PRINTED: 03/22/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345446	B. WING		03/06/2024	
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 95 LOCUST STREET CONNELLY SPG, NC 28612	1 00/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION	
F 000	was conducted 03/05	mplaint investigation survey 5/24 to 03/06/24. Event ID# g intake was investigated:	F 00	00		
	NC00213972. One ( a deficiency. Intake	g intake was investigated.  1) of 3 allegations resulted in  NC00213972 resulted in  Past non-compliance was				
		580 at a scope and severity J				
	CFR 483.25 at tag F	684 at a scope and severity J				
	Tag F684 constituted Care.	l Substandard Quality of				
F 580 SS=J		urvey was conducted. njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 58	80		
	consult with the residence consistent with his or representative(s) who (A) An accident involvesults in injury and head physician intervention (B) A significant charmental, or psychosodeterioration in health status in either life-the clinical complications (C) A need to alter the aneed to discontinue treatment due to advocmmence a new for	nediately inform the resident; lent's physician; and notify, ther authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a th, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to				
ABODATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITI F	(X6) DATE	

Electronically Signed 03/19/2024

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.

PRINTED: 03/22/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345446	B. WING _			03/0	06/2024
	ROVIDER OR SUPPLIER PINES HEALTH AND RE	EHABILITATION		9	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LOCUST STREET CONNELLY SPG, NC 28612		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	(14)(i) of this section, all pertinent informatic is available and proviphysician.  (iii) The facility must a resident and the resident as specified in §483.  (B) A change in resident (e)(10) of this section (iv) The facility must rupdate the address (ruphone number of the representative(s).  §483.10(g)(15)  Admission to a composite di §483.5) must disclose its physical configuratiocations that comprispart, and must specifications that comprispart is a composite dispersion to a composite	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph . ecord and periodically mailing and email) and	F	580	Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(	0
		345446	B. WING		· · · · · · · · · · · · · · · · · · ·	03/	06/2024
	ROVIDER OR SUPPLIER	REHABILITATION		95 I	REET ADDRESS, CITY, STATE, ZIP CODE LOCUST STREET NNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	between the bed at the nightstand. Up Resident #1 had a area, a quarter-size forehead, and bruis Resident #1 exhibit distress. Neurolog (refers to an assess responses, such as nervous system is obtained, and all w Resident #1 was as monitored throughd with continued neu that were noted wit 7:30 AM and 7:40 whaving trouble breas Services (EMS) we local hospital. Res subdural hematoms surface of the brain brain tissue along to left-sided pneumoth space between the lung to collapse). If (procedure where a through the mouth with breathing), Elic reversed (refers to medication to rapid effect), and a chest pneumothorax. Renonsurvivable, her and Resident #1 pa	the floor of her room in and wall with her head next to on assessment by Nurse #1, laceration to the right eyebrow ed hematoma to the right sing to the right hand. It is included the respiratory included the respiratory included the respiratory included the remainder of the simpaired), vital signs were represented within normal limits. It is included the remainder of the shift rological checks and vital signs which is included the remainder of the shift rological checks and vital signs him normal limits. Between AM Resident #1 was observed withing and Emergency Medical recalled to transport her to a rident #1 was diagnosed with a recalled to transport her to a rident #1 was diagnosed with a recalled to transport her to a rident #1 was intubated and the recenter of the brain) and recreated the recent of the brain and recreated the recent into the trachea to aid requise (anticoagulant) was the administration of the recreated for the resident #1's injury was family elected hospice care reassed away on 02/15/24.	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG			PLETED
		345446	B. WING				C <b>06/2024</b>
	ROVIDER OR SUPPLIER PINES HEALTH AND I	REHABILITATION	1	STREET ADDRESS, O 95 LOCUST STREE CONNELLY SPG,		, 00.	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	fracture, hypotension paroxysmal atrial filth heartbeat), and fatige A physician order daread, Eliquis 2.5 mill 8:00 AM and 8:00 F. The Medical Doctor progress note dated Resident #1's past of frontal hematoma.  A nurse progress now written by Nurse #1 an unwitnessed fall was found lying on between the bed and positioned at the night assessed and had a portion of the right thumb, a significant shoulder, and a hemisize of a quarter to be lice pack and steris Neurological checks signs were blood proper respiratory (breathing and oxygen saturation of the right confines assigned nurse on 0 11:00 PM to 7:00 AI 1:30 AM she was si	oses that included left hip in (low blood pressure), orillation (type of irregular gue.  ated 02/02/24 for Resident #1 ligrams (mg) twice a day at it.  (MD) history and physical in 20/05/24 revealed in part, medical history included in part, medical history included in part, resident #1 had at approximately 1:30 AM and interright side on the floor in dwall with her head ghtstand. Resident #1 was a laceration above the outer eye, bruise to the right side of interest in a part in the top right side of the head. It is were applied. It is were applied. It is were applied. It is were an initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure (BP) 127/82, pulse 79, and in the sesure initiated and initial vital essure initiated and initial vit	F	580			
	headed down the ha	a) #1 had just walked past allway Resident #1 resided oud noise. NA #1 looked into					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILD	ING _	<del></del>	l ,	C
		345446	B. WING				06/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•	٤	STREET ADDRESS, CITY, STATE, ZIP CODE		
0011505	DINEC HEALTH AND	DELIA DIL ITATIONI		9	5 LOCUST STREET		
COLLEGE	E PINES HEALTH AND	REHABILITATION		(	CONNELLY SPG, NC 28612		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 580	Continued From pa	nne A		580			
1 000	1	-		300			
		and informed Nurse #1 she					
		lurse #1 stated upon					
		ng the room, Resident #1 was					
		ner right side on the floor					
		I and bed with her head near					
	_	e noticed blood on the floor					
		ent, Resident #1 had a cut in					
		of the right eye, bruising to the mall hematoma on the top					
		ad with no other injuries or					
		The eye area was cleaned					
		blied and staff held ice packs to					
		o the swelling. Nurse #1					
		#1 denied any pain other than					
		t eye area and Tylenol (over					
		edication) was administered					
		Nurse #1 recalled Resident					
	·	reaching for the water pitcher					
		vhen she fell out of bed and					
	_	determine was Resident #1					
		or lost her balance when					
	reaching over to the	e nightstand. Nurse #1					
		t #1 was on an anticoagulant					
		nough she had obvious head					
		r nursing judgement when					
	making the decision	n not to send Resident #1 out					
		n evaluation at the time of her					
	fall. Nurse #1 adde	ed from the time Resident #1					
	was found on the fl	oor and up until her (Nurse #1)					
	shift ended, Reside	ent #1 was talking normal,					
	displayed no respir	atory distress, neurological					
	· ·	leted per facility protocol and				ĺ	
	_	neurological checks were				ĺ	
		#1 was assisted back into bed				ĺ	
	with a fall mat place	ed on the floor in-between the				ĺ	
	bed and wall as a s	safety precaution and				ĺ	
		ainder of the shift. Nurse #1					
	explained based or	n her assessment of Resident					
	#1, she did not feel	I that Resident #1 was in any				ĺ	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	COMF	E SURVEY PLETED
		345446	B. WING _				C / <b>06/2024</b>
	ROVIDER OR SUPPLIER PINES HEALTH AND I	REHABILITATION		95 LC	EET ADDRESS, CITY, STATE, ZIP CODE OCUST STREET INELLY SPG, NC 28612	1 00	100/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580		ge 5 s Resident #1 was alert and ed level of consciousness or	F s	580			
	uncontrolled bleeding	ng and confirmed she did not all provider at the time of the note in the physician					
	written by Nurse #3 Resident #1's room slow, struggled resp noted a blood press 7, pulse 100, and on	- ·					
	Nurse #3 recalled oright around shift choright around shift choright around shift choright around shift choright around was not breathing riverse #3 stated Resther right side, as should and when she straiged Resident #1 had a howhich she described to a lump or swelling the right side of the addition, Resident # side of the mouth are she described as Clipattern that involves breathing followed be Nurse #1 explained so oxygen was proved (LPM) via a non-rebused with the right side of the mouth are she described as Clipattern that involves the shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the right side of the mouth are shear of the right side of the mouth are shear of the right side of the	on 03/05/24 at 1:45 PM, In the morning of 02/13/24 ange between 7:30 AM and otified by NA #2 that Ing with Resident #1 and she Ing with Resident #1's head, Ing with Resident #1's head, Ing with Ing					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  IG	_	(X3) DATE	LETED
		345446	B. WING _			03/0	) 06/2024
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, 95 LOCUST STREET CONNELLY SPG, NC		1 00/1	30/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page oxygen), she obtained Resident #1 to the Eplaced on the hemathand she started stern awake and breathing transport her to the Industry the During an interview of Nurse #4 recalled or sometime around the stated Resident #1 went with Nurse #3 tassess. Upon enter recalled Resident #1 gasps, had bruising eye area with steries gray-looking. Resident able to open her eye straight ahead. Nurse and cart ready just Nurse #3 was able to breathing with sternathe facility, took over hospital.  Review of the hospit revealed Resident # evaluation following facility with obvious anticoagulant medic	e 6 ed physician orders to send D, EMS was notified, ice was oma to reduce the swelling, nal rubs to keep Resident #1 g until EMS arrived to	F	880	DEFICIENCY)		
	blood on the surface (displacement of bra the brain). Resident where a flexible tube or nose into the trac she was on anticoag reversed (refers to the	of the brain) with shift in tissue along the center of #1 was intubated (procedure is placed through the mouth nea to aid with breathing), ulant medication that was					

STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345446	B. WING _			C <b>03/06/2024</b>	
NAME OF PRO	OVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (	CODE	00/00/2021	
				95 LOCUST STREET			
COLLEGE P	PINES HEALTH AND RE	EHABILITATION		CONNELLY SPG, NC 28612			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA	D 4.T.C.	
6 k c r	between the lung and collapse) and a chest pneumothorax. Resion nonsurvivable, her fal	to have left-sided air leaks into the space chest causing the lung to tube was placed for the	F 5	580			
I r t t c c s t t c c s t t c c s t t c c c s t t c c c c	Director of Nursing (Director of Nursing (Director of Nursing (Director) and third shift on 02/13/24 did not automatically send a resident on an to the hospital for an even with obvious heather nurse's judgement were normal, they could the resident had an a The DON stated Nursing fudgement and follow monitored frequently, neurological checks remainder of the shift until first shift when Nicesident #1 was notices had been earlier. By Nurse #3 who notices at low Nurse #3 who notices arrived at the facility to Administrator recalled arrived at the facility to AM, she was informed.	emained normal and she in condition throughout the . The DON stated it wasn't A #2 started rounds that ced to appear different than Resident #1 was assessed ced Resident #1's oxygen ne was given a and EMS was notified for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345446	B. WING _			C <b>3/06/2024</b>
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP OF STATE STATE, ZIP OF STATE STAT	•	0/00/2024
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 580	just after the start area when NA #2 breathing right. Troom with the nurs was lying in bed, so forehead with ster she was difficult to flutter when you condition the check Resident #1 when she returned breathing was vere EMS had already pretty quickly and hospital. The Admincident, they had fall policy or fall protifying the MD wanticoagulant med explained the expinitiate neurological and the decision to and/or send the rebased on the clinicity in the Medical Enot notified on 02/was on anticoaguland sustained a hospital for evaluation with neurological conditions and the date but Resident #1's fall, call the provider on hospital for evaluation with neurological conditions.	inistrator explained sometime of first shift, she was in the reported Resident #1 was not he Administrator went into the se and recalled Resident #1 she had a pump knot on her i-strips applied to the cut and a arouse but her eyes would alled her name. The it out to the nurses' station to 1's code and transfer status and id to the room, Resident #1's y shallow and the nurse stated been notified. EMS arrived transported Resident #1 to the inistrator explained prior to this never had a statement in their rotocol about immediately when a resident on dication had a fall. She further ectation was for the nurse to all checks, assess the resident or call the MD/on-call provider esident out to the hospital was call assessment and nurses'  The interview on 03/05/24 at 1:12 poctor (MD) confirmed he was 13/24 when Resident #1, who lant medication, fell at 1:30 AM ead injury. The MD could not it stated when he was notified of the was told the nurse did not or send Resident #1 out to the ation and decided to monitor her checks. Then around 6:30 AM ed showing acute changes, she is hospital for an evaluation and	F	580		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE COMP	SURVEY PLETED
			A. BOILD	1140	<del></del>	، ا	С
		345446	B. WING				06/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2024
					95 LOCUST STREET		
COLLEGE	PINES HEALTH AND RI	EHABILITATION			CONNELLY SPG, NC 28612		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 9	F	580			
		ard, the outcome was not					
	positive. The MD sta	•					
	Resident #1 was also						
		elt that would be more of an					
	issue than a fall with	head trauma and if she had					
	symptoms of pneumo	othorax while at the facility					
	_	would have expected her to					
		ry difficulties but she didn't.					
	1	Resident #1's respiratory, vital					
		al checks were normal, even					
	_	e hospital immediately					
	_	as likely a Computerized					
		iated as CT and refers to an at produces detailed internal					
	images of the body) s						
	1 -	d the hospital may have just					
	sent her back to the f	· · · · · · · · · · · · · · · · · · ·					
	I .	e definitely progressed over					
	• •	n Resident #1 did show an					
		lition, he restated staff					
	_	change and sent Resident					
		ne MD explained stated at					
	the time, the facility d	lid not have a policy or fall					
	1 .	the provider when a resident					
	on anticoagulant med	dication had a fall. The MD					
	I .	ay for sure if Resident #1					
	I .	hospital immediately after					
	her fall there would h						
		been notified, he would have					
		aution and given orders for					
	ner to be sent to the I	hospital for an evaluation.				I	
	The Administrator wa	s informed of Immediate				I	
	Jeopardy on 03/06/24						
	The facility provided t	the following Corrective					
		mpliance date of 03/05/24:					
	Address how correcti	ve action will be					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUC	OTION		E SURVEY PLETED
		345446	B. WING _			03	C / <b>06/2024</b>
	ROVIDER OR SUPPLIER PINES HEALTH AND I	REHABILITATION		95 LOCUST	RESS, CITY, STATE, ZIP CODE STREET 'SPG, NC 28612	1 00	100/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	1. The facility failed Resident #1 who wa medication, had an approximately 1:30 lying on her right side and the wall with nightstand. Resided portion of the right wa quarter, a bruise to a small red area to hematoma approximate top right side of Address how the fact residents having the the same deficient portion (DON) and residents who had a and were on anticoa were reviewed to errolirector/Nurse Practice with the same deficient. Address what meass systemic changes in deficient practice with a side of the same deficient practice with a systemic changes in deficient practice with a side of the same deficient practice with a systemic changes in deficient practice with a side of the side of the systemic changes in deficient practice with a side of the si	to notify the physician when as on Eliquis, an anticoagulant unwitnessed fall on 2/13/24 at AM. The Resident was found le on the floor between her h her head positioned at the nt #1 has a bruise to the top wrist approximately the size of the right side of right thumb, her right shoulder, and a mately the size of a quarter to the head.  Cility will identify other expotential to be affected by bractice:  The potential to be affected by bractice:  The the potential to be affected a fall during the last 30 days agulant medications. The falls assure the Medical titioner (NP)/on-call provider and told the resident was on to new concerns were found.  The potential be put into place or made to ensure that the	F	580			
	On 2/14/24 the Reg	ional Operations Manager					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345446	B. WING _		0	C 3/06/2024	
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 95 LOCUST STREET CONNELLY SPG, NC 28612	TE, ZIP CODE		
(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 ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Director of Nursing, notifying the physiciaresident on an anticated fall or a fall with a her Beginning 2/14/24 The Assistant Director of Leadership provided regarding notifying to immediately when a has an unwitnessed injury. The Director the Administrator on charge of tracking a education and ensureceive education provided receive educated the Admin Nursing on notifying immediately when a fall or a fall with a head on 3/4/24. The Director of Administrator on 3/4 charge of tracking and education and ensure education and ensure receive education provided receive education	istrator, DON, Assistant and Nursing Leadership on an/NP or on-call when a bagulant has an unwitnessed and injury immediately. The Director of Nursing, and Nursing and Nursing and Nursing and Rursing and Rursing and Rursing and Staff or an anticoagulant fall or a fall with a head of Nursing was educated by 2/14/23 that she would be in all staff to ensure they received a ring no staff will work without a tion. Any new hires will are to the start of their shift, it will be of Regulatory Compliance and Director of Regulatory Compliance and Director of the physician/NP/on-call resident has an unwitnessed and injury. The staff provided education to all son and over the phone with trainer verbal feedback to as understood, to immediately all if a resident has a fall with a head injury. The	F 5	80			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345446	B. WING				/06/2024	
	ROVIDER OR SUPPLIER	REHABILITATION	•	95 LO	ET ADDRESS, CITY, STATE, ZIP CODE CUST STREET NELLY SPG, NC 28612	1 00.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	was updated to say unwitnessed fall or physician/NP/on-ca immediately.  Indicate how the face performance to make sustained:  4. The DON or destresidents twice weet for 8 weeks to ensure notified of any unwiting injury who are on at The facility will monensure that the defit will not recur by reviduring audits and reperformance Improte the DON monthly for time, the QAPI comeffectiveness of the continued auditing correction are necesured and acceptable corrections as evidenced by facilitative will not recur by reviduring audits and reperformance Improte the DON monthly for time, the QAPI comeffectiveness of the continued auditing of correction are necesured as evidenced by facilitative will not conclude a complete the correction are necesured as evidenced by facilitative will be a concluded and acceptable corrections. Review sheets dated 02/14, departments received on anticoagulant meassessed by the nutries.	for Notification of Change: when a resident has an a fall with a head injury the ll provider should be notified cility plans to monitor its are sure that solutions are sure that solutions are dignee will audit five (5) kly for 4 weeks, then weekly rephysician and NP are thessed falls or falls with head in anticoagulant immediately, itor the corrective actions to cient practice is corrected and itewing information collected aporting to Quality Assurance evement committee (QAPI) by or three (3) months. At that mittee will evaluate the interventions to determine if or adjustments to the plan of assary.	F:	580				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345446	B. WING _	_		03/	06/2024
	ROVIDER OR SUPPLIER  PINES HEALTH AND RE	EHABILITATION		95	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LOCUST STREET ONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 580 F 684 SS=J	regarding the facility's to verbalize what to d and who to notify of the nurses revealed they education on 03/04/2 the facility's fall protocto call the MD/provide resident had a fall wit regardless if the resident medication. Review of tools dated 02/15/24 they were completed action plan with no concludity of Care CFR(s): 483.25	ceived in-service education is fall protocol and were able to when a resident had a fall the fall. Interviews with received additional in the change to color and verbalized they were the immediately anytime and in the or without injury and in the facility's monitoring through 03/05/24 revealed as outlined in the corrective oncerns identified.		580 684			
	applies to all treatment facility residents. Bas assessment of a resident residents received accordance with professor practice, the compreherance plan, and the resident resident processor plan, and the resident on record revidence plan, and the resident on record revidence plan, and the resident on record revidence plan, and the resident pla	nensive person-centered sidents' choices.  is not met as evidenced siew and Medical Doctor lews, the facility failed to sness of a head injury leek medical treatment for a nticoagulant medication) bleeds for 1 of 3 residents is (Resident #1). On ately 1:30 AM Resident #1			Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345446	B. WING			03/06/2024
	ROVIDER OR SUPPLIER	REHABILITATION	•	STREET ADDRESS, CITY, 95 LOCUST STREET CONNELLY SPG, NC	· · · ·	00/00/2021
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)	
F 684	Resident #1 had a area, a quarter-siz forehead, and bru Resident #1 exhib distress. Neurolog assessment of mo such as reflexes, to system is impaired were obtained, an limits. Resident # monitored through with continued net were noted within AM and 7:40 AM In having trouble bre Services (EMS) who local hospital. Resubdural hematom surface of the brain tissue along left-sided pneumon space between the lung to collapse). (procedure where through the mouth with breathing), ar reversed (refers to medication to rapice effect), and a chesp pneumothorax. Resident #1 part of the findings included the sident #1 part of the sident #1 part o	pon assessment by Nurse #1, a laceration to the right eyebrow ted hematoma to the right ising to the right hand. Ited no signs of respiratory gical checks (refers to an otor and sensory responses, to determine if the nervous did were initiated, vital signs did all were noted within normal 1 was assisted back to bed and tout the remainder of the shift turo checks and vital signs that normal limits. Between 7:30 Resident #1 was observed athing and Emergency Medical ere called to transport her to a sident #1 was diagnosed with a na (buildup of blood on the n) with shift (displacement of the center of the brain) and thorax (when air leaks into the lung and chest causing the Resident #1 was intubated a flexible tube is placed or nose into the trachea to aid atticoagulant medication was on the administration of dily reverse the anticoagulant set tube was placed for the esident #1's injury was a family elected hospice care wassed away on 02/15/24.	F	684		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	_	(X3) DATE SURVEY COMPLETED
		345446	B. WING _			C 03/06/2024
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY 95 LOCUST STREET CONNELLY SPG, NO		00/00/2027
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F 684	A nursing admission dated 02/02/24 reveroriented to person, provided to person, provided to stand and with one-person phyweakness in all extra limitations in range of the A physician order daread, Eliquis 2.5 mill 8:00 AM and 8:00 P.  The Medical Doctor progress note dated Resident #1's past in frontal hematoma.  The discharge Minim 02/13/24 revealed Resident #1's past in frontal hematoma.  The discharge Minim 02/13/24 revealed Resident #1's past in frontal hematoma.  A nurse sessed. She staff assistance with received antianxiety anticoagulant and of MDS assessment per A nurse progress now written by Nurse #1 an unwitnessed fall was found lying on the bed and positioned at the night experience of the right thumb, a sr	rillation (type of irregular que.  a observation assessment aled Resident #1 was place, time and situation. She and pivot from the wheelchair resical assistance and had emities with no functional of motion.  ated 02/02/24 for Resident #1 digrams (mg) twice a day at M.  (MD) history and physical 02/05/24 revealed in part, nedical history included  and Data Set (MDS) dated desident #1's cognition was required partial/moderate a rolling left and right and total transfers. Resident #1, antidepressant, pioid medications during the eriod.  ated dated 02/13/24 at 2:00 AM read in part, Resident #1 had at approximately 1:30 AM and her right side on the floor	F6	84		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345446	B. WING				06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2024
COLLEGE	PINES HEALTH AND R	EHABILITATION			OCUST STREET NNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 16	F	684			
	Ice pack and steri-str Neurological checks signs were blood pre respiratory (breathing and oxygen saturatio	were initiated and initial vital ssure (BP) 127/82, pulse 79, g) rate 18, temperature 97.7, n 93% on room air.					
	PM, Nurse #1 confirm assigned nurse on 02 11:00 PM to 7:00 AM 1:30 AM she was sitt Nurse Aide (NA) #1 hurses' station and w Resident #1 resided noise. NA #1 looked informed Nurse #1 she noticed Resident position and Resident side on the floor in-be	nterview on 03/05/24 at 12:31 ned she was Resident #1's 2/13/24 during the hours of . Nurse #1 recalled around ing at the Nurses' station, and just walked past the as headed down the hallway when they heard a loud into Resident #1's room and ne was on the floor. Nurse diately entering the room, #1's bed was in a low t #1 was lying on her right etween the wall and bed with phtstand. She noticed blood					
	had a cut in the eyeb bruising to the right hon the top right side of injuries or obvious fractleaned with steri-str packs to her forehead #1 recalled Resident than pointing to the ri (over the counter pair administered per star recalled Resident #1 the water pitcher on tout of bed and the bed Resident #1 must have balance when reaching to the right part of the water pitcher on tout of the days and the bed Resident #1 must have balance when reaching in the right part of the r	nding order. Nurse #1 stating she was reaching for he nightstand when she fell est she could determine was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF D		345446	D. WING			03/	06/2024	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
COLLEGE	PINES HEALTH AN	D REHABILITATION			95 LOCUST STREET			
		-		۱ ۱	CONNELLY SPG, NC 28612			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD   CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	Continued From p	page 17	F	684				
	anticoagulant med	dication and although she had						
	_	ry, she used her nursing						
		making the decision not to send						
		the hospital for an evaluation						
		fall. Nurse #1 added from the						
		was found on the floor and up						
		1) shift ended, Resident #1 was						
	,	splayed no respiratory distress,						
		ks were completed per facility						
	_	vital signs and neurological						
	checks were norn	nal. Resident #1 was assisted						
	back into bed with	a fall mat placed on the floor						
	in-between the be	ed and wall as a safety						
		onitored the remainder of the						
	shift. Nurse #1 co	onfirmed she did not call the MD						
	or on-call provide	r at the time of the fall but did						
	place a note in the	e physician communication						
	book. Nurse #1 e	explained based on her						
	assessment of Re	esident #1, she did not feel that						
	Resident #1 was	in any immediate danger as						
	Resident #1 was	alert and talking with no altered						
	level of conscious	ness or uncontrolled bleeding.						
		phone interview with Nurse #2						
		33 AM, NA #1 recalled on						
		ne between 1:00 AM and 2:00						
		king down the hall and						
		inside Resident #1's room and						
		the floor beside her bed. NA						
		s not sure how Resident #1 fell						
		e floor and stated Resident #1						
		while she was trying to reach for						
	_	1 stated she immediately						
		who came to the room to						
		#1. NA #1 recalled Resident #1						
		ner eye and was talking but did						
		ad any bumps, hematomas or						
		NA #1 explained after Resident						
	⊨#1 was assisted b	pack into bed, she (NA #1)						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345446	B. WING _			C <b>03/06/2024</b>
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE 95 LOCUST STREET CONNELLY SPG, NC 2861		03/00/2024
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F 684	throughout the remarecall Resident #1 distress.  During a joint teleph 03/06/24 at 5:33 AM gone into Resident is being notified Resid Upon entering the received while trying to Nurse #2 stated Resident #1 lying or and wall and Reside of bed while trying to Nurse #2 stated Resident eyebrow hematomas and expect the assessment. Note that the second hour, the second hour, the sent out to the hosp neurological check and revealed Resident #1's vital is minutes for the first the second hour, the sent out to the hosp neurological check and revealed Reside pulse of 84, and resident #1 was oriented to provide the spontaneously and 3 millimeters (normal 2 mm to 4 mm in brint in the dark) equal in had normal hand, and	et's vital signs periodically ainder of the shift and did not isplaying any signs of the shift and did not isplaying any signs of the shift and did not isplaying any signs of the shift and the shift	Fé	684		
	written by Nurse #3 Resident #1's room	ote dated 02/13/24 at 8:03 AM read in part, NA went into and noted she was having irrations. Vitals obtained and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  PINES HEALTH AND	REHABILITATION		95 LOC	TADDRESS, CITY, STATE, ZIP CODE SUST STREET ELLY SPG, NC 28612	1 00	3072024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	7, pulse 100, and of placed on Resident obtained to send he Department (ED) for During an interview Nurse #3 recalled or right around shift chr. 40 AM, she was resident and shift chr.	wure of 130/74, respiratory rate xygen saturation at 88%. Ice #1's head and new orders or to the Emergency revaluation.  on 03/05/24 at 1:45 PM, on the morning of 02/13/24, hange between 7:30 AM and notified by NA #2 that	F	684				
	was not breathing in Nurse #3 stated Re the right side, as shand when she straig Resident #1 had a li which she described to a lump or swelling the right side of the addition, Resident # side of the mouth at she described as C pattern that involves breathing followed be Nurse #1 explained so oxygen was provided to the explained so oxygen was provided by the side of the month of the light provided in the second pattern that involves the system of the second pattern that involves the support oxygen, she obtain Resident #1 to the light provided in the swelling to keep Resident # EMS arrived to train	ng with Resident #1 and she ight. Upon entering the room, sident #1's head was tilted to be normally did when she slept, ightened Resident #1's head, nematoma to the forehead did as a big pump knot (refersing on the head) that covered forehead and eye. In the forehead and breathing.  Resident #1 was a full code wided at 15 liters per minute foreather mask (device used to be of higher concentrations of foreight explains and the forehead and she started sternal rubs in awake and breathing until sport her to the hospital.						
	#2 confirmed she w Resident #1 on 02/	on 03/05/24 at 2:02 PM, NA as assigned to provide care to 13/24 during the hours of 7:00 a #2 explained at the start of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345446	B. WING _			C 3/06/2024	
	ROVIDER OR SUPPLIER	REHABILITATION	,	STREET ADDRESS, CITY, STATE, ZIP CO. 95 LOCUST STREET CONNELLY SPG, NC 28612		0/00/2024	
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F 684	report and NA #1 ha #1 fell out of bed durhead and had some darker. NA #1 also neurological checks completed on Residand everything was were talking and she Resident #1 lying in right, which was how could see somewha Resident #1's foreheappeared to be breat Around 7:15 AM who resident to the dining looked into Resident and it looked like she assisted the other rewent straight back to noticed it wasn't a trowas breathing with a she immediately not who came to the root During an interview Nurse #4 recalled or sometime around the stated Resident #1 went with Nurse #3 assess. Upon enter recalled Resident #1 gasps, had bruising eye area with steri-s gray-looking. Residable to open her eye straight ahead. Nurserash cart ready just	ands with NA #1 for shift d informed her that Resident ring the night, bumped her bruising that would likely get reported to NA #2 that and vital signs were ent #1 throughout the shift fine. NA #2 recalled as they e looked into the room, bed with her head tilted to the w she normally slept, and she t of a knot/bruising to	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
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F 684	Continued From pag	e 21	F 6	884			
	_	l rubs until EMS arrived at and transported her to the					
	dated 02/13/14 noted AM and at 8:01 AM the facility. The EMS arrival, Resident #1 veceiving supplement non-rebreather mask throughout care. Rehematoma over her routward and Cushing irregular respirations pressure indicative obrain), hypertension rate) alongside abnowith a strong suspicit (brain bleeding). Du Resident #1 continue breathing with increa and the hospital was Diffuse Axonal Injury refers to a type of traffrom a blunt injury to Telephone attempt of an interview with the unsuccessful.  The hospital radiology confirmed Resident #1 subdural hemorrhagic centimeters rightwark herniation (displaced under the falx cerebrials).	sing periods of irregularity notified to prepare for (abbreviated as DAI and umatic brain injury resulting the brain) upon arrival.  n 03/06/24 at 11:21 AM for EMS Responder was  ly report dated 02/13/24 #1 had an acute left large with at least 1.5 d midline shift with subfalcine brain tissue that moves i which is the membrane that brail hemispheres of the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRI	UCTION	(X3) DATE SURVEY COMPLETED C		
		345446	B. WING			1	06/2024	
	ROVIDER OR SUPPLIER	REHABILITATION	•	95 LOCUS	DRESS, CITY, STATE, ZIP CODE T STREET LY SPG, NC 28612	, 30.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 22	F	684				
	surrounds the brain right and left tentori and fourth ventricle (bleeding inside or a that contain the censubarachnoid hemo and an anterior right. Review of the hospirevealed Resident evaluation following facility with obvious anticoagulant medic diagnosed with a sublood on the surface (displacement of brothe brain). Resident where a flexible tubor nose into the trace she was on anticoareversed (refers to a medication to rapidl effect) and also four pneumothorax (where the lung and collapse) and a chest effect and a collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and a chest effect and reversed the lung and collapse and reversed the lung and	orrhage along the brainstem,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRU	` '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			95 LOCUST	DRESS, CITY, STATE, ZIP CODE  STREET Y SPG, NC 28612	1 03/	06/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I PROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	water which was proleaving the room. The recall NA #1 walked another resident's car #1's room and she was he looked into Resider lying on the floor with her head near the immediately called for room and upon assecut above her eye at on her forehead with obvious fractures identified they did not automated anticoagulant medicevaluation following injury, but rather were and if neurological continued to monitor acute change in con Nurse #1 used her infollowing the fall, Refrequently, her vital stremained normal and condition throughout The DON stated it with appear different than Resident #1 was assenticed Resident #1's he was given a nor was notified for an endotted the strength of the pour interview of the policy and interview of the policy in the policy and the	dent #1 asked for a drink of wided by NA #1 before he DON stated she seemed ed down the hall to answer all light after leaving Resident was walking back up the hall, dent #1's room and observed in between the bed and wall he nightstand. NA #1 or Nurse #1 who went to the essment, Resident #1 had a nd a small hematoma upon in no other deformities or entified. The DON explained tically send a resident on ation out to the hospital for an a fall, even with obvious head in the total property in the total property in the total property in the resident had an dition. The DON stated for an a fall, even with obvious head in the total property in the resident had an dition. The DON stated for an a fall was monitored signs and neurological checks in the remainder of the shift. For any it until first shift when NA at Resident #1 was noticed to in she had been earlier. Seessed by Nurse #3 who is oxygen saturation was low, in-rebreather mask, and EMS mergent hospital transfer.	F	584			
	arrived at the facility AM, she was informed	ed on 02/13/24 when she between 6:30 AM and 7:00 ed by staff that Resident #1 enight but was doing fine and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345446	B. WING	B. WING		03/	06/2024
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION			9	STREET ADDRESS, CITY, STATE, ZIP CODE 15 LOCUST STREET CONNELLY SPG, NC 28612			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	normal. The Administ questioned staff about reported they heard at into Resident #1's room the floor between head near the nightst the time of the fall, Reand told Nurse #1 she pitcher off the nightst to grab it. Nurse #1 smonitored throughout change in condition. The start of first shift, area when NA #2 repure breathing right. The area was lying in bed, she forehead with steri-stishe was difficult to an flutter when you calle Administrator went on check Resident #1's owner when she returned to breathing was very shed by the shear of the Administrator went on the check Resident #1's owner she returned to breathing was very shed shad already been pretty quickly and transpital. The Administricident, they had new fall policy or fall protonotifying the MD whe anticoagulant medical explained the expectation in the decision to call and/or send the resident.	trator explained when she at what happened, staff a noise and when they went but to check, she was lying the bed and wall with her and. Staff also reported at esident #1 was alert, talking the had knocked the water and and fell out of bed trying stated Resident #1 was at the shift with no acute Then sometime just after the Administrator was in the orted Resident #1 was not Administrator went into the and recalled Resident #1 had a pump knot on her rips applied to the cut and ouse but her eyes would d her name. The ut to the nurses' station to code and transfer status and the room, Resident #1's hallow and the nurse stated en notified. EMS arrived hisported Resident #1 to the strator explained prior to his ever had a statement in their col about immediately	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345446	B. WING	B. WING		03/06/2024	
NAME OF PROVIDER OR SUPPLIER				٤	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
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COLLEGE	PINES HEALTH AND	REHABILITATION		(	CONNELLY SPG, NC 28612		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	PM, the Medical Do not notified on 02/1 was on anticoagula and sustained a he recall the date but s Resident #1's fall, he call the provider or hospital for evaluati with neurological chasses and out to the from what he had he positive. The MD s Resident #1 was all pneumothorax and issue than a fall wit symptoms of pneur following her fall, he have some respirat He explained since signs and neurolog if she had gone to the following her fall, it Tomography (abbreimaging technique images of the body detected anything a sent her back to the symptoms could have a few hours and whacute change in correcognized the acu #1 to the hospital. facility did not have notifying the providanticoagulant medicallicallicallicallicallicallicallical	interview on 03/05/24 at 1:12 potor (MD) confirmed he was 3/24 when Resident #1, who ant medication, fell at 1:30 AM ad injury. The MD could not stated when he was notified of the was told the nurse did not send Resident #1 out to the ion and decided to monitor her necks. Then around 6:30 AM is showing acute changes, she hospital for an evaluation and leard, the outcome was not tated he was unaware	F	684	,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
	345446		B. WING			C 03/06/2024		
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP C 95 LOCUST STREET CONNELLY SPG, NC 28612		30,730,232-7			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 684	outcome but had he erred on the side of her to be sent to the The Administrator w Jeopardy on 03/06/2 The facility provided Action Plan with a condition Plan with	have been a different been notified, he would have caution and given orders for hospital for an evaluation.  as informed of Immediate 24 at 11:10 AM.  the following Corrective ompliance date of 03/05/24:  tive action will be ose residents found to have	F	684				
	2/13/24 immediately an anticoagulant methe resident; initiated signs noted to be with Address how the factoresidents having the the same deficient policy. An audit of current the last 30 days was Nursing and the Sta 2/14/24 to identify a affected by the same negative findings.  Address what meas systemic changes medicient practice will	Resident #1 was on Eliquis, dication. Nurse #1 assessed dineuro checks with all vital thin normal limits.  Callity will identify other potential to be affected by ractice:  Interesidents with falls during a completed by the Director of ff Development Nurse on the other residents possibly be practice. There were no the other will be put into place or the other possible with the side of the other place.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345446	B. WING _	B. WING		C 3/06/2024	
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 95 LOCUST STREET CONNELLY SPG, NC 28612		3/30/2324		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Development Nurse of must always be asseresident is on an antishould be notified impedicated to review all medication record to anticoagulant and to notified immediately of Nursing was educate 2/14/23 that she would staff to ensure they reconsuring no staff will education. Any new prior to the start of the responsibility of the Dithis is completed. Educated to say: wunwitnessed fall or a MD/NP/on-call should On 3/4/24 The Direct educated the Administ Nursing on notifying the immediately when a refall or a fall with a head on 3/4/24. The Direct Development Nurse processed fall or a fall with a head on a fall with a head of a fall or a fall with a head allowed to work before education will be additional must	prirector of Nursing and Staff on the following: residents assed after falls and if the coagulant the MD/NP/on-call mediately. Staff were Il residents with falls and verify if they are receiving an ensure the provider is of a fall. The Director of d by the Administrator on Id be in charge of tracking all eceived education and work without receiving this hires will receive education eir shift, it will be the Director of Nursing to ensure lucation to be completed by  for Notification of Change when a resident has an fall with a head injury the d be notified immediately.  For of Regulatory Compliance estrator and Director of he physician/NP/on-call resident has an unwitnessed ad injury.  For of Nursing and the Staff provided education to all ediately call the sident has an unwitnessed ad injury. Staff will not be retraining is completed. The led to the new hire Staff will give the trainer	F6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345446	B. WING _	B. WING		024	
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 95 LOCUST STREET CONNELLY SPG, NC 28612	•	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COR	(X5) MPLETION DATE	
F 684	would be in charge of they received education without receiving hires will receive education will be the Director of Nursing to Education will be completed by their shift, it will be the Director of Nursing to Education will be completed to make sustained:  4. The Director of Nureview the daily fall results and reported to the physic weeks, then 4 falls and reported to the physic weeks, then 4 falls and a falls a week for one Nursing or designed consecutive QAPI med QAPI committee will be the interventions to dauditing is necessary.  Date of compliance 3  The Corrective Action 03/06/24 and conclude an acceptable correct as evidenced by facili interviews. Review of sheets dated 02/14/2 departments received on anticoagulant medicated by the nurst be immediately	ector of Nursing was inistrator on 3/4/23 that she if tracking all staff to ensure ion and ensuring no staff will go this education. Any new cation prior to the start of e responsibility of the ensure this is completed. Inpleted by 3/4/24.  It plans to monitor its esure that solutions are ensure that solutions are all a falls with a head injury were can immediately for 4 week for 4 weeks, and then emonth. The Director of will bring these audits to 3 eetings. At that time the evaluate the effectiveness of etermine if continued to maintain compliance.	F6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMP	SURVEY PLETED
			7 50.25.			С	
		345446	B. WING			03/	06/2024
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION		EHABILITATION		9	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LOCUST STREET CONNELLY SPG, NC 28612		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867 SS=D	were able to verbalize had a fall and who to with nurses revealed education on 03/04/24 the facility's fall protoc to call the MD/provide resident had a fall wit regardless if the resid medication. Review of tools dated 02/15/24 they were completed action plan with no concept (CFR(s): 483.75(c)(d)(d) §483.75(c) Program of facility must establist policies and procedure collections systems, and adverse event monitor procedures must include following:  §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be usuare high risk, high volopportunities for impressions with the facility systems to identify, or information from all do not limited to the facility with the facility systems to the	the facility's fall protocol and what to do when a resident notify of the fall. Interviews they received additional 4 regarding the change to col and verbalized they were er immediately anytime a the or without injury and lent was on anticoagulant of the facility's monitoring through 03/05/24 revealed as outlined in the corrective oncerns identified. The content of the facility is monitoring through 03/05/24 revealed as outlined in the corrective oncerns identified. The content of the facility is monitoring in the corrective oncerns identified. The content of the corrective oncerns identified as and implement written the facility is monitoring. The policies and under and monitoring, including oring. The policies and under at a minimum, the maintenance of effective druse of feedback and input other staff, residents, and wes, including how such ed to identify problems that ume, or problem-prone, and		867			3/8/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED			
	<b>345446</b> B. WIN		B. WING			03/06/2024		
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 95 LOCUST STREET CONNELLY SPG, NC 28612	I	03/00/2024		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 867	will be used to devel indicators.  §483.75(c)(3) Facility and evaluation of pe including the method development, monitor for the systematically identification analyze and use data adverse events in the facility will use the daprevent adverse eve \$483.75(d) Program systemic action.  §483.75(d)(1) The facility will development and track performance implementing those and track performance improvements are resulting to the systemic action.  §483.75(d)(2) The facility will use determine underlying impacting larger systs (ii) How they will development to elevel to prevent qualisafety problems; and (iii) How the facility will have the facility will hav	y development, monitoring, rformance indicators, lology and frequency for such bring, and evaluation.  y adverse event monitoring, is by which the facility will fy, report, track, investigate, a and information relating to e facility, including how the lata to develop activities to ints.  systematic analysis and  acility must take actions be improvement and, after actions, measure its success, be to ensure that healized and sustained.  acility will develop and didressing: a systematic approach to great causes of problems items; elop corrective actions that affect change at the systems ity of care, quality of life, or it will monitor the effectiveness in provement activities to	F 8	67				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345446	B. WING _	B. WING		C 03/06/2024		
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION		,	STREET ADDRESS, CITY, STATE, ZIP CODE 95 LOCUST STREET CONNELLY SPG, NC 28612					
(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 IOSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 867	performance improve high-risk, high-volume consider the incidence of problems in those outcomes, resident siresident choice, and siresident choice, and siresident events, analytimplement preventive that include feedback facility.  §483.75(e)(3) As partimprovement activitied distinct performance number and frequence conducted by the faciand complexity of the available resources, assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this section is \$483.75(g) Quality as \$483.75(g)(2) The quassurance committee governing body, or defunctioning as a governing as a governing as a governing as a governing body.	cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.  mance improvement nedical errors and adverse yze their causes, and actions and mechanisms and learning throughout the extension of their performance s, the facility must conduct improvement projects. The extension of the facility must reflect the scope facility's services and as reflected in the facility at §483.70(e). It is must include at least at focuses on high risk or identified through the data are described in paragraphs atton.  The seessment and assurance.  The seessment and assurance.	F8	67				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345446  NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		03/06/2024		
			STREET ADDRESS, CITY, STATE, ZIP CODE 95 LOCUST STREET CONNELLY SPG, NC 28612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 867	(e) of this section. T  (ii) Develop and impaction to correct ideal (iii) Regularly review data collected under resulting from drug resulting from	ander paragraphs (a) through the committee must:  Ilement appropriate plans of intified quality deficiencies; and analyze data, including the QAPI program and data regimen reviews, and act on take improvements.  IT is not met as evidenced to ons, record review, and staff try's Quality Assessment and committee failed to maintain dures and monitor the ecommittee put into place fication and complaint completed on 03/26/21. This deficiencies in the areas of the intification that were originally entification and complaint completed on 03/26/21 and did during the complaint ented on 03/06/24. The the facility during two federal nows a pattern of the facility's in effective QAA Program.  In the interview and Medical off interviews, the facility failed on-call provider when	F 867	The facility failed to maintain implemented procedures and monitor interventions the committee put into proceduring the recertification and comprince investigation survey of 3/24/21. This for 2 deficiencies recited on the curre complaint investigation survey of 3/6/25 the areas of: Notification of Change (F580) and Quality of Care/Profession Standards (F684). The continued failed during two surveys of record shows a pattern of the facility's inability to sust an effective Quality Assurance Performance Improvement (QAPI) program.  On 3/7/24 the Quality Assurance Committee held a meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewing the ongoing compliance related to the issues regarding the F580 and F684 received on the complaint survey of 3/24/21.	place plaint was nt 24 in nal ure plainin the stages	

Facility ID: 923110

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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		345446	B. WING _	B. WING		03/	06/2024	
NAME OF PROVIDER OR SUPPLIER  COLLEGE PINES HEALTH AND REHABILITATION			98	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LOCUST STREET ONNELLY SPG, NC 28612				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	to notify the Physicial Computerized Tomograncelled by the facil F684: Based on reconductor (MD) and staft to recognize the serior following a fall and seresident on Eliquis (awith a history of brain reviewed for accident During the recertifical investigation survey ensure a resident who with head injury resundered an interviewed for accident who with head injury resundered an interview of the computer of the properties of	tion and complaint of 03/26/21, the facility failed on when a resident's graphy (CT) scan had been ity.  rd review and Medical if interviews, the facility failed ousness of a head injury eek medical treatment for a nticoagulant medication) in bleeds for 1 of 3 residents its (Resident #1).	F	367	educated the Administrator, the Director Nursing, and the Staff Development Coordinator on the appropriate function of the QAPI Committee and the purpose of the Committee to include identifying issues and correction of repeat deficiencies, use of rounding tools, dail review of documentation, and observations during leadership rounds. 3/7/24, the Regional Clinical Manager of provide weekly oversight for 12 weeks and will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee training or other interventions. By 3/7/2 the Administrator educated the QAPI committee members consisting of Med Director, Director of Nursing, Staff Development Coordinator, Unit Manage Minimum Data Set Nurse, Wound Nurse Activities Director, Dietary Manager, Environmental Services Manager, Director of Social Services, and the Director of Rehabilitation, on weekly ris review of the audit findings for compliant and/or revision when necessary.  The QAPI committee will continue to monthly to identify issues related to quassessment and assurance activities a needed and will develop and implement appropriate plans of action for identified facility concerns.  Completion date 3/8/2024	e  y  By will  ee r 4, ical ers, ee, k nce eet ality s t		