyger A review of the Resid notes from 1/1/22 to on 2 liters of oxygen A review of the May Administration Recor for if oxygen saturated discontinue use of ox had a daily check ma addition, the MAR has as needed for oxyge was blank for number administered and nu On 5/23/22 at 10:40 made of Resident #90 listening to the radio. concentrator was set viewed horizontally a Resident #96 was of AM, while lying in be oxygen regulator on	and nods her head when a was non-verbal. Oxygen inula and was to continue dered. Data Set (MDS) (9/22 indicated Resident #96 d decision-making skills and o total assistance from staff aily Living (ADLs). She was n use. dent #96's nursing progress 5/25/22 indicated she was via nasal cannula. 2022 Medication rd (MAR) revealed an entry ons greater than 92% may kygen at 9:00 AM. The form ark and staff initials. In ad an entry for oxygen at 2L n saturations below 90% and er of liters of oxygen rsing initials. AM, an observation was 16 while she was lying in bed . The oxygen regulator on the t at 1.5 liters flow when	F 6	 that oxygen is to be proper minute continuously cannula. On observation by the A of Nurse on 06/16/2022 rate was confirmed to b the oxygen delivery in p 2. Corrective action for the potential to be affect deficient practice. On 6/16/2022, the nursi audited all current resid oxygen. Oxygen flow rafor compliance and order confirmed with the physis there were no confliction place. As of 6/16/2022, compliance in place. 3. Measures /System prevent reoccurrence of practice: On 06/14/2022, the Direction Nurse Consultant began full time, part time, and agency nurses on the for exceeding the amount or and the order confirmed. The liter amount she eye level. 	Assistant Director e and the O2 flow be set at 2 lpm and blace as ordered. For residents with the by the alleged ing team began lents receiving ate was observed ers for oxygen sician to assure g oxygen orders in . 100% ic changes to f alleged deficient ector of or of Nurses and n education to all PRN Nurses and oblowing: v of oxygen must dered by the MD d by the nurse. nould be verified at djusting the oxygen tory status should	
	An observation occu Resident #96, which	rred on 5/25/22 at 9:00 AM of revealed the oxygen		oxygen notify the MD/R Oxygen orders sho	P of your findings.	

Facility ID: 923403

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			()(0)	E CONCEPTION		O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED
		345370	B. WING		0	5/26/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHURS	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 695	Continued From page	e 59	F 695	5		
	regulator on the conc flow by nasal cannula eye level.	entrator was set at 1.5 liters when viewed horizontally at M, an interview occurred		 assure there are no conflicting of place. Documentation of notificatio education should be completed i progress notes for the resident a 	n and n the	
	with Medication Aide with Resident #96 and stated she had been	(MA) #1 who was familiar d provided her care. She employed at the facility for		the resident's condition. This information has been integr	ated into	
	reviewing the May 20 she checked and initia	oxygen continuously. After 22 MAR, the MA indicated aled the entry that read "if		the standard orientation training required in-service refresher cou all staff identified above and will reviewed by the Quality Assuran	rses for be ce	
	the resident was usin	reater than 92% may ygen" at 9:00 AM meaning g oxygen. Stated the oxygen cked with the oxygen on.		process to verify that the change been sustained. The facility spe in-service will be provided to all a Nurses and CNA's who give resi	cific agency dents	
	confirmed the oxygen concentrator was set	mpleted with Nurse #2, who regulator on the at 1.5 liters when viewed		care in the facility. Any nursing s does not receive scheduled in-set training will not be allowed to wo training has been completed by 2022.	ervice rk until	
	liters when standing of #2 adjusted the flow t oxygen as ordered. Ir reviewed Resident #9	vel and looked to be set on 2 over the concentrator. Nurse to administer 2 liters of addition, Nurse #2 96's May 2022 MAR and tions were checked with		4. Monitoring Procedure to ensitive plan of correction is effective specific deficiency cited remains and/or in compliance with regula requirements.	and that corrected	
	oxygen on and that re continuously. Nurse # should have been obt confusing in relation t	esident utilized oxygen 2 stated a clarification order tained as the orders are very o the oxygen use. Nurse #2		The Director of Nurses or design monitor compliance utilizing the Quality Assurance Tool weekly x then monthly x 3 months or until	F695 2 weeks resolved.	
	would be responsible was at the right settin	-		Monitoring will occur on each shi include weekends. The Director Nursing will monitor compliance oxygen liter flow according to ME	of with) orders.	
	Director on 5/25/22 at Resident #96's active	ducted with the Medical t 11:37 AM. He reviewed physician orders and rders from 6/28/21 and		Reports will be presented to the Quality Assurance committee by Director of Nurses to ensure com action is initiated as appropriate.	the rective	

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			0 (0) ····· -·-·		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC
F 695	Continued From page	e 60	F 695	5	
		sing. The Medical Director		Compliance will be monitored and the	
	acknowledged Resid			ongoing auditing program reviewed a	
		rs via nasal cannula and was		weekly Quality Assurance Meeting. T	
		eded order. The Medical		weekly QA Meeting is attended by the	
		ould provide a clarification		Administrator, Director of Nursing, MI	
		eceive oxygen at 2 liters via		Coordinator, Therapy Manager, Healt	
	nasai cannula as ne	intended it to be originally.		Information Manager, and the Dietary Manager.	
	During an interview v	vith the Administrator and			
		n 5/26/22 at 1:10 PM, they			
		expectation for oxygen to be			
		red rate, checked daily by			
		r MA and obtain clarification			
F 698	orders when there wa Dialysis	as a question.	F 698		6/27/22
SS=D	CFR(s): 483.25(l)		1 0 90		0/21/22
	§483.25(I) Dialysis.				
		ure that residents who			
		ve such services, consistent			
	•	ndards of practice, the on-centered care plan, and			
	the residents' goals a	· · ·			
	-	Γ is not met as evidenced			
	by:				
	Based on observation	ons, record review and		The statements made on this plan of	
		al Director (MD) interviews,		correction are not an admission to an	d do
	the facility failed to ol			not constitute an agreement with the	
	•	the care and monitoring		alleged deficiencies. To remain in compliance with all feder	ral
	Resident 44). This wa	alysis (Resident #30 and as for 2 of 2 resident		and state regulations the facility has t	
		The findings included:		or will take the actions set forth in this plan of correction. The plan of correct	;
	1. Resident #30 was	admitted on 10/19/20 with		constitutes the facility's allegation of	
	End Stage Renal Dis	ease.		compliance such that all alleged	
				deficiencies cited have been or will be	e
		/30's April and May 2022 / included an order dated		corrected by the dates indicated. F698	

Event ID: YHE211

Facility ID: 923403

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>			OATE SURVEY OMPLETED
		345370	B. WING			05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	CODE	
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 698	Continued From page	e 61	F 69	8		
	10	very Monday, Wednesday		The facility failed to obtain physician orders for the ca monitoring residents on he resident #30 and resident	re and modialysis for	
Resident #30's quarterly Minimum Data Set (MDS) assessment dated 3/15/22 indicated sh was cognitively intact and coded as receiving dialysis.	lated 3/15/22 indicated she		1. Corrective action for re affected by the alleged def For resident # 44 orders for monitoring of the dialysis s obtained and implemented	icient practice: or care and site were		
	a care area dated 5/2 scheduled for hemod Interventions include hours of any bleeding pressure readings of keep the dressing on ordered, monitor for a touching the fistula) a sound when listening	lab work to the graft arm, the dialysis access site as a thrill (vibrations felt when and a bruit (a loud swishing		 2. Corrective action for return of the potential to be affected deficient practice. All residents receiving dial potential to be affected by deficient practice. On 06/1 Director of Nursing and nu began auditing 100% of diat to ensure the dialysis batch firing to the eMAR. Those each shift assessment of potential to potential to the second context of the context	25/2022. esidents with I by the alleged ysis have the this alleged 6/2022, the rsing team alysis residents h orders were orders included	
	Review of Resident #30's April and May 2022 medication administration records (MARs) and treatment administration records (TARs) did not include any documentation related to dialysis or her dialysis access site.			shunt site, post dialysis we shift monitoring for bleedin shunt dressing removal, pe dressing on, and dialysis fi was completed on 06/16/2 3. Measures /Systemic of	g, post dialysis ermcath requency. This 022.	
	4/1/22 to 5/18/22 did documentation of mo	nitoring post dialysis s or evidence of monitoring		On 06/14/2022, the Director Nurse/Assistant Director o Nurse Consultant began e full time, part time, PRN N	leged deficient or of f Nurses and ducation of all	
	record for vital sign for	#30's electronic medical ollowing a dialysis treatment ital signs documentation on		agency nurses on the follo Order Process This in-service included th	wing: Dialysis	

Facility ID: 923403

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		345370	B. WING			05/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
PINEHUR	ST HEALTHCARE & REF	IABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 698	Continued From page	e 62	F 698	8		
	or 5/23/22.	/22, 5/2/22, 5/16/22, 5/20/22		topics: • How and when to end orders • Dialysis communication from dialysis		
	AM with Resident #30 in her left upper arm a have her graft assess improve the blood flo when she first started	w. Resident #30 stated I dialysis, the facility was		Dialysis protocol The Director of Nursing any nurse who has not r training by 06/26/2022 w to work until the training This information has been	eceived this vill not be allowed is completed. en integrated into	
	dialysis clinic. She sta ago because the facil were documenting ar	een the facility and the ated that stopped a long time lity nor the dialysis clinic nything. She stated the		the standard orientation required in-service refre- all staff identified above reviewed by the Quality process to verify that the	sher courses for and will be Assurance e change has	
	thrill or bruit, assess I treatment, check her not remove her press Resident #30 stated s	utinely check her graft for a ner vital signs after a dialysis graft for bleeding and did ure dressing from her graft. she removed her own		been sustained. The fac in-service will be provide Nurses and CNA's who care in the facility. Any does not receive schedu	ed to all agency give residents nursing staff who iled in-service	
	dressing.			training will not be allow training has been compl 2022.		
	PM with the Administ was not completing o communication form	with Resident #30 to		 Monitoring Procedu the plan of correction is specific deficiency cited 	effective and that remains corrected	
	practice stopped. She monitoring her vital si	he was not certain why the e stated the staff were igns and her graft site but d any documentation to		and/or in compliance with requirements. The Director of Nurses of monitor compliance utiliz Quality Assurance Tool N	or designee will zing the F698	
	AM with the MD. He	npleted on 5/25/22 at 11:35 stated he was not aware that onitoring Resident #30 after		then monthly x 3 months The Director of Nursing compliance with Dialysis monitoring order process	will monitor s care and	

Facility ID: 923403

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						D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		345370	B. WING		05	/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 698	Continued From page	e 63	F 698	3		
	expected the facility t monitoring and care f			by the Director of Nurses to ens corrective action is initiated as appropriate. Compliance will be and the ongoing auditing progra reviewed at the weekly Quality A	monitored m	
	(MA) #1 on 5/25/22 a was not aware of any assessment of Reside She stated she recall	t 2:00 PM. She stated she ongoing monitoring or ent #30 and her dialysis site. ed there should not be blood done on her access arm.		Meeting. The weekly QA Meetin attended by the Administrator, D Nursing, MDS Coordinator, The Manager, Health Information Ma and the Dietary Manager.	Director of rapy	
	PM with Nursing Assi the only thing she did treatments was give h bed. NA #5 stated she signs post dialysis be folder that she took w obtained her vital after stated she was not av post dialysis site press monitored for signs of was only aware that r	appleted on 5/25/22 at 2:40 stant (NA) #5. She stated after Resident #30's dialysis her food and lay her down in e did not obtain any vital cause Resident #30 had a with her and the dialysis staff er her treatments. NA #5 ware that Resident #30's usure dressing should be f bleeding. She stated she no blood pressure or lab in her left arm because of		Date of Compliance: 06/27/2022	2	
	5/25/22 at 2:45 PM. S post dialysis weight, p saturation and occasi pressure. Nurse #2 st Resident #30's dialys should be monitored removed until the follo she was not aware of	owing day. She also stated the need to assess site daily for a thrill and bruit				

Facility ID: 923403

If continuation sheet Page 64 of 84

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING			05/	26/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 698	Continued From page	9 64	F	698			
	5/25/22 at 3:00 PM of she had just returned Her left arm graft site dressing in place. She when she got back to stated nobody had to leave her dialysis site until the following day did not obtain her vita dressing after each di An interview was com PM with Unit Manage Resident #30 left for H third shift at approxim the nurse was respon #30's dialysis commu apparently it was not while. UM #1 stated s need to obtain Reside her graft dressing for leave the dressing in after Resident #30's distated the reason she because there were m UM #1 the only thing need to assess her gr	alysis treatment. apleted on 5/25/22 at 3:46 r (UM) #1. She stated her dialysis treatments on ately 5:45 AM. She stated sible for sending Resident nication folder with her but happening and hadn't for a he was not aware of the ent #30's vital signs, check bleeding or the need to place until the following day tialysis treatment. She					
	PM with the Administr (DON). The Administr expected the nurses t	ducted on 5/26/22 at 1:00 rator and Director of Nursing rator and DON stated they to obtain Physician orders, and be knowledgeable					

Facility ID: 923403

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PRINTED: 06/30/2022

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2022 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		345370	B. WING			_	05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER			00 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	Continued From page regarding the care of		F	698				
	a diagnosis of end sta Resident #44's compt a care area dated 12/ hemodialysis 3 times included checking for bleeding episodes, no lab work to the graft a the dialysis access sit thrill (vibrations felt wi a bruit (a loud swishin stethoscope over fistu- vital signs as ordered Resident #44's quarte (MDS) dated 3/22/202 had moderately impai extensive assistance living and received dia Review of Resident # Physician orders only 3/2/2022 for dialysis e and Friday. Review of Resident # medication administrat include any documen	rehensive care plan included /14/2021 with a focus for weekly. Interventions the at least 24 hours of any to blood pressure readings of arm, keep the dressing on te as ordered, monitor for a hen touching the fistula) and mg sound when placing ula site) and obtaining her l. erly Minimum Data Set 22 indicated the resident ired vision and required with all activities of daily						

Facility ID: 923403

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/30/2022 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345370	B. WING			05	/26/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			00 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 698	Continued From page access site.	966	F	698			
	2022 through 5/18/22 documentation of mor treatments, monitoring						
	5/24/2022 at 11:12 AN had just returned from sometimes the nurses he returned from dialy Nurse Assistants (NA returned to the facility	s would check on him after vsis but most of the time the) check on him when he . He further stated the utinely check his vital signs					
	assigned to Resident dialysis on Tuesdays, She further stated she when he returned fror complete a set of vita the past, dialysis resid to dialysis. The form i any changes in medic change in health statu	#4. She stated she was					
	PM with the Administr was not completing or communication forms dialysis. She stated sh practice stopped. She	with Resident #44 to he was not certain why the					

Facility ID: 923403

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 06/30/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	LE CONSTRUCTION		(X3) DATE	
		345370	B. WING			05/	26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
	was unable to find any it. An interview was com AM with the MD. He so the facility was not mo his dialysis treatments dialysis access site. He facility to provide neck for dialysis residents. An interview was com PM with the Administr (DON). The Administr expected the nurses to implement those order regarding the care of Competent Nursing S CFR(s): 483.35(a)(3)(§483.35 Nursing Serv The facility must have the appropriate comp provide nursing and re- resident safety and at practicable physical, r well-being of each res- resident assessments and considering the n diagnoses of the facilit accordance with the fa- at §483.35(a)(3) The fac- licensed nurses have and skill sets necessa- needs, as identified the	y documentation to support pleted on 5/25/22 at 11:35 tated he was not aware that onitoring Resident #44 after s and not assessing the le stated he expected the essary monitoring and care ducted on 5/26/22 at 1:00 rator and Director of Nursing ator and DON stated they o obtain Physician orders, rs and be knowledgeable a dialysis resident. taff 4)(c) rices e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care umber, acuity and ty's resident population in acility assessment required	F 69				6/27/22

Facility ID: 923403

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							0.0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE COMP	PLETED
		345370	B. WING _			05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 726	Continued From page	e 68	F	726			
	limited to assessing,	ing care includes but is not evaluating, planning and it care plans and responding					
	§483.35(c) Proficience The facility must ensu- to demonstrate comp techniques necessary needs, as identified the assessments, and dee This REQUIREMENT by: Based on staff interve facility failed to provide of 2 agency nursing a			The statements made on this plan of correction are not an admission to and not constitute an agreement with the	do		
	facility's mechanical s femur fracture (Resid residents reviewed fo included: The finding	nitted on 4/1/8/20 with			alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	ken	
	Resident #3's quarterly Minimum Data Set dated 7/22/21 indicated severe cognitive impairment, non-ambulatory and total staff assistance of 2 with transfers.				 corrected by the dates indicated. F726 The facility failed to provide documenter evidence of safe use of a mechanical I for 2 agency nursing assistants. 1. Corrective action for resident(s) 		
	falls dated 8/5/21 rea	d care planned for a risk of d she was a mechanical assistance of 2 staff.			affected by the alleged deficient practic Resident #3 was sent to the orthopedis on 11 / 09/2022 for follow up care relat to complaints of left knee pain related to	st ed	
	the mechanical sling follows on page #25:	acture instructions for use of lift dated 3/2020 read as when lowering the spreader esident's legs and feet were			an apparent injury during use of a mechanical lift for transfers by two staf that occurred on 10/26/21. The x-ray th was ordered post incident and obtained	nat	

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		MEDICAID SERVICES					NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1 Y Z	ATE SURVEY OMPLETED
		345370	B. WING				05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD PINEHURST, NC 28374		REET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER			0 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From page	e 69	F 72	26			
	well clear of moving r				on 10/26/2021 resulted that there was	sno	
					evidence of a fracture but there was s		
	Reviews of Resident	#3's nursing notes included			tissue swelling to the medial aspect of		
	a note dated 10/26/2	1 at 2:03 PM that read 2 staff			left knee.	-	
	-	anical sling lift to transfer her					
		d of left knee pain. There			2. Corrective action for residents wi		
		velling noted. She was given			the potential to be affected by the alle	ged	
		cal Director (MD) ordered a			deficient practice.		
	knee x-ray.				All residents requiring use of a		
					mechanical lift for transfers have the		
	Resident #3's left kne				potential to be affected by this alleged		
		vas no evidence of a fracture			deficient practice. On 6/17/2022, the		
	but soft tissue swellin			Director of Nurses and Assistant Director			
	left knee.				of Nurses began competency evaluation	ion	
					of all Certified Nursing Assistants,		
	Dovious of a puraing r	ata datad 11/5/21 at 12:19			Medication Aides and agency nursing		
	•	note dated 11/5/21 at 12:18			aides on use of the mechanical lift. As of 6/26/2022 all of the above are i	2	
	pain to her left knee.	complained of increased					
		check on her left knee			compliance. Competency evaluation v continue for 100% of newly hired certi		
	· ·				nursing assistants to include staff or	neu	
	replacement hardwar	e.			agency nursing assistants, along with		
	Poviow of the orthop	edic consult note dated			medication aides by the Assistant Dire		
		it #3's leg was caught when			of Nurses or Director of Nurses.	SCIOI	
		n the wheelchair and had			Competency re-evaluation will occur		
	-	dditional x-rays revealed a			following mechanical lift related incide	onts	
	left periprosthetic dist	-			or injuries based on the	1113	
					investigation/identified root cause of the	he	
	Review of an undated	d Investigation Guide			incident.		
		mer Director of Nursing					
	(DON) read Resident	-			3. Measures /Systemic changes to		
		M on 10/26/21. The aides			prevent reoccurrence of alleged defici	ent	
		sling lift to transfer Resident			practice:		
		complained of knee pain			•		
		. The MD was notified and			On 06/168/2022, the Director of		
	-	. Review of the conclusions			Nurse/Assistant Director of Nurses an	d	
	with root cause analy				Nurse Consultant began education of		
		parthritis, hypothyroidism			full time, part time, PRN Nurses and		
		eplacement. She was			agency nurses, certified nursing		

Facility ID: 923403

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						0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		345370	B. WING		05/	26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
PINEHUR	ST HEALTHCARE & REH	IABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 726	Continued From page	e 70	F 72	6		
	referred to orthopedic	es. Attached to the vere staff written statements		assistants and med aides on t following: This in-service included the fo topics:	bllowing	
	was completed by ag #9 read she and ager Resident #3 back to b	statement dated 11/10/21 ency Nursing Assistant (NA) ncy NA #10 were putting bed using the mechanical		Transfer safety and mech On 6/15/2022 the Nurse const education with the Administrat of Nurses. Assistant Director of	ultant began or, Director	
	each side of the lift m battery pack part of a	ng so, her legs were on ast (hydraulic motor and lift attached to the sling ead Resident #3 was pulled		 and Nursing team on The investigation process incident, Root Cause Analysis follow up/competency evaluat 	and needed	
	between her legs whe	oved to get the lift mast from en she complained of pain.		education based on the root c investigation. • The orientation process a	nd	
	her to assist her with back to bed using the	ated dated 11/10/21 NA #10 read NA #9 asked transferring Resident #3 mechanical sling lift. She red sling to the lift bar and		competency evaluation for me lifts for Certified Nursing assis Medication Aides and Agency assistants. The Director of Nursing will er	tants, nursing	
	began to lift her up wi side of the lift mast. N back so the mast wou and then placed her o	hile her legs were on each IA #9 pulled Resident #3 Ild not be between her legs on the bed. She complained		any nurse who has not receive training by 06/26/2022 will not to work until the training is cor This information has been inte	ed this be allowed npleted. egrated into	
	AM with Unit Manage	npleted on 5/25/22 at 3:46 r (UM) #1. She stated		the standard orientation trainin required in-service refresher of all staff identified above and w reviewed by the Quality Assur	ourses for rill be ance	
	aides that no longer v stated she did not rec			process to verify that the chan been sustained. The facility s in-service will be provided to a	pecific Ill agency	
	received training on the mechanical sling lifts	-		Nurses and CNA's who give re care in the facility. Any nursin does not receive scheduled in training or competency evaluation	g staff who -service	
	at 11:23 AM with NA only the spotter durin	#10. She stated she was g the lift transfer. When written statement, she		training or competency evaluate be allowed to work until the tra- been completed by June 26, 2	aining has	
		all if Resident #3's legs		4. Monitoring Procedure to e	ensure that	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /	ECONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345370	B. WING		05/26/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		800 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIC	
F 726	Continued From page	e 71	F 726			
	lifted. NA #10 stated proper use of the faci until after the inciden Multiple telephone m to return call to discu involving Resident #3 A telephone interview at 11:34 AM with the completed an investig that the aides hit her lift mast. She stated a 11/11/21 on the corre sling lift and she did n and NA #10 received facility's mechanical s 10/26/21. An interview was con PM with the Administ Administrator provide mechanical sling lift f 11/11/21 after the inc stated she expected trained and knowledg	B's injury were unsuccessful. Was completed on 5/26/22 former DON. She stated she gation and it was determined left knee on the side of the all the staff were in-served tot use of the mechanical not recall if the agency NA #9 training on the use of the sling lifts prior to the injury on ducted on 5/26/22 at 1:00 rator and DON. The ed evidence of training on the or NA #9 and NA #10 dated ident. The Administrator all the nursing staff to be		the plan of correction is effective a specific deficiency cited remains of and/or in compliance with regulato requirements. The Director of Nurses or designed monitor compliance utilizing the F7 Quality Assurance Tool for staff competency and the F689 audit to assure safe transfers via mechanic by observing mechanical lift transfer various shifts to include weekends x 2 then monthly x 3 or until resolve The Director of Nursing will monitor compliance with competency evalue for the use of mechanical lifts for a certified nursing assistants and medication aides (staff/agency) as facility orientation and following a mechanical lift related incident that in resident injury or if need indicate part of the identified root cause an investigation. Reports will be preset the weekly Quality Assurance com by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be me and the ongoing auditing program reviewed at the weekly Quality Ass Meeting. The weekly QA Meeting i attended by the Administrator, Direc Nursing, MDS Coordinator, Therap Manager, Health Information Mana and the Dietary Manager.	orrected ry e will 726 ol to cal lift ers on weekly ved. or uation II part of t results ed as d ented to mittee e onitored surance s ector of Dy	
F 756 SS=D		w, Report Irregular, Act On (2)(4)(5)	F 756	Date of Compliance: 06/27/2022	6/27/22	

Facility ID: 923403

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILU T		ISTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	OMPLETED
		345370	B. WING			05/26/2022	
IAME OF PF	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP COD	θE	
INEHUR	ST HEALTHCARE & REF	ABILITATION CENTER			LAKE BOULEVARD HURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 756	Continued From page	e 72	F7	756			
	§483.45(c) Drug Reg						
	§483.45(c)(1) The drug regimen of each resident						
	must be reviewed at						
	licensed pharmacist.						
	8/183 /15(c)(2) This re	view must include a review					
	of the resident's med						
	.						
		armacist must report any					
	-	tending physician and the ctor and director of nursing,					
	and these reports mu						
	-	de, but are not limited to, any					
		riteria set forth in paragraph					
		an unnecessary drug.					
		noted by the pharmacist					
	separate, written rep	ist be documented on a					
		ind the facility's medical					
		of nursing and lists, at a					
		nt's name, the relevant drug,					
	÷ .	e pharmacist identified.					
		ysician must document in the					
		cord that the identified reviewed and what, if any,					
	• •	n to address it. If there is to					
		medication, the attending					
		ument his or her rationale in					
	the resident's medica	l record.					
	§483.45(c)(5) The fa	cility must develop and					
	•	procedures for the monthly					
	drug regimen review	that include, but are not					
		s for the different steps in					
		s the pharmacist must take					
		ifies an irregularity that n to protect the resident.					
	requires urgent action		1				1
		Γ is not met as evidenced					

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		MEDICAID SERVICES				0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		345370	B. WING		05/2	6/2022
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 756	Continued From pag	e 73	F 75	56		
	Based on record rev staff, Pharmacy Cons the facility failed to ar made by the Pharma residents whose med (Resident #61). The findings included Resident #61 was ad 12/20/21 with diagno neoplasm of the brain A review of the active the following: " An order dated 1 (Ativan- an antianxie (mg) 1 tab by mouth anxiety, nausea, or s " An order dated 1 (Haldol- an antipsych 2 tablets by mouth ev agitation until sympto " An order dated 2 (Haldol- an antipsych 2 tablets by mouth ev agitation. A Pharmacy Medicat progress note dated recommendations we to the Administrator a (DON). The facility w the recommendation	iews and interviews with sultant and Medical Director, ct upon recommendations cy Consultant for 1 of 6 lications were reviewed d: mitted to the facility on ses that included malignant in and anxiety disorder. e physician orders revealed 12/20/21 for Lorazepam ty medication) 0.5 milligrams every hour as needed for hortness of breath. 12/20/21 for Haloperidol notic medication) 2 mg, give very 2 hours as needed for mos are under control. 12/20/21 for Haloperidol 2/20/21 for Haloperidol 2 ery 4 hours as needed for ion Regimen Review 3/11/22 indicated ere found with a report sent and Director of Nursing as unable to locate a copy of report.		 The statements made on a correction are not an administration of constitute an agreement alleged deficiencies. To remain in compliance we and state regulations the factor will take the actions set plan of correction. The plan constitutes the facility's alle compliance such that all all deficiencies cited have bee corrected by the dates indiffected by the dates indiffected by the alleged deficencies and the alleged deficiencies for resident #67 Corrective action for mathematications for use of the amedications. Corrective action for mathematications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications for use of the amedications. Corrective action for mathematications. Corrective action for mathematica	ssion to and do ht with the with all federal acility has taken forth in this n of correction egation of leged en or will be cated. on y the Pharmacy 1. esident(s) icient practice : /2022 the ed to include a opriate clinical ntipsychotic esidents with by the alleged etor of Nurses uditing of all nmendations ure that y the pharmacy ewed by the mplemented as	
	was cognitively intac He was coded with re	4/22 indicated Resident #61 t with no behaviors noted.		ordered. This will be comp 06/26/2022.3. Measures /Systemic c prevent reoccurrence of all	hanges to	

Facility ID: 923403

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 756	Continued From page	e 74	F 75	6	
	period as well as hos			practice: Beginning on 06/16/2022 the Nurs Consultant educated the Director	
	notes dated 4/11/22 a recommendations we	and 5/10/22, indicated are found with a report sent		Nurses and nursing team on the for topics:	ollowing
		nd DON. The facility was py of these recommendation		Drug regimen reviews should an audit of the monthly pharmacy consultant recommendations to as	ssure
		d with the Medical Director M, who stated the former him with pharmacy		that they have been addressed by physician and orders received as of recommendations have been implemented timely.	
	a dozen out of 50 plu came through each n	t stated he may "have seen s recommendations that nonth" and was unable to d the recommendations		Drug regimen reviews are up the individual resident documents steps in the process have been completed.	
	dated 3/11/22, 4/11/2 #61.	2 or 5/10/22 for Resident		This information has been integra the standard orientation training a required in-service refresher course	nd in the ses for
	who explained the for	st on 5/26/22 at 8:55 AM rmer DON did not respond to		all staff identified above and will b reviewed by the Quality Assurance process to verify that the change I	e nas
	include the ones that responses. The Cons she sent the same re	dations consistently to required physician sulting Pharmacist stated commendations regarding the PRN psychotropic		been sustained. Any staff who do receive scheduled in-service train not be allowed to work until trainir been completed by June 26, 2022	ing will ng has
	medications each mo change from month to recommendation wou a response was iden	onth as she had seen no o month. A duplicate uld continue to be made until tified. The pharmacist		 Monitoring Procedure to ensu- the plan of correction is effective a specific deficiency cited remains of and/or in compliance with regulator 	and that corrected
	DON via email and th physician for follow-u	dations were sent to the ne DON would provide to the p if the recommendation response and signature.		requirements. The Director of Nurses or designed monitor compliance utilizing the F Quality Assurance Tool for complia with the Drug Regimen Review Pr	756 ance
	On 5/26/22 at 11:34 / held with the former I receiving the pharma			weekly x 2 weeks then monthly x or until resolved. The Director of N will monitor for follow through of p	3 month Jursing

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REI	HABILITATION CENTER	3 F		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 756	recommendations ea Consulting Pharmaci always have time to other things to do". left employment with	ach month from the ist but stated she "didn't do them since" she "had 5 The Former DON added she the facility in April 2022.	F 756	review and that all orders received initiated. Reports will be presente weekly Quality Assurance commit the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be m and the ongoing auditing program reviewed at the weekly Quality Ass Meeting. The weekly QA Meeting attended by the Administrator, Dire Nursing, MDS Coordinator, Therap Manager, Health Information Mana and the Dietary Manager.	d to the tee by onitored surance is ector of by
SS=D	CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(c)(3) A psyc affects brain activitie processes and behavious but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehi- resident, the facility r §483.45(e)(1) Reside psychotropic drugs a unless the medicatio specific condition as in the clinical record;	opic Drugs. chotropic drug is any drug that s associated with mental vior. These drugs include, , drugs in the following ensive assessment of a must ensure that ents who have not used are not given these drugs n is necessary to treat a diagnosed and documented	F 758		6/27/22

Facility ID: 923403

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						<u>10. 0938-03</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		345370	B. WING		0	5/26/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHURST HEALTHCARE & REHABILITATION CENTER				300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 758	Continued From page	e 76	F 75	8			
	behavioral intervention						
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented					
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PF beyond 14 days, he c	RN order to be extended or she should document their ent's medical record and					
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of	er evaluates the resident for					
	Based on record rev Pharmacy Consultant the facility failed to er psychotropic medicatt duration (Resident #6 adequate clinical india antipsychotic medicat	iew and interviews with the t, Medical Director, and staff, nsure an as needed (PRN) ions were time limited in 61) and failed to have an cation for the use of an tion (Resident #61). This nts whose medications were		The statements made on this p correction are not an admission not constitute an agreement wi alleged deficiencies. To remain in compliance with a and state regulations the facilit or will take the actions set forth plan of correction. The plan of constitutes the facility's allegati	n to and do th the Il federal y has taken i in this correction on of		
	The findings included Resident #61 was ad	l: mitted to the facility on		compliance such that all allege deficiencies cited have been or corrected by the dates indicate F758 The facility failed to ens	[.] will be d.		

Event ID: YHE211

Facility ID: 923403

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						0.0938-03	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	IPLE CONSTRUCTION	· · ·	E SURVEY PLETED	
		345370	B. WING		05	05/26/2022	
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHURS	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 758	Continued From page	e 77	F	758			
	12/20/21 with diagnosine neoplasm of the brain	ses that included malignant n and anxiety disorder.		needed (PRN) psychotropic me were time limited in duration an have an adequate clinical indica	d failed to ation for		
	the following:	e physician orders revealed 20/21 for Lorazepam (Ativan-		the use of the antipsychotic me resident # 61.1. Corrective action for reside			
	an antianxiety medication) 0.5 milligrams (mg) 1 tab by mouth every hour as needed for anxiety, nausea, or shortness of breath. - An order dated 12/20/21 for Haloperidol (Haldol-			affected by the alleged deficien For resident # 61, Haldol was discontinued on 6/17/2022. For	the		
	an antipsychotic med by mouth every 2 hou	lication) 2 mg, give 2 tablets urs as needed for agitation		Lorazepam the clinical indication Anxiety Disorder. As of 6/17/20 were received from the physicia	22 orders an that		
	until symptoms are u - An order dated 12/2 give 2 tablets every 4 agitation.	20/21 for Haloperidol 2 mg,		included a 14 day stop date wit reevaluation for Lorazepam and appropriate clinical indications 2. Corrective action for reside	d includes for use. ents with		
	Record (MAR) indica	lication Administration ted Resident #61 had		the potential to be affected by the deficient practice. On 06/15/2022 the pharmacy control of the pharmacy of all surrents to	onsultant		
		ed dosage of Lorazepam as needed dosages of es.		will begin review of all current n antipsychotic medications for a clinical indication and time limit	ppropriate ed duration		
	A quarterly Minimum Data Set (MDS) assessment dated 4/4/22 indicated Resident #61			for PRN antipsychotic medicate Any concerns noted will be revi the MD for changes to assure of	ewed with clinical		
	• •	n antianxiety medication nt period as well as hospice nedications were not		indications are appropriate and psychotropic medications are ti in duration. This process will be completed by 06/26/2022.	me limited		
	-	lay 2022 MARs revealed ceived the as needed dosage		 Measures /Systemic change prevent reoccurrence of alleged practice: 			
	of the Lorazepam 14 times in May. Reside	times in April and seven ent #61 had received the as ne Haloperidol nine times in		On 06/16/2022 the nurse consu educate the Director of Nursing Nurse, and Administrator on the	, MDS		
	April and four times in			acceptable indications for Antip medications. Beginning on 6/16/2022, the Di	sychotic		

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
		345370	B. WING		0	5/26/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN ((X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETIO DATE
F 758	Continued From page	e 78	F 75	8		
		o documented medical		Nurses, Assistant Directo	or of Nurses and	
		e of PRN Haloperidol.		Nurse Consultant began		
	-	·		full time, part time, and P		
		d with the Medical Director		agency nurses on the fo	llowing:	
		1:37 AM, who stated he was		Clinical indications for	or antipsychotic	
		on that required all as		medications		
		otropic medications to be		Stop date with evalu		
		on. He indicated he thought		physician for prn antipsy		
	hospice residents we			medications to include re	esidents on	
	-	n, the MD stated he was t #61 who was admitted to		Hospice services This information has bee	n intograted into	
		ice services in place. He		the standard orientation f		
		61's medical record and		required in-service refres		
		as the reason for the use of		all staff identified above a		
		s Lorazepam. The MD was		reviewed by the Quality A		
	unaware of any psyc	hiatric diagnoses prior to his		process to verify that the	change has	
	admission to the facil	lity.		been sustained. Any sta		
				receive scheduled in-ser		
	On 5/25/22 at 2:45 P			not be allowed to work u	•	
		e #2 who was familiar with		been completed by June	26, 2022.	
		is aware he had PRN orders				
	for both Lorazepam			4. Monitoring Procedur		
	reported that when R	either the Haloperidol or		the plan of correction is e specific deficiency cited r		
		y both relieved his agitation		and/or in compliance with		
	-	aracterized his agitation as		requirements.		
	asking for family mor			The Director of Nurses o	r designee will	
		se and tearfulness. Nurse		monitor compliance utiliz		
	-	61 did not display any		Quality Assurance Tool for		
		s towards staff or others.		with the antipsychotic me	-	
		er interventions such as		weekly x 2 weeks then m	-	
		usic or calling his family		months. The Director of I	-	
	before medication wa	as utilized.		monitor for acceptable cl		
	On E/2E/22 -+ 2:47 D	M on interview was hald		indication/diagnosis for a		
		M, an interview was held		and time limited duration		
		who was aware there was a for psychotropic medications		antipsychotic medication presented to the weekly		
		enrolled on hospice care		Assurance committee by	-	
		owed to have indefinite PRN		Nurses to ensure correct		

Facility ID: 923403

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345370	B. WING		05/26/2022
AME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
INEHUR	ST HEALTHCARE & REI	HABILITATION CENTER		00 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 758	Continued From pag	e 79	F 758		
	psychotropic medica	tions.		initiated as appropriate. Complia	nce will
	A phone interview wa consulting Pharmacia She was able to revie Resident #61 and sta for the physician to p for the PRN Haloperi used minimally and o consulting Pharmacia	as conducted with the st on 5/26/22 at 8:55 AM. ew her monthly DRR's for ated she had not requested rovide a qualifying diagnosis dol, as she expected it to be on a short-term basis. The st stated she had been r the PRN Haloperidol and		be monitored and the ongoing au program reviewed at the weekly Assurance Meeting until deemed longer necessary for compliance unnecessary medications and psychotropic medications. The w Meeting is attended by the Admir Director of Nursing, MDS Coordin Therapy Manager, Health Inform Manager, and the Dietary Manage	Iditing Quality no reekly QA histrator, hator, ation
F 947 SS=E	5/26/22 at 1:10 PM a employed at the facil aware all PRN psych time limited duration care, to allow for rea- the medication or if a needed. The DON al was not an appropria use of PRN Haloperi	Training for Nurse Aides	F 947		6/27/22
	§483.95(g) Required aides. In-service training m	in-service training for nurse ust-			
	§483.95(g)(1) Be suf continuing competen be no less than 12 he	ce of nurse aides, but must			
		e dementia management abuse prevention training.			

Event ID: YHE211

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	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		05/26/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
PINEHUR	ST HEALTHCARE & REH	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO HE APPROPRIATE DATE
F 947	Continued From page	e 80	F 9	47	
	determined in nurse	aides' performance reviews ent at § 483.70(e) and may needs of residents as			
	to individuals with co address the care of t	rse aides providing services gnitive impairments, also he cognitively impaired. Γ is not met as evidenced			
	by: Based on record rev	iew and staff interviews, the		The statements made on t	his plan of
	with annual dementia Nurse Aides reviewe	de Nursing Assistants (NAs) a training for 4 of 5 sampled d for required in-service		correction are not an admis not constitute an agreemen alleged deficiencies.	t with the
	training (NAs #1, #2, The findings included			To remain in compliance wi and state regulations the fa or will take the actions set f	cility has taken
	-	vas 7/26/10. Review of		plan of correction. The plan constitutes the facility's alle	
		vealed she was not provided		compliance such that all all	
	annual dementia trai	•		deficiencies cited have bee corrected by the dates indic	n or will be
	NA #2's date of hire v	was 10/21/13. Review of		F947	
	in-service records rev annual dementia train	vealed she was not provided ning.		The plan of correcting the s deficiency. The plan should processes that lead to the o	address the
	NA #3's date of hire v	was 6/17/20. Review of		cited:	-
		vealed she was not provided		The facility failed to provide	
	annual dementia trai	-		assistant annual dementia 1. Corrective action for re	sident(s)
		was 10/23/08. Review of		affected by the alleged defi	
	annual dementia trai	vealed she was not provided ning.		Nursing Assistants #1, 2, 3 complete Dementia Trainin Cognitively Impaired Resid	g ("Care of the
	On 5/26/22 at 10:08	AM, the Administrator stated		Care Academy online traini	
	she reviewed the in-s #2, #3 and #12 and c	service records for NA's #1, could not find documentation		06/26/2022.	
	that they were provid			2. Corrective action for re	
	annually. She stated	the Staff Development		the potential to be affected	by the alleged

Facility ID: 923403

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					OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	r
		345370	B. WING		05/26/202	22
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE	
PINEHURS	ST HEALTHCARE & RE	HABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPL TO THE APPROPRIATE DA	K5) LETIO ATE
F 947	Continued From pag		F 94			
		longer employed at the		deficient practice.		
	•	w months. The Administrator		Beginning on 06/16/202 Nurses/Assistant Directo		
		ad identified a problem with for the staff, but would		began auditing all nursir		
		up to date with dementia		med aides to identify co		
	training.			Dementia training. This	-	
				completed as of 6/16/20		
				staff nursing assistants /		
				not completed annual D		
				Education and all agenc assistants were in comp		
				Certified Nursing Assista	-	
				identified without comple		
				training will complete the		
				the Cognitively Impaired		
				Health Care Academy of		
				06/26/2022 and any age		
				assistants will be provide education by 6/26/2022.		
				Nurses will begin monito		
				6/26/2022 for ongoing co	•	
				quarterly basis for both		
				certified nursing assistar	nts.	
				3. Measures /Systemi	c changes to	
				prevent reoccurrence of	alleged deficient	
				practice:		
				The administrator will fire		
				Training via Health Care training to all full time, pa	-	
				needed nursing assistar		
				have the annual educati		
				All identified nursing ass		
				complete the Dementia		
				06/26/2022 at which time		
				nursing assistants and n		
				in-serviced prior to work certified nursing assistar		

Event ID: YHE211

Facility ID: 923403

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		ND HUMAN SERVICES				FOR	D: 06/30/2022 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		345370	B. WING			05/	/26/2022
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINEHURST HEALTHCARE & REHABILITATION CENTER					INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 947	Continued From page	e 82	F 9	47	6/26/2022 prior to working.		
					This information has been integrated the standard orientation training and i required in-service refresher courses all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not the allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains corrective and/or in compliance with regulatory requirements. The Director of Nurses/Assistant Director of Nurses will monitor compliance util the Dementia Training Quality Assura Tool weekly x 2 weeks then monthly 2 months. The Director of Nursing/Assis Director of Nurses will monitor all nur assistants and med aides for complia with the completion of annual Dement training. Reports will be presented to weekly Quality Assurance committee the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monit and the ongoing auditing program reviewed at the weekly Quality Assurance	in the for be n that that that ected ector izing ince c 3 stant sing nce tia the by tored	
					attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager and the Dietary Manager.		

Event ID: YHE211

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		ID HUMAN SERVICES			FORM APPROVE		
		MEDICAID SERVICES			OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345370	B. WING		05/26/2022		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHUR	ST HEALTHCARE & REF	ABILITATION CENTER		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		

Event ID: YHE211

Facility ID: 923403

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