		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( )	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345011	B. WING		С	
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	03/28/2024	
			2	79 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION	L	EXINGTON, NC 27292		
(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 COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC	
E 000	Initial Comments		E 000			
F 000	An unannounced recertification and complaint investigation survey was conducted on 3/18/2024 through 3/28/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9BNO11. INITIAL COMMENTS		F 000			
	survey was conducte 3/22/2024. The surve 3/25/2024 when imme identified at CFR 483 surveyor returned to allegation; from 3/26/ survey continued rem	ediate jeopardy was .21 at tag F660 and a validate the credible 2024 until 3/27/2024 the totely; and survyor returned ate the credible allegation for				
	The following intakes NC00203363 NC00204372 NC00210752 NC00213560 NC00215072 NC00215091 NC00204755 NC00204755 NC00208111 NC00211889 NC00211079	were investigated:				
	10 of 23 complaint al deficiency.	llegations resulted in				
		was identified at: 607 at a scope and severity 2/13/2024 and ended on				

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.

TATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
		345011	B. WING _				C 03/28/2024
	ROVIDER OR SUPPLIER	ING AND REHABILITATION		2	TREET ADDRESS, CITY, STATE, ZIP CODE 79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	Continued From page 2/15/2024.	e 1	F	000			
F 550 SS=G	of K which began on 3/28/2024. CFR 483.12 at tag FC o.f J which began on 2/15/2024. CFR 483.21 at tag FC of J which began on 3/24/2024. CFR 483.25 at tag FC of K which began on 3/28/2024. CFR 483.45 at tag F7 of K which began on 3/28/2024. The tags F600, F607 Substandard Quality An extended survey of Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenance	300 at a scope and severity 7/14/2023 and ended on 307 at a scope and severity 2/13/2024 and ended on 360 at a scope and severity 2/14/2024 and ended on 384 at a scope and severity 7/14/2023 and ended on 760 at a scope and severity 7/14/2023 and ended on 7/14/2023 and ended on 7/14/2023 at a scope and severity 7/14/2023 at a scope at a scope at a scope at a sco	F	550			4/23/24

Facility ID: 923005

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STATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		G	í co	MPLETED
						С
		345011	B. WING			)3/28/2024
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP (	CODE	
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 550	Continued From page			50		
F 330	Continued From page		F 5	50		
	individuality. The facil promote the rights of	· ·				
	8/83 + 10(a)(2) The fac	cility must provide equal				
	•	e regardless of diagnosis,				
		or payment source. A facility				
		aintain identical policies and				
		ansfer, discharge, and the				
		under the State plan for all				
	residents regardless	of payment source.				
	§483.10(b) Exercise	of Rights.				
		right to exercise his or her				
	rights as a resident of or resident of the Unit	f the facility and as a citizen ted States.				
		cility must ensure that the				
		his or her rights without				
	from the facility.	n, discrimination, or reprisal				
		sident has the right to be				
		oercion, discrimination, and				
	•	ty in exercising his or her				
	exercise of his or her	orted by the facility in the rights as required under this				
	subpart. This REQUIREMENT	is not met as evidenced				
	by:					
		iew, resident, and staff		The statements included i	n this plan of	
		failed to treat a resident in a		correction are not an admi		
	-	n two Nurse Aides (NAs)		not constitute agreement v		
	-	e residents' wounds in front		deficiencies herein. The pl		
		and were rough during		is completed in the complia		
		when the resident was		and federal regulations as		
		in pain (Resident #35) they		remain in compliance with		
	-	The resident stated the NAs made her feel angry		state regulations, the center will take the actions set for		
		eated her that way for 1 of 1		following plan of correction		

Facility ID: 923005

If continuation sheet Page 3 of 110

		MEDICAID SERVICES				<u>VO. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
			A. BUILDING				
		345011	B. WING			C	
	ROVIDER OR SUPPLIER	040011		STREET ADDRESS, CITY, ST		3/28/2024	
				279 BRIAN CENTER DRIVE			
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S	PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC	
F 550	Continued From page	e 3	F 55	0			
	resident reviewed for	pain.		plan of correction c	onstitutes the center⊡s		
				allegation of compl	iance. All alleged		
	The findings included	1:		deficiencies cited h			
				completed by the d	ates indicated.		
		mitted to the facility on		F550			
		ses that included: diabetes tructive pulmonary disease,			discharged from the		
		pressure ulcer to left lower			NA# 2 and NA#3 were		
		licer to the right lower leg.			24 by the Director of		
		5 5			resident rights, dignity,		
		nterview were conducted		and respect. This e			
		03/18/24 at 12:01 PM.			n resident verbalizes or		
		sting in bed on her back and			with care, and talking		
		her voice was very soft in er. Resident #35 stated that		to resident, not abc providing care.	but resident while		
	-	) had just given her a bed		All residents have t	he potential to be		
		ort hair was very nice and			icient practice. All alert		
		r was very rough. Resident			ents and non-alert and		
		scribe what rough meant,			responsible party were		
		ng-haired NA, identified as		-	Interdisciplinary Team		
		a bed bath and she was			ed on 4/11/24 related to		
		at was very rough and then		dignity while perfor			
		dentified as NA #3 came in onto my side and "I was in so		-	onsultant conducted g care on 4/5/24 and no		
	-	wounds on my bottom.		other issues were i			
		that she was crying and			N and Administrator		
		and both NAs kept saying		initiated an in-servi			
	"we are sorry" but jus	st kept on "wiping me." She		include contract sta	aff) on resident rights		
		d NA #3 were talking to each			ity while providing care		
		ids on my bottom but not to			education included not		
	-	#35 stated it made her "feel			a resident regarding		
		they treated me that way" alking about her wounds but			and not addressing		
		ig in so much pain during		verbalizes or demo			
		the staff did not stop the		symptoms of pain v	-		
	care but continued to	-		performed. This ed	ucation was completed aff or contract staff who		
	Resident #10 was ad	mitted to the facility on		did not receive the			
	02/07/23.	-			allowed to work until		

Facility ID: 923005

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TATEMENT (	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345011	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	545011		STREET ADDRESS, CITY, STATE, ZIP CODE	03/28/2024	
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(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 COMPLET	
F 550	Continued From page	e 4	F 550			
	revealed that Resider An interview with Res (Resident #10) was of 12:06 PM, she stated Resident #35 she wa bath and got the basi went to Resident #35 bath. She stated she but she heard the ent provided to her room that she could hear N #35 and heard Resid she was scrubbing he had completed wash she went and got NA wash her back side. I during the process bo talking to themselves indicated they were ro of Resident #35's sor not talking to Resider time NA #1 and NA #	rly MDS dated 01/19/24 ht #10 was cognitively intact. sident #35's roommate conducted on 03/18/24 at I NA #2 came in and told s going to give her a bed n and filled it with water and 's bedside to begin her bed did pull the privacy curtain, tire exchange of care being mate. Resident #10 stated IA #2 scrubbing Resident ent #35 state to NA #2 that er too hard. When NA #2 ing the front of Resident #35 #3 to help turn her and Resident #10 stated that oth NA #2 and NA #3 were about how bad it was, and eferring to the size and color res on her bottom were but nt #35. She stated the whole 2 were washing her ving and screaming saying it		complete. The Director of Nursing this to the new hire orientation on The Administrator or designee wil conduct 3 random resident audits dignity while performing care wee weeks, then 2 random resident au dignity while performing care wee weeks. The Administrator or designee wil these audit results to the Quality Assurance Performance Improver (QAPI) Committee x 2 consecutiv meetings. The QAPI committee w evaluate the effectiveness of the a plan and will make additional inter and recommendations based on t audits to ensure continued compli Date of Compliance: 4/23/24	4/12/24. on kly x 4 udits on kly x 4 l bring ment e ill above ventions he	
	she stated she had b 4 days as agency sta given Resident #35 a stated that Resident a especially when she NA #2 stated, "She is her back side." NA #2	ed on 03/18/24 at 2:23 PM, een coming to the facility for ff. NA #2 confirmed she had bed bath earlier today. She #35 "was in pain and crying" rolled her over to her side. a raw in her peri area and on 8 came in and helped turn er side to help wash her back				

If continuation sheet Page 5 of 110

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	D: 04/19/2024 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345011	B. WING				C /28/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURSI	NG AND REHABILITATION			279 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550 F 565 SS=D	her peri area and her but did not see real te and saying that it hurt you will understand," in peri area and bottom. NA #3 was interviewe who confirmed she as completing Resident # that when she entered was resting on her ba dried her front side an onto her side to wash side. She stated wher over, she was moanin one point put her hand The Director of Nursir on 03/21/24 at 10:28 / expected the staff to t though they are family professional manner. of customer service tr treating the residents Resident/Family Grou CFR(s): 483.10(f)(5) (i §483.10(f)(5) The resi and participate in resit (i) The facility must pr group, if one exists, with to make residents and upcoming meetings in (ii) Staff, visitors, or ot	It when she started washing back side, she began to cry ears, but she was moaning $\therefore$ NA #2 stated, "If you see it referring to Resident #35's and on 03/18/24 at 2:56 PM esisted NA #1 with #35's bed bath. She stated d the room Resident #35 ck, NA #2 had washed and het hey turned Resident #35 her peri area and her back in they turned Resident #35 her peri area and her back in they turned Resident #35 heg and saying ouch and at ds over her face. Ing (DON) was interviewed AM. She stated she reat each resident as y and in a respectful and She explained she did a lot raining to remind staff on in a dignified manner. up and Response D)-(iv)(6)(7) ident has a right to organize dent groups in the facility. rovide a resident or family <i>i</i> th private space; and take h the approval of the group, d family members aware of in a timely manner. ther guests may attend ily group meetings only at		550			4/23/24

Facility ID: 923005

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/202 FORM APPROVE OMB NO. 0938-039	
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2024	
		345011	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		79 BRIAN CENTER DRIVE		
			L L	EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 565	Continued From page	e 6	F 565			
	10	provide a designated staff	1 000			
		ved by the resident or family				
	1	and who is responsible for				
		and responding to written				
	requests that result fi					
		consider the views of a				
		oup and act promptly upon				
	U U	ecommendations of such sues of resident care and life				
	in the facility.					
		be able to demonstrate their				
		ale for such response.				
	(B) This should not b	e construed to mean that the				
		ent as recommended every				
	request of the reside	nt or family group.				
	§483.10(f)(6) The res	0				
	§483.10(f)(7) The res	sident has a right to have				
	family member(s) or	-				
	representative(s) me	et in the facility with the				
		epresentative(s) of other				
	residents in the facilit					
		T is not met as evidenced				
	by: Based on record rev	view, and staff and resident		F565		
		failed to provide resolution		Residents # 67, #64 and #59 were		
		Meeting group grievances for		interviewed on 4/9/24 and 4/11/24 by t	the	
		ent Council Meetings. The		Social Services Director and/or		
	Resident Council had			Administrator regarding resident cound	cil	
		acks and ice water being		grievances on ice water and snack		
		ing (11/9/2023, 12/7/2023,		delivery. Grievance was written and th		
	2/22/2024, and 3/21/	2024).		issues were addressed with the nursin department.	lg	
	Findings included:			All residents have the potential to be		
				affected by this deficient practice.		
	On 11/9/2023 the Re	sident Council Meeting		Resident council meeting was held on		
		ents continued to have issues		4/11/24, by the Activities Director and		

Event ID:9BNO11

Facility ID: 923005

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		345011	B. WING				C 28/2024
NAME OF P	ROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP CODE			1 00	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			9 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 565	Continued From page	e 7	F 56	65			
	with ice water not bei				grievances filed for ice water or snack delivery.		
		ce Report dated 11/9/2023			On 4/11/24 the Administrator in-service	ed	
	was not being passed	nt Council reported ice water			the Activities Director on recording concerns of the residents during the		
		Report noted the Director of			resident council meeting and giving the	e	
		nonitored and re-educated			concerns to the appropriate departmer		
	-	f on passing out snacks and			head for resolution. Once the departme	ent	
	ice water before bedt	ime.			head resolves the concerns it is to be		
	The Pesident Counci	I Minutes for 12/7/2023 were			given to the Administrator and Activitie Director in writing and presented in the		
	-	he residents talked about			next council meeting. The Administrate		
		e water not being passed out			educated the department heads on		
	on night shift.				resolving concerns with written resolut		
					and to be given to the Administrator an	nd	
		ce Report dated 12/7/2023 nt Council reported ice water			Activities Director. All new employees		
	was not being passed	•			hired to the facility will have orientation resident council/resident group	ion	
		e report noted under the			participation and the right to voice a		
		tion the DON had monitored			grievance. This education will become		
		ed out at night and the DON			part of the "new hire" packet/orientation	n	
	would continue to mo	onitor.			for all new hires.		
	A review of the Resid	ent Council Minutes for			The Administrator will review resident council meeting minutes for concerns a	and	
		dents had discussed issues			writing resolutions from the appropriate		
	that continued to be c	ongoing, and the issues			department x 2 months.		
	would be followed up	-			Results of these audits will be presented		
		ident Council Minutes did			by the Administrator or designee and w	vill	
	not elaborate on wha	t the issues were.			be reviewed by the Quality Assurance Performance Improvement Committee	x 2	
	On 3/21/2024 at 10:0	0 am during the Resident			consecutive meetings.	~ ~ ~	
		ollowing residents voiced			Date of Compliance: 4/23/24		
		en brought up before in					
	Resident Council Me have issues with the	etings and they continued to concerns:					
	a. Resident #67 wa 3/24/2022.	is admitted to the facility on					

Facility ID: 923005

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	` '			COMPLETED	
						'	С
		345011	B. WING			03/	28/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION	LEXINGTON, NC 27292				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	Set assessment dated was cognitively intact present. Resident #67 stated of Meeting on 3/21/2024 were not delivered du evenings and he has Resident #67 stated to brought up in the Resimonth. b. Resident #64 wa 11/1/2023. Resident #64's quarted assessment dated 3/6 cognitively intact and On 3/21/2024 at 10:0 Council Meeting Resi snacks and ice were of the issue had been bu Council Meetings in the c. Resident #59 wa 4/15/2021. A quarterly Minimum 1/4/2024 indicated Resi intact and had no befort Resident #59 stated of that she was on the G the Resident Council Administrator regarding	<ul> <li>#67's annual Minimum Data d 2/12/2024 indicated he and had no behaviors</li> <li>during the Resident Council 4 at 10:00 am that snacks uring the day or in the not received ice at night. Doth issues had been sident Council Meeting last</li> <li>s admitted to the facility on</li> <li>erly Minimum Data Set 5/2024 indicated she was had no behaviors.</li> <li>0 am during the Resident dent #64 stated the evening delivered inconsistently and rought up in the Resident the past few months.</li> <li>s admitted to the facility on</li> <li>Data Set assessment dated esident #59 was cognitively haviors.</li> <li>on 3/21/2024 at 10:00 am Grievance Committee with President and met with the ng any grievances brought</li> </ul>	F	56			
	up during Resident C	ng any grievances brought ouncil. She stated when Iministrator, they report any					

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/19/2024 MAPPROVED O. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345011	B. WING				C 6/28/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURSI	NG AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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 565	with the staff regardin stated she was not av snacks and water bein continued to be a prof On 3/20/2024 at 12:00 conducted with the Ad stated when there are Resident Council Mee Committee, which cor Council President (wh and Resident #59, me who then follows up of explained ice water not evenings had been a also explained she ga ice water not being pa it had come up in the During an interview w (DON) on 3/20/2024 at had provided education had come in late in th water had been given explained she had ch were available for the explained she had not correction or document to make sure the reside water. The DON state out in the evening bef provided before each An interview was com- pm with the Administr	the Administrator speaks g the issues. Resident #59 ware the complaints about ng delivered at night had blem. 5 pm an interview was ctivity Director (AD). She e grievances from the etings, the Grievance nsists of the Resident no is currently hospitalized) eet with the Administrator on the concerns. The AD ot being delivered in the recurring issue. The AD ove the grievances for the assed out to the DON when Resident Council Meetings. ith the Director of Nursing at 12:19 pm she stated she on for the staff at night and e evening to ensure ice to the residents. She also ecked to make sure snacks residents. The DON	F	565			
	who meet with her an						

Facility ID: 923005

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					с
		345011	B. WING		03/28/2024
NAME OF PF	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE	
				LEXINGTON, NC 27292	
(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 COMPLETION
F 565	Continued From page	e 10	F 565		
		e meetings. She stated the	1 000		
		sponsible for putting the			
	•	evances into the Resident			
		h are reviewed the next day			
		ouncil meeting, during the			
	morning meeting. Thi monthly Quality Assu	s is part if the facility's			
F 600	Free from Abuse and	-	F 600		4/23/24
SS=K					
	8/83 12 Freedom fro	m Abuse, Neglect, and			
	Exploitation	ili Abuse, Negleci, aliu			
	•	right to be free from abuse,			
		ation of resident property,			
		efined in this subpart. This			
	includes but is not lim	involuntary seclusion and			
		ical restraint not required to			
	treat the resident's m				
	§483.12(a) The facilit	y must-			
	§483.12(a)(1) Not use	e verbal, mental, sexual, or			
	physical abuse, corpo	•			
	involuntary seclusion				
	This REQUIREMENT	is not met as evidenced			
	Based on record rev	iew, staff, resident.		F600	
		Services (EMS) Personnel,		1.	
		urse Practitioner, facility		Resident # 244 was discharged from	the
		edical Director, family, and		facility on $7/24/23$ .	~
	Physician Assistant in neglected to provide	intravenous (IV) antibiotic		On 03/27/2024 the Director of Nursing reviewed all current residents receivir	-
		d for 14 days to a resident		antibiotics for IV access placement/	····
	when his IV access b	ecame dislodged and		patency/ function, orders for	
	neglected to direct him	m to a higher level of care,		administration of IV antibiotic therapy	
	· · · · · · · · · · · · · · · · · · ·				
		ess line for 1 of 3 residents 244) for abuse/neglect.		course to ensure residents are receiv their antibiotics as ordered by the	ing

Event ID:9BNO11

Facility ID: 923005

If continuation sheet Page 11 of 110

OLITICI		MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345011	B. WING		C 03/28/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•
				279 BRIAN CENTER DRIVE	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
E 600		- 44			
F 600	Continued From page		F 60		
	-	gh likelihood of physical		physician and do not requ	-
	-	ering the IV antibiotic as		of care to meet resident c	
	untreated by the infecti	ous disease clinic. The faction had the high		On 03/27/2024 the Directo	5
	likelihood of causing	5		educated all licensed nurs residents to a higher level	
	extremities or possibl			needs of the resident can	
		ity also failed to protect a		facility to avoid serious ha	
		free of sexual abuse for 1 of		impairment/ neglect of set	
	U U	for abuse/neglect (Resident		On 03/27/2024, the Direct	
		tact male resident (Resident		educated all licenses nurs	-
		d in the bathroom of his		physician orders, notificat	-
		esident (Resident #38), a		and documenting any bar	
	severely cognitively in	mpaired resident, with her		antibiotic administration.	On 03/27/2024
	pants off, brief off, an	d shirt pulled up near her		the Director of Nursing ed	ucated all
	-	acility's investigation in an		certified nursing assistant	
		38 stated Resident #241 had		changes in resident basel	-
		d her breast(s) and stated		new acute observations to	
		being taken advantage of by		observed IV issues. On 03	
	Resident #241.			Director of Nursing educa	
				heightened awareness of	
		began on 07/14/23 when		neglect, what constitutes	-
		ccess become dislodged,		to provide necessary care	
		cted to re-establish his IV to a higher level of care to		the residents to ensure re appropriate goods and se	
		was restored and he could		03/27/2024, the Director of	
		ation he was prescribed.		reviewed all current reside	
		was removed on 03/28/24 for		antibiotics for IV access	
		the facility implemented a		placement/patency/ functi	on. orders for
	credible allegation of			administration of IV antibi	
		eopardy began on 2/13/24		course to ensure resident	
	-	nd was removed on 2/15/24		their antibiotics as ordered	-
	when the facility imple			physician and do not requ	lire a higher level
		ite jeopardy removal. The		of care to meet resident c	
	-	t of compliance at a D (no		The Director of Nursing w	-
		ential for more than minimal		hired licensed nurses. Ed	ucation
		ediate jeopardy) to ensure		completed 3/27/24.	
		ucation and monitoring		The Director of Nursing or	-
	system are in place.			review all residents receiv	
			1	medications to ensure IV	access and

Event ID:9BNO11

Facility ID: 923005

If continuation sheet Page 12 of 110

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345011	B. WING			
		545011		STREET ADDRESS, CITY, STATE, ZI		8/28/2024
NAME OF P	ROVIDER OR SUPPLIER			PCODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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 TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 12	F 600			
	The findings included	1:		medication delivery acco	rding to orders.	
	Ŭ			This audit will be conduc		
	1. This tag is cross	ed referred:		x 2 months, then one-tim	e weekly x	
				month.		
		rd review, staff, family,		The Director of Nursing v		
		Services (EMS) personnel, urse Practitioner, facility		medication audits to the Assurance Performance		
		2, and Medical Director		Committee x 3 consecuti	-	
		failed to send Resident #244		QAPI committee will eval		
		oom (ER) as directed by the		effectiveness of the abov		
l		fice on 07/14/23 to have his		make additional interven	•	
	intravenous (IV) acce	ess restored and to resume		recommendations based	on the audits to	
		ibed IV antibiotics. Resident		ensure continued compli		
		serted central catheter		Date of Compliance: 4/23	3/24	
	, ,	dislodged on 07/11/23 and		2.		
		10 was notified by the fice to send Resident #244		Resident #241 was disch	harged from the	
		PICC line reinserted so that		facility on 2/14/24. On 2/13/2024, social wor	rker completed	
		antibiotics as ordered and		100% interviews of alert	•	
		end him to the ER. Resident		residents for sexual abus		
		from the facility on 07/24/23		02/13/2024 the treatmen	-	
	-	e Infectious Disease office		completed 100% skin ch	ecks of	
	on 07/26/23, had his	IV access restored and his		cognitively impaired resid		
		d at an outpatient infusion		abuse. Findings included		
		practice affected 1 of 2		residents affected by alle	eged abuse.	
		or significant medication		On 02/12/2024 the Dime	ton of Number	
	errors.			On 02/13/2024 the Direc	-	
	F760 <sup>.</sup> Based on reco	rd review, staff, family,		began in-service of all fu and PRN (as needed) sta		
		urse Practitioner, facility		administration, housekee		
		2, and Medical Director		nursing, therapy, and ma		
		failed to prevent a significant		(including agency) on the		
	medication error whe	en staff failed to administer		prohibition/reporting polic	cy. This training	
		intravenous (IV) antibiotic		will include all current sta	-	
		24/23 after the residents		agency. This training incl		
		central catheter (PICC line)		right to be free from abus		
	-	of 2 residents reviewed for		screening of residents fo	-	
	-	n error (Resident #244).		indicative of potential per behavior, identifying wha		
	1 1 CSIUCIIL #244 S IIIIC	ction if left untreated could	1		ແບບກອກແບເຮອ	1

Facility ID: 923005

If continuation sheet Page 13 of 110

		ND HUMAN SERVICES				FOR	D: 04/19/20 MAPPROVE
TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	O. 0938-039 E SURVEY PLETED
		345011	B. WING _			03	C 6/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				279	9 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LE	XINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 13	E	500			
1 000					abuna recognizing signs of abuna		
	lead to loss of limb fu				abuse, recognizing signs of abuse, understanding behavioral symptoms of	of	
	During an interview w	vith the Director of Nursing			residents that may increase their risk		
		t 4:14 PM, she stated if the			abuse and/or of being victimized, what		
	infectious disease off	fice called on 07/14/23 and			do if abuse is observed or suspected,	and	
	gave an order to sen	d Resident #244 to the ER			assuring resident safety. Staff were a		
		e sent him to the ER. She			educated to have heightened awaren		
		was no documentation of			understanding, and identifying resider	nt	
		sal to go to the ER and she			#38 behaviors that placed her at an	~	
		nce of documentation to the me. The DON stated that it			increased risk of abuse and monitorin prohibiting, and preventing abuse for	g,	
	-	o not administer Resident			resident#38. Staff were also asked if	they	
	-	as prescribed and they			were aware of any abuse occurring o	-	
		to the ER so his IV access			resident in the facility. No staff were a		
	could be restored, an	nd his IV antibiotics resumed.			of any other alleged abuse occurring		
					the facility. The Director of Nursing wi		
		as interviewed on 03/21/24 at			ensure that any of the above-identifie		
		that Resident #244 was "very			staff (all staff including agency) who c		
		y non complaint with staff," Vhat he did not want he did			not complete the in-service training by 02/13/2024 will not be allowed to wor	-	
		ined he pulled his PICC line			until the training is completed. The	N	
	-	mpted to get vascular			Director of Nursing will ensure this tra	inina	
		successful. The nursing staff			will be included in the new hire orienta	•	
	spoke to Infectious D	visease on 07/17/23 and			for any newly hired staff.		
		at he was still receiving					
		nd not receiving the IV			The Director of Nursing or designee v		
		istrator stated, "I feel like we			conduct resident behavior monitoring		
		uld have done, we notified			audits of staff for knowledge of Abuse		
	refused everything."	our due diligence." "He			neglect policy, signs, and symptoms, reporting with education 12 times week		
					4 weeks, then 5 times weekly x 4 wee	-	
	The Administrator wa	as notified of the immediate			then 1 time a week x 4 weeks.	,	
	jeopardy on 03/27/24						
					The Director of Nursing will bring thes	e	
	The facility provided	-			audits to the Quality Assurance		
	allegation of immedia	ate jeopardy removal:			Performance Improvement committee	эх 3	
	   Identify those recipion	nts who have suffered or			-	000	
	Identify those recipie	nts who have suffered, or serious adverse outcome as			consecutive meetings. The QAPI committee will evaluate the effectiven of the above plan and will make addit	e	ss

Event ID:9BNO11

Facility ID: 923005

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							D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	E SURVEY PLETED
		345011	B. WING			03	/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 14	F 60	00			
	a result of the noncor				interventions and recommendations		
		•			based on the audits to ensure contin	nued	
	The facility neglected to provide intravenous				compliance.		
		s to a resident when his			Date of Compliance 4/23/24		
	intravenous access b	tibiotics was necessary to					
		There was a high likelihood					
		pairment when Resident					
	-	myelitis (infection of the					
	, , ,	occus bacteremia (infection					
	of the bloodstream le						
	the facility neglected						
		vide the ordered services. irector of Nursing reviewed					
		eceiving IV antibiotics for IV					
		atency/ function, orders for					
		intibiotic therapy course to					
		receiving their antibiotics as					
		cian and do not require a					
	higher level of care to needs.	o meet resident current					
	Specify the action the	e entity will take to alter the					
		ilure to prevent a serious					
		m occurring or recurring, and					
	when the action will b	be complete:					
	On 03/27/2024 the D	irector of Nursing educated					
		n directing residents to a					
	•	the needs of the resident					
		facility to avoid serious harm					
		ct of services needed. On					
	-	ctor of Nursing educated all Ilowing physician orders,					
		an and documenting any					
	barriers to IV antibiot						
		tor of Nursing educated all					
	certified nursing assis	stants on reporting changes					
	in resident baseline, a						1

Facility ID: 923005

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · ·	MPLETED
						С
		345011	B. WING		0	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
				LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 15	F 60	00		
	-	de observed IV issues. On	1.00			
		tor of Nursing educated all				
staff on heightened awareness of the definition of						
		utes neglect, and how to				
		re and services to the				
		esident receive appropriate On 03/27/2024, the Director				
	of Nursing reviewed a					
	U U	s for IV access placement/				
		lers for administration of IV				
		Irse to ensure residents are				
	-	itics as ordered by the require a higher level of care				
		ent needs. The Director of				
		newly hired licensed nurses.				
	Education completed	3/27/24.				
		Director will be responsible				
		ntation of this immediate				
	jeopardy removal for	the alleged non-compliance.				
	Alleged Date of IJ Re	emoval: 3/28/24				
	On 03/28/24 an onsit	e credible allegation				
	validation was condu	cted. The audit of all in				
		/ antibiotics was reviewed				
		idents. Those two residents' n record, dressings, and				
	-	n were all verified, and no				
		d. Interviews with all staff				
	-	d been educated on neglect,				
		lentify it, and who and when				
	-	ews with all nursing staff				
	revealed that they ha	ing any changes in resident				
		nedication administration to				
		and carrying out any orders				
		uring that it was documented				
	in the medical record					

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			LETED
		345011	B. WING				C 28/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>  00/</u>	20/2024
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			279 BRIAN CENTER DRIVE		
					LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 600	Continued From page	e 16	∫ F	600			
	transferring the reside	ent to a higher level of care verbalize the process for					
		t to the ER for treatment. of 03/28/24 was validated.					
		s admitted to the facility on ses of Parkinson's disease					
	#241 was cognitively moderate assistance wheelchair and walke	7/2024 indicated Resident					
	indicated he was inde set-up assistance wit	e Plan dated 2/9/2024 ependent but could require h transferring to his e Plan did not indicate he					
	10/13/2023. Residen	mitted to the facility on t #38 cumulative diagnoses schizoaffective disorder, posttraumatic stress					
	#38 was severely cog not ambulate, and sh assistance for transfe	19/2024 indicated Resident gnitively impaired, she did e required extensive ers and toileting, she did not and she was occasionally					
	stated she had impair	Plan was reviewed and red cognitive function due to cess related to dementia,					

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/19/2024 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING			_		C 28/2024
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
					279 BRIAN CENTER DRIVE			
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		1	LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	head injury; she requi daily living due to den and limited mobility; a wandering and decrea The Care Plan include monitoring and report function, providing a h assisting with decision cognitive function; ass living such as shower care as needed; provi ordered, and anticipat behaviors. Resident #47 was add 12/22/2023 with diagr disorder, and diabeter A review of Resident Minimum Data Set (M 2/13/2024 indicated h Resident #47's Care H indicated he did not h behaviors. An interview was com 10:25 am with Resider roommate of Resident stated Resident #241 their room on the eve were watching televis then wheeled Resider and shut the door, an Resident #47 stated h Nurse Aide (NA) #1 a Nurse Aide #1 that Resider	tion use, and a history of ired care with all activities of nentia, decreased balance, and she had behaviors of ased safety awareness. ed interventions of ting any changes in cognitive nome like environment, and n making for impaired sisting with activities of daily ring, bathing and personal iding medications as te the residents needs for mitted to the facility on noses of stroke, mood s. #47's most recent quarterly IDS) assessment dated he was cognitively intact. Plan dated 2/10/2024 have cognitive issues or ducted on 3/21/2024 at ent #47, who was the	F	600				

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/19/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING					C 28/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
				<u> </u>				
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE		(X5) COMPLETION DATE
F 600	Continued From page went to get the Nurse		F	600				
	went to get the Nurse	-						
	interviewed by phone Resident #47's (room light and he told her h Resident #241, was tr lady" (Resident #38) i Aide #1 stated she wa and there was a resid she checked the bath other residents in the dismissed the allegati further for the two resistated she might have	ion and did not look any idents. Nurse Aide #1						
	remember what happ in the bathroom with I 2/13/2024. She state something unpleasan was unable to verbali and she did not reme happened in the facili On 2/13/2024, during into the allegation of s Nursing interviewed F Resident #47, and he pushed Resident #38 the door. Resident #4 #1 entered the room t mouthed the words th Resident #38 were in	she stated she could not ened when she was found Resident #241 on d she thought it was t and she felt violated but ze any details of the incident mber if the incident ty or somewhere else. the facility's investigation sexual abuse, the Director of Resident #241's roommate, stated Resident #241 into his bathroom and shut 47 stated when Nurse Aide to answer his call light he nat Resident #241 and						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/19/2024 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING		_	( 03/2	; 28/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				279 BRIAN CENTER DRIVI	E		
PINEACR	ES CENTER FOR NURSI	NG AND REHABILITATION		LEXINGTON, NC 27292	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #38 was cor rubbing against her be she could not break th tore the tape and pus Resident #241 also st that he did not touch he down. A phone interview wat 1:03 pm with Residen facility had accused he Resident #38. He stat they held hands, and stated he went into th #38 because she need she could not remove assistance. Nurse #1 was intervied at 9:33 am, she stated staffing company, and nurse on 2/13/2024 of shift. Nurse #1 state #241's room at approxi- him his evening media she did not see Resid went to the bathroom and when she opened in her wheelchair, her beside her wheelchair down to the floor, and just below her breasts #241 was standing wi abdomen, he was full #1, Resident #38 was	on 2/13/2024 and he stated mplaining about her brief ecause it was too tight, and he tape on the brief, so he hed the brief down for her. ated during the statement her he just pushed the brief s conducted 3/22/2024 at t #241 and he stated the im of doing something to ted they were friends and he bought her candy. He e bathroom with Resident ded to use the toilet and	F 60		DEFICIENCY)		
	called for Nurse #2 to residents.	help her separate the					

Facility ID: 923005

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04 FORM AP OMB NO. 09	PROVED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE SUR COMPLETE	
		345011	B. WING		_	C 03/28/2	2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(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	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		(X5) DMPLETION DATE
F 600	Continued From page	20	F 60	0			
	called her to Nurse #2 #241 was with Reside she needed her assis #241 was standing at when she arrived at th let her in, and he stat #38 change her brief. took Resident #241 o assisted Resident #38 spoke with Resident # #241 out of the bathro her Resident #241 sti her "boobs." Nurse # #38 said Resident #2 was not pleasurable, Resident #38 did not did not appear to be th Resident #241 when Review of Resident # revealed a note by the on 2/13/2024 at 11:15 notified by Nurse #2 of discovered in Residen Resident #38 stated F her breasts and stimu. Progress Note further were separated; Resi Party was notified of the investigation was initi Note also stated Resi stated she felt safe; a During a review of the the incident the Direct	and she stated Nurse #1 2's unit and stated Resident ent #38 in his bathroom and tance. She stated Resident the door to the bathroom he room and did not want to ed he was helping Resident Nurse #2 stated Nurse #1 ut of the room and she 8 with dressing, and she #38 after assisting Resident bom and Resident #38 told mulated her and touched 2 further stated Resident 41 did not hurt her, but it or painful. Nurse #2 stated act like she was upset and rying to get away from she entered the bathroom. 38's Nurse's Progress notes e Director of Nursing (DON) 9 pm which stated she was of Resident #38 being ht #241's bathroom and Resident #241 had touched lated her. The DON's revealed the residents dent #38's Responsible					

If continuation sheet Page 21 of 110

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		IO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED	
						С	
		345011	B. WING		0	3/28/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	ODE		
PINE ACR	ES CENTER FOR NURS	SING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 600	Continued From pag	e 21	F 600				
		Resident #38 stated she	1 000				
		s not hurt or scared; it felt					
	good; and she felt lik	e he (Resident #241) was					
	playing a game, and advantage of.	she was being taken					
	On 3/21/2024 at 1.3/	apm the Director of Nursing					
		ed, and she stated she					
		Il from the Nurse #2 on					
		n. She stated during the					
	1 ·	told her Resident #38 was					
		41's bathroom with Resident					
		nt #38 was found with					
		/as undressed from the waist #241 stated he was helping					
		om. She stated she and the					
	Social Worker began						
	immediately and Res	sident #38 was calm and did					
		istress. The DON stated					
		se #1, Nurse #2, Nurse Aide					
		7 after they interviewed					
		esident #241. She stated nt #241 on 1:1 observation					
		rom Resident #38. The DON					
		requested a room change					
	and he was moved to	o another room that evening.					
	A Progress Note writ	ten by the Physician's					
		4/2024 stated Resident #38					
		allegation of sexual assault					
		The Progress Note stated					
	-	ent #38 was found with her					
		d down and a male resident The Progress Note further					
	-	was severely cognitively					
		bry of bipolar disorder and					
		aumatic stress disorder and					
	-		1			1	
	her recall of events is	s limited. The PA's Progress					

Facility ID: 923005

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CENTERS STATEMENT OF	FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		FORM OMB NC (X3) DATE	
AND PLAN OF C	ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345011	B. WING		_		C 28/2024
NAME OF PRO	VIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
PINE ACRE	S CENTER FOR NURSI	NG AND REHABILITATION		79 BRIAN CENTER DRIVE EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	abnormal findings were exam; no pain was re- not appear to be in ac The Physician's Assis on 3/21/2024 at 11:59 was on call when Res- boathroom with Reside off, and her pants were stated she saw Reside she could recall some what had happened. could remember a ma stated she denied pair was normal. On 3/19/2024 at 4:30 conducted with the Fa #38, and he stated the on the evening of 2/13 was found Resident # boathroom partially und facility had separated Resident #38 and pro ncidents. He stated F cognitively impaired a ncident after it happe On 3/22/2024 at 12:32 nterviewed, and she s completed a plan of cr of sexual abuse on 2/ was found sitting in he #241, in his bathroom below her breasts, he ner wheelchair, and h ankles. She stated th	ising, bleeding or other re found from the physical ported; and the resident did ute distress. tant (PA) was interviewed a mand she stated she ident #38 was found in the nt #241 when her brief was e pulled down. The PA ent #38 the next day and things but could not specify The PA stated Resident #38 n in the bathroom. She n and her physical exam pm a phone interview was umily Member of Resident e Administrator called him 8/2024 and reported she 38 in male resident's clothed. He stated the Resident #241 from tected her from any further Resident #38 was severely nd did not talk about the ned.	F 600				

Facility ID: 923005

If continuation sheet Page 23 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345011	B. WING				C 28/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           Y MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE           LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE           DEFICIENCY)         DEFICIENCY)				(X5) COMPLETION DATE	
F 600	staff and residents inv and Nurse #2 put Res observation and at Re transferred him to and Administrator further is began education aboud Prohibition and Report with all staff including dietary department, m housekeeping depart and administration stated educated all staff on the abuse, and what to de abuse reported to the they had continued to they had taken the re their monthly Quality. The Administrator wa jeopardy on 03/22/20 The facility provided the allegation of immedia Resident #38: Identify those recipier are likely to suffer, a se a result of the noncor On February 13, 2024 #241's room. Nurse # resident #241's bathro her ankles with her br wheelchair with resider resident #241. Nurse Nurse #1 immediately who is cognitively inta bathroom and stayed	volved. She stated Nurse #1 sident #241 on 1:1 esident #47's request, they other room. The stated she and the DON ut the facility's Abuse rting Policy on 2/13/2024 the nursing department, ment, therapy department aff. She stated they he kinds of abuse, signs of o if the staff suspect or have m. The Administrator stated o educate all new staff and sults of their monitoring to Assurance Meetings. s notified of the immediate 24 at 7:55 pm. he following credible te jeopardy removal for hts who have suffered, or serious adverse outcome as npliance: 4, nurse #1 entered resident 1 observed resident #38 in pom with her pants down to	F	600			

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/19/2024 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345011	B. WING				C <b>28/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACRES CENTER FOR NURSING AND REHABILITATION					79 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Nurse #2 assessed, or resident #38, who is as with a diagnosis of De #2 then removed resid her room. Nurse #2 m Nursing (DON) of inci- resident #241. DON incident with resident administrator notified nurse and requested incident in the building notification by phone Nursing (DON) and tr facility to meet with R severely cognitively in Dementia/Alzheimer as DON and treatment m residents' body as a r and incontinent care w #38. The assessment had no obvious bruisi or genitals. On 2/14/20 notified of incident wit 2/20/2024 the psych g #38. On 2/13/2024, upon incident, the Administ was determined that to notified police and ad submitted initial allega Agency at 10:59 pm. notified Resident #38' on-call provider of the Administrator and pol of resident #241, nursi- regarding alleged abu	Aressed, and interviewed severely cognitively impaired ementia/Alzheimer's. Nurse dent #38 and returned her to otified the Director of dent with resident #38 and notified Administrator of #38 and resident #241. The social worker and treatment their assistance with g. On 2/13/2024, upon of incident, the Director of eatment nurse drove to the esident #38, who was npaired, with a diagnosis of and was assessed by the urse for any injury on the esult of the alleged abuse was provided for resident revealed that resident #38 ng or redness on her body 024 the psych provider was th resident #38. On provider visited with resident	F	600			

If continuation sheet Page 25 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 04/19/2024 FORM APPROVED MB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(3) DATE SURVEY COMPLETED
		345011	B. WING				C 03/28/2024
	ROVIDER OR SUPPLIER	ING AND REHABILITATION		:	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	<b>•</b>	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	conduct interview for 02/13/2024, the Social Nursing interviewed r alleged abuse. On 2/ resident #241's room 101B to 108B. Reside back to his room by n discharged on 2/14/2 On 02/14/2024, the A alleged abuse investi investigation findings abuse of resident #38 the Administrator sub report to the State Su 241 was discharged f 02/14/2024. On 2/13/2024, social interviews of alert and sexual abuse. On 02/ completed 100% skin impaired residents for included: No other re- abuse. Specify the action the process or system fai adverse outcome fror when the action will b On 02/13/2024 the Di in-service of all full-tir needed) staff, admini dietary, nursing, thera (including agency) on prohibition/reporting p	<ul> <li>meet Resident #38 and alleged abuse. On al Worker and Director of esident #38 regarding 13/2024 at 10:00 pm mate was moved from room ent #241 was then taken turse remaining 1:1 until he 4.</li> <li>dministrator concluded gation and based on , unsubstantiated the alleged 8. On 02/14/2024 at 1:59 am, mitted an investigation trvey Agency. Resident # from the facility on</li> <li>worker completed 100% d oriented residents for 13/2024 the treatment nurse or checks of cognitively r signs of abuse. Findings sidents affected by alleged</li> <li>e entity will take to alter the lure to prevent a serious in occurring or recurring, and the complete.</li> <li>frector of Nursing began ne, part-time, and PRN (as stration, housekeeping, apy and maintenance</li> </ul>	F	600			

Facility ID: 923005

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 04/19/202 DRM APPROVE NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345011	B. WING				C 03/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		-	BRIAN CENTER DRIVE INGTON, NC 27292		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	training included: Res abuse, Abuse Types, red flags indicative of behavior, identifying v recognizing signs of a behavioral symptoms increase their risk of victimized, what to do suspected, and assur were also educated to awareness, understa resident #38 behavio increased risk of abus prohibiting and preve Staff were also asked abuse occurring to an staff were aware of al occurring in the facilit will ensure that any o (all staff including age the in-service training allowed to work until The Director of Nursii will be included in new newly hired staff. Alleged date of IJ rem The facility provided of action accomplished 03/22/24. The facility Resident #241 being immediately after the and continued until he facility on 2/14/24. Th investigation by interve 2/13/2024. The facility	sidents' right to be free from screening of residents for potential perpetrator what constitutes abuse, abuse, understanding of residents that may abuse and/or of being of fabuse is observed or ring resident safety. Staff o have heightened nding and identifying rs that placed her at an se and monitoring, nting abuse for resident #38. d if they were aware of any my resident in the facility. No ny other alleged abuse ry. The Director of Nursing f the above-identified staff ency) who do not complete by 02/13/2024 will not be the training is completed. mg will ensure this training w hire orientation for any noval was 02/15/24. evidence of correction of for Resident #38 on r provided documentation of put on 1:1 observation incident was discovered e was discharged from the he facility began an viewing all staff involved on ty also provided sessment of Resident #38 by	F	600			

Facility ID: 923005

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
		345011	B. WING		0	C 3/28/2024	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COL			
		ING AND REHABILITATION	2	79 BRIAN CENTER DRIVE			
			L	EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 600	Continued From page	e 27 2024. The facility provided	F 600				
F 607 SS=J	evidence of actions a residents by providing residents that were can not answer a question documentation of que any residents that were regarding any allegat were reported. The fi- education for all staff including agency and their abuse and negle provided documentat review of the monitor Quality Assurance Co- included the review m all employees. The IJ was validated. Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The faciliti implement written pol §483.12(b)(1) Prohibit neglect, and exploitat misappropriation of re §483.12(b)(2) Establit to investigate any suc	ccomplished for all other g skin assessments of all ognitively impaired and could nnaire. They also provided estionnaires completed with are able to answer questions ions of abuse and no issues acility provided in-service , for all departments, contracted staff regarding ect policy. The facility ion of their monitoring, ing, and their monthly committee meeting which nonitoring and in-servicing of removal date of 02/15/24 abuse/Neglect Policies -(5)(ii)(iii) ary must develop and licies and procedures that: it and prevent abuse, tion of residents and esident property, sh policies and procedures	F 607				

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	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345011	B. WING		0	C 3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	SING AND REHABILITATION		LEXINGTON, NC 27292		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	facilities in accordand Act. The policies and but are not limited to §483.12(b)(5)(ii) Pos- employee rights, as o (3) of the Act. §483.12(b)(5)(iii) Pro- retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on record rev Physician's Assistant to immediately report abuse to the adminis reviewed for sexual a severely cognitively i (Resident #38) was t #241), a cognitively i bathroom in his room roommate, a cognitively (Resident #47), used Aide (NA) #1 about F #38. NA #1 did not r Resident #241 and F During this time whe allegation to a nurse, bathroom with Resid nurse, who was com medications to Resid Resident #38 with he shirt pulled up to below	<ul> <li><i>i</i>-funded long-term care</li> <li>ce with section 1150B of the</li> <li>d procedures must include</li> <li>the following elements.</li> <li>sting a conspicuous notice of</li> <li>defined at section 1150B(d)</li> <li>ohibiting and preventing</li> <li>d at section 1150B(d)(1) and</li> <li>T is not met as evidenced</li> <li><i>v</i>iew, staff, resident, and</li> <li>t interviews the facility failed</li> <li>t an allegation of sexual</li> <li>strator for 1 of 3 residents</li> <li>abuse (Resident #38). A</li> <li>impaired female resident</li> <li>taken by a resident (Resident ntact male resident, into the</li> </ul>	F 607	Past noncompliance: no plar correction required.	n of	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345011	B. WING			PRIVE 2292 DER'S PLAN OF CORRECTION (X5) RRECTIVE ACTION SHOULD BE COMPLETION	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 607	A review of the facility Exploitation Policy da facility's staff will repor- the Administrator with immediately if the eve- allegation involve abu- Resident #241 was an 2/1/2024 with diagnos and weakness. An admission Minimu assessment dated 2/7 #241 was cognitively behaviors, and requir walking and used a w ambulation. Resident #38 was add 10/13/2023. Residen diagnoses included: disorder, bipolar disor stress disorder. A quarterly Minimum assessment dated 1/7 #38 was severely cog required moderate as toileting, she did not h was occasionally inco bladder. The MDS a Resident #38 could re for 150 feet without as Resident #47 was add 12/22/2023 with diagn disorder, and diabete	<ul> <li>dividual and ted 10/20/2020 stated the set of all alleged violations to an specified timeframes: ents that caused the set.</li> <li>dividual to the facility on sets of Parkinson's disease</li> <li>m Data Set (MDS)</li> <li>7/2024 indicated Resident intact, had not had ed moderate assistance with theelchair and walker for</li> <li>mitted to the facility on t #38's cumulative dementia, schizoaffective rder, and posttraumatic</li> <li>Data Set (MDS)</li> <li>19/2024 indicated Resident sistance for transfers and nave any behaviors, and she ontinent of bowel and sessment further indicated oll herself in her wheelchair sistance.</li> </ul>	F	607			

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		<u>0. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
						С
		345011	B. WING		03	/28/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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	(X5) COMPLETIO DATE
F 607		IDS) assessment indicated	F 607			
	into the allegation of s Nursing interviewed F Resident #47, and he pushed Resident #38 the door. Resident #47 mouthed the words th Resident #38 were in stated Nurse Aide #1 An interview was con 10:25 am with Resider roommate of Resider stated Resident #241 their room on the eve were watching televis then wheeled Reside and shut the door, an Resident #47 stated F Nurse Aide (NA) #1 a	the facility's investigation sexual abuse, the Director of Resident #241's roommate, e stated Resident #241 into his bathroom and shut 47 stated when Nurse Aide to answer his call light he hat Resident #241 and the bathroom, and he got Nurse #1. ducted on 3/21/2024 at				
	Resident #38 were in Aide #1 went to get th On 3/21/2024 at 5:03 interviewed by phone Resident #47's (room light and he told her h Resident #241, was t lady" (Resident #38) Aide #1 stated she we and there was a resid she checked the bath other residents in the	the bathroom and Nurse he Nurse. pm Nurse Aide (NA) #1 was and stated she answered mate for Resident #241) call he thought his roommate, rying to have sex with "that in the next room. Nurse ent to the next resident room lent in the room and then proom and there were no				

Facility ID: 923005

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		MEDICAID SERVICES	(¥2) MEILTI	IPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		345011	B. WING		03/28/2024
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DDE
PINE ACR	RES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE TE APPROPRIATE DAT
F 607	further for the two res stated she might have	sidents. Nurse Aide #1 e told Nurse #2 about	F 6	07	
	Resident #47's allegation but she was not sure if she told someone.				
on 3 repo Res Bath have the to R mec sittin her her pulle state han and brie Nurs at 9	on 3/22/2024 at 9:10 reported to her there Resident #241's roon Resident #241 pushe bathroom, and he tho have sex. She state the bathroom with Re to Resident #241's ro medication. Nurse #1 sitting in her wheelch her brief on the floor her pants pulled down pulled up to just below stated Resident #241 hands around his abo	A phone interview was conducted with Nurse #1 on 3/22/2024 at 9:10 am and she stated no one reported to her there was an allegation by Resident #241's roommate (Resident #47) that Resident #241 pushed Resident #38 into his oathroom, and he thought they were going to have sex. She stated she found Resident #38 in he bathroom with Resident #241 when she went to Resident #241's room to give him his evening medication. Nurse #1 stated Resident #38 was sitting in her wheelchair beside the commode with her brief on the floor beside her wheelchair and her pants pulled down to the floor, and her shirt bulled up to just below her breasts. She further stated Resident #241 was standing with his nands around his abdomen, he was fully clothed,			
	brief and was doing a Nurse #2 was intervie at 9:15 am and she s Resident #241's roon	ewed by phone on 3/22/2024 tated she was called to n by Nurse #1 and Nurse #1			
	#38 in Resident #241 were pulled down, he her shirt was pulled u She stated when she room Resident #38 w in front of the commo	esident #241 and Resident 's bathroom and her pants er brief was on the floor, and up to just below her breasts. arrived at Resident #241's vas sitting in her wheelchair de with her pants below her e floor, and her shirt pulled			
	up to just below her b interviewed by phone am and she stated N	and her of the particular eragain on 3/22/2024 at 9:56 urse Aide #1 did not notify erallegation, she was notified			

Facility ID: 923005

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/19/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING					C <b>28/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
PINE ACRES CENTER FOR NURSING AND REHABILITATION					279 BRIAN CENTER DRIVE			
					EXINGTON, NC 27292			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 607	Continued From page		F	607				
		esident #38 in the bathroom stated if Nurse Aide #1 told on she would have						
	Worker and the Direct indicated Nurse Aide and 9:15 pm the room call light on and when he stated Resident #2 in the next room and (inappropriate) with he Nurse #2 stated she assistance and when 9:25 pm with Nurse # in her wheelchair with ankles, her shirt pulle	er. The written statement by was called by Nurse #1 for she entered the room at 1 Resident #38 was sitting her pants down to her						
	(DON) was interviewe received a phone call 2/13/2024 at 9:30 pm the phone call Nurse was found in Residen Resident #241. The I reported Resident #33 the waist down, and F her to go to the bathro was not aware Nurse Nurse #1 or Nurse #2 Resident #241's room allegation of abuse an reported it to either N	The DON stated during #1 told her Resident #38 t #241's bathroom with DON stated Nurse #2 8 was found undressed from Resident #241 was helping bom. The DON stated she Aide #1 had not reported to that Resident #47, mate had reported an hd Nurse Aide #1 had not urse #1 or Nurse #2. The de #1 should have reported						

Facility ID: 923005

If continuation sheet Page 33 of 110

	-	ID HUMAN SERVICES				FORM	/ APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ווסו	E CONSTRUCTION	(X3) DATE	0.0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
			A. BOILD	-			С
		345011	B. WING				28/2024
NAME OF P	ROVIDER OR SUPPLIER	L	- 1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				2	279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		I	LEXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORTOR	-SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)		
F 607	Continued From page	≥ 33	F	607	,		
			•				
	On 3/22/2024 at 12:3	2 pm the Administrator was					
	interviewed, and she						
		correction for the reporting of					
		al abuse that occurred on					
		dent #38 was found sitting in					
	her wheelchair with R						
	bathroom, with her sh breasts, her brief in th	nirt pulled up to below her					
		ants pulled down to her					
	-	trator stated Nurse Aide #1					
		itely reported the allegation					
		urse would report to the					
	Director of Nursing or	her.					
	The Administrates was	e vestified of locus dista					
	Jeopardy on 3/22/202	s notified of Immediate					
		24 at 11.25 am.					
	On 3/22/2024 at 11:2	5 am the Administrator					
	stated the facility had	completed a plan of					
	correction regarding r	eporting of abuse on					
	2/13/2024:						
	Corrective estion for r	resident(s) offected by the					
	allegation of deficient	resident(s) affected by the					
	•	4, between 9:00 pm and					
	· · ·	41's roommate, Resident					
		ide #1 that Resident #241					
		ne lady in the next room and					
	he was being fresh (ir	nappropriate) with her.					
		she checked the next room					
		room and there was only					
	one resident in the ne						
	On February 13, 2024						
		n to give him his medications					
	-	e #1 observed resident #38 athroom with her pants down					
	to her ankles with her	-					
		dent #241standing beside					

Facility ID: 923005

If continuation sheet Page 34 of 110

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	IPLETED
						С
		345011	B. WING			3/28/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From page	e 34	F 60	70		
		Resident #38. Nurse #1 called Nurse #2 for assistance and Nurse #2 immediately removed				
		was cognitively intact, and				
	stayed with him to en	sure Resident #38's and				
		y. Nurse #2 stayed with				
1     		rely cognitively impaired ed her for injuries, dressed				
		her. Nurse #2 notified the				
	Director of Nursing of	f the incident, and the				
		otified the Administrator.				
	The Administrator not the Treatment Nurse	tified the Social Worker and				
	assistance with the ir	-				
		ministrator notified the				
		Protective Services, and				
		legation report to the State 59 pm. The Administrator				
		sident #38's responsible				
		provider of the alleged				
	abuse. The Administ					
		ew with Resident #38, Nurse				
		arding the alleged abuse. nd Administrator interviewed				
		sident #47 for alleged abuse				
		ent #38 was returned to her				
	,	was moved to another room				
	remained on 1:1 with	as returned to his room and				
	discharged on 2/14/2					
	On 2/14/2024 the Ad	ministrator concluded the				
		ation of abuse and based on				
	investigation finding t	he allegation was ne allegation of abuse of				
		14/2024 at 1:59 am the				
		ed the investigation report to				
	the State Survey Age	ncy.				
	Corrective action for	residents with the potential				

Facility ID: 923005

If continuation sheet Page 35 of 110

TATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	). 0938-039 SURVEY LETED
			A. BUILDIN	G		C
		345011	B. WING			28/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From page	e 35	F 60	07		
		cial Worker completed				
		alert and oriented residents				
		n 2/13/2024 the Treatment				
rd O M		n assessments for 100% of				
		ve impairments for any signs				
	were affected by the	ncluded no other residents alleged abuse.				
	Measure/systemic ch	anges to prevent				
	reoccurrence of alleg					
	-	ector of Nursing began				
	in-service education	of all full-time, part-time, and				
	prn (as needed) staff					
		y, nursing, therapy, and				
	-	ng agency) on the abuse policy.  The training will				
		iff including agency. This				
		use types, reporting abuse				
		ely to the nurse/Director of				
	-	or, what to do if abuse is				
		ed, assuring residents safety,				
	zero tolerance of reta	allation of reporting along with notification of				
		it, Adult Protective Services,				
		ency. Staff were also asked				
	if they were aware of	any abuse occurring to any				
		y and what to do if observed				
	-	aff were aware of any other				
	-	ing in the facility. The ill ensure that any of the				
	-	(all staff including agency)				
		te the in-service training by				
		allowed to work until the				
		mpleted. This training will be				
	included in new hire of hired staff.	prientation for any newly				
	Monitoring procedure	e to ensure the plan of				
	womoning procedure	i lo ensure lhe plan ol				

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If continuation sheet Page 36 of 110
	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/19/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING		_	( 03/:	28/2024
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION					
				EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page cited remains correcter regulatory requirement Beginning the week of Administrator or desig process to ensure res and any abuse identif according to facility per recognizing and report Administrator or desig members to monitor in for reporting alleged a report to. The monito weeks and then monter resolved. Reports will monthly Quality Assurt Administrator or desig action is initiated as a be monitored, and on reviewed at month Quality Immediate jeopardy re Date of Compliance is Review of the Plan of date of 2/15/2024: The facility provided of with staff who cared fi #241, and Resident # reported an allegation	e 36 ed and/or in compliance with nts: of 2/14/2024, the gnee will monitor the abuse sidents are free from abuse fied reported and addressed olicy using the QA Tool for rting abuse. The gnee will interview 5 staff f staff know the procedure abuse and when and who to oring will be completed for 4 thy for 2 months or until II be presented to the rance Committee by the gnee to ensure corrective appropriate. Compliance will -going auditing program uality Assurance Meeting.	F 607				
	the Administrator of th an investigation bega 2/13/2024. The Soc Resident #38 and all	cial Worker interviewed other residents that were arding any abuse allegations					

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	S FOR MEDICARE &			CONSTRUCTION		O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · ·	E SURVEY IPLETED
						С
		345011	B. WING		0:	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
			27	79 BRIAN CENTER DRIVE		
PINE ACR	LES CENTER FOR NURS	SING AND REHABILITATION	L	EXINGTON, NC 27292		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETIO DATE
				DEFICIENCY)		
F 607	Continued From non	- 07	<b>F</b> 007			
F 007	Continued From pag		F 607			
	allegations of abuse.					
		ssments on all residents that				
		aired, and no signs of abuse				
		13/2024. The Director of				
		rvice education on 2/13/2024				
		ng of all types of abuse to the rsing/ Administrator; what to				
		ed or suspected; assuring				
		o tolerance of retaliation of				
	reporting allegations					
		w enforcement, Adult				
		and State Survey Agency.				
		viewed all staff to ensure				
		of any abuse that had				
		y on 2/13/2024. The facility				
		in the orientation packet for				
	all newly hired staff a					
	-	's Administrator began				
		nterviews of 5 staff members				
		then 5 staff members a				
		o monitor through interviews				
		edure for reporting alleged				
		I who to report to. The facility				
		tion of sign in sheets for				
	-	vere interviewed regarding				
		no issues identified. The				
	-	documentation of the				
		completed with no issues				
		of Correction compliance				
	date of 2/15/24 was	validated on 3/22/24.				
F 641	Accuracy of Assessn	nents	F 641			4/23/24
SS=D	-					
	§483.20(g) Accuracy	of Assessments				
		st accurately reflect the				
	resident's status.					
	This REQUIREMEN	T is not mat as suideneed				
		i is noi mei as evinencen				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		
NU PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·		OMPLETED
		345011	B. WING			03/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
PINE ACR	RES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 641	Continued From page	e 38	F 64	1		
	Based on record rev	iew and staff interviews the ately code the Minimum		F641		
	Data Set (MDS) asse reviewed for accident	essment for 1 of 4 residents ts (Resident #79).		Resident #79 minimur assessment was mod	ified on 3/25/24.	
	Findings included:			The Administrator and audited all in house re the past 30 days for a	sidents with falls for	
		mitted to the facility on oses of agitation and a sease.		assessment. Any resid incorrectly coded for fa the MDS and complete The Administrator edu	dent who was alls was modified by ed by 4/10/24.	
	#79 was at high risk f deconditioning and p The Care Plan was u fall without injury with	sychoactive medication use. pdated on 12/25/2023 for a i interventions of rounds and neuro-checks		nurses on accuracy of residents who had fall The Interdisciplinary te a week for any resider ensure that eh MDS is during the look back p will be conducted x 2 1	assessments for s on 4/1/24. eam will audit 5 days t who has a fall and reflective of the fall eriod. These audits	
	-	esident #79's medical record, Ind for a fall without injury on without injury on		hired "MDS coordinate with orientation on the but not limited to the a completion ensuring c The MDS nurse will be to the Quality Assuran	ir position including accuracy of MDS ompliance. ing the audit results	
	#79 was severely cog not had a fall since hi dated 10/1/2023.	9/2024 indicated Resident gnitively impaired and had is last MDS assessment		Improvement committe meetings. The QAPI c evaluate the effectiver plan and will make add and recommendations audits to ensure contin	committee will ness of the above ditional interventions s based on the	
	interviewed on 3/21/2 the falls on 11/15/202 recorded on the quar Assessment (MDS) d	et (MDS) Coordinator was 2024 at 3:15 pm and stated 23 and 12/26/2023 were not terly Minimum Data Set lated 1/9/2024. The MDS ne must have missed the MDS to be coded		Date of Compliance: 4	1/23/24	

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	OMB NO. 093 (X3) DATE SURV	
ND PLAN OF		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE	)
		345011	B. WING		03/28/20	)24
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		BRIAN CENTER DRIVE (INGTON, NC 27292		
(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 CON	(X5) IPLETIO DATE
F 641	interviewed and state which included all dep morning to go through since the last meeting is a part of the meeting	D pm the Administrator was ed the administrative team, partment heads, meets each h each fall that has occurred g and the MDS Coordinator ng each morning. She	F 641			
F 660 SS=J	any falls the MDS Co the MDS assessment	Process	F 660		4/23	/24
	The facility must deve effective discharge pl on the resident's disc of residents to be act transition them to pos reduction of factors le readmissions. The fa- process must be con- rights set forth at 483 (i) Ensure that the dis resident are identified development of a disc resident. (ii) Include regular re- identify changes that discharge plan. The oupdated, as needed, (iii) Involve the interdi- by §483.21(b)(2)(ii), i developing the dischar (iv) Consider caregive and the resident's or person(s) capacity ar	cility's discharge planning sistent with the discharge .15(b) as applicable and- scharge needs of each d and result in the charge plan for each evaluation of residents to require modification of the discharge plan must be to reflect these changes. isciplinary team, as defined n the ongoing process of arge plan. er/support person availability				

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	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING	i		
		345011	B. WING			C
	ROVIDER OR SUPPLIER	545011	STREET ADDRESS, CITY, STATE, ZIP (		03/28/2024	
NAIVIE OF PI	ROVIDER OR SUPPLIER			279 BRIAN CENTER DRIVE	UE	
PINE ACR	RES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
0(0)15						()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 660	Continued From page	<u>-</u> 40	F 66	0		
1 000			FOO	8		
	(v) Involve the reside representative in the					
	· ·	form the resident and				
	resident representativ					
		lent's goals of care and				
	treatment preference	-				
		resident has been asked				
	. ,	receiving information				
	regarding returning to					
		icates an interest in returning				
		a facility must document any				
	referrals to local cont					
	appropriate entities m	-				
	(B) Facilities must up					
		plan and discharge plan, as				
	-	nse to information received				
		contact agencies or other				
	appropriate entities.	č				
		e community is determined				
		e facility must document who				
	made the determinati	on and why.				
	(viii) For residents wh	no are transferred to another				
		narged to a HHA, IRF, or				
	LTCH, assist resident					
	· ·	lecting a post-acute care				
		a that includes, but is not				
		IRF, or LTCH standardized				
	patient assessment d					
		on resource use to the extent				
		The facility must ensure that				
	the post-acute care s	-				
		ta on quality measures, and				
		is relevant and applicable to				
	the resident's goals o preferences.	or care and treatment				
		lete on a timely basis based				
	on the resident's nee	ds, and include in the clinical				

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			ATE SURVEY
			A. BUILDIN	G		
		345011	B. WING			С
		545011	B. WING			)3/28/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	JE	
PINE ACR	ES CENTER FOR NURS	SING AND REHABILITATION		279 BRIAN CENTER DRIVE		
				LEXINGTON, NC 27292		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 660	Continued From pag	e 41	F 6	60		
		plan. The results of the				
		iscussed with the resident or				
		tive. All relevant resident				
	information must be					
		ilitate its implementation and				
	to avoid unnecessary	y delays in the resident's				
	discharge or transfer					
	This REQUIREMEN	Γ is not met as evidenced				
	by:					
	Based on record rev	iew, resident, facility staff,		F660		
	and shelter staff inter	view the facility failed to				
	develop and impleme	ent an effective discharge		Resident #241 was discharge	ed on	
	planning process to e	ensure discharge needs and		2/14/24. The facility Administ	rator made	
	goals were identified	with the resident and the		multiple attempts to contact r	esident #241	
		n (IDT) as active participants		by phone with the phone nur		
	÷ .	in order to prepare the		on 3/23/24. The voicemail bo		
	resident for an effect			and a message could not be		
		for a resident who was a		administrator sent a text mes	•	
		On 2/14/24 Resident #241		notifying me of the attempt to		
	-	out the facility verifying his		voicemail being full, inquiring		
	discharge location and if his care needs were			was ok and if he had any cur		
	able to be met. In addition, the resident was			need that I could help with an		
		daptive equipment required		a return call. As of 3/24/2024		
		g walker). Resident #241		the Administrator has not rec	-	
		pped off at a homeless		follow up text or phone call fr		
		tinued to reside and felt		#241. If resident#241 contac		
		arful. These failures created		administrator the administrat		
		arm for Resident #241. This ected 1 of 4 residents		as to care needs of resident to provide assistance with cu		
	reviewed for discharg			needs.		
	Immediate ieopardy	began on 02/14/24 when the		Residents discharged from the	ne facility	
		nned discharge of a resident		have potential to be affected	•	
		discharge location and		deficient practice.	29 110 00110	
		t's needs were able to be		On 3/22/24 the Director of N	ursina	
	-	jeopardy was removed on		reviewed the last 30 days of	-	
		acility implemented an		discharges to community for		
		allegation of immediate		of a discharge plan that inclu	•	

Facility ID: 923005

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		MEDICAID SERVICES					<u> </u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING	G			
		245044	B. WING			C	
		345011				03	/28/2024
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			9 BRIAN CENTER DRIVE EXINGTON, NC 27292		
					•		
(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) COMPLETIC DATE
F 660	Continued From page	e 42	F 66	50			
		r scope and severity of a D			shelter, water) were met, location was		
		al harm with potential for			identified, physician appointments and		
		arm that is not immediate			discharge was safe and orderly. There		
	jeopardy) to complete	e education and ensure			were no issues identified during this		
	monitoring systems p	out into place are effective.			review, regulatory criteria were met fo	r	
	<b>-</b>				safe discharge of all 13 residents		
	The findings included	1:			reviewed. There were no issues ident		
	Resident #2/11 was a	dmitted to the facility on			during this review, regulatory criteria we met for safe discharge of all 13 reside		
		hospital stay for a surgical			reviewed. On 3/22/24 the Director of	mo	
	-	nitted with diagnoses that			Nursing reviewed the last 30 days of		
		r, Parkinson's disease,			un-planned discharges to community	for	
	chronic obstructive p				documentation to support the voluntar	Ъ	
		wer quadrant pain, major			revocation of all services without		
		muscle weakness, lack of			clearance or proper notice to impleme		
	coordination.				safe and orderly discharge. There we		
	Resident #2/11's adm	ission Minimum Data Set			no issues identified during this review regulatory criteria were met for unplar		
		2/07/24 revealed he was			discharge of all 2 residents reviewed.	incu	
	cognitively intact. Resident #241 was coded as						
	having the goal to discharge to the community.				On 3/22/2024 the Administrator comp	leted	
	The assessment indi	cated no discharge planning			education with the interdisciplinary tea	am.	
	-	g. Resident #241 was coded			Education included: the discharge		
		valker and wheelchair,			planning processes for facility initiated		
		stance with toileting hygiene,			resident initiated discharges; determin	iing	
		dressing, personal hygiene, ject from the floor.  He			when safe discharge planning is attainable and/or unsafe		
		with rising from a seated			discharge/against medical advice.		
		a chair to the bed and from			Education also included understandin	g	
		ileting transfers, tub or			the regulatory requirements for the	-	
		king 10 feet, walking 50 feet,			discharge planning processes, in the		
		. Resident #241 was coded			State Operations Manual for F660, to		
	as taking antidepress	sant medications.			ensure the interdisciplinary team		
	Poviow of Posidort's	#241's care plan initiated an			understands the intent of the regulation	on as	
		#241's care plan initiated on iewed on 02/13/24, revealed			follows and has discharge planning processes in place for residents prior	to	
		n to discharge to [assisted			planned discharges. The discharge	.0	
	-	ble to do so". Interventions			planning process will address each		
	included evaluate and				resident's discharge goals and needs		

Facility ID: 923005

If continuation sheet Page 43 of 110

ND PLAN OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING     C       A. BUILDING     B. WING     C       03/28/       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       PINE ACRES CENTER FOR NURSING AND REHABILITATION       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES						OMB NO. 0938-	
345011         B_WING         03/28/           VAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         279 BRANC RETRE FOR NURSING AND REHABILITATION         279 BRANC RETRE FOR NURSING AND REHABILITATION         279 BRANC RETRE NON PC CORRECTION (EACH OPRICINCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D         PROVIDERS FLAN OF CORRECTION (EACH OPRICINCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D         PROVIDERS FLAN OF CORRECTION (EACH OPRICINCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D         PROVIDERS FLAN OF CORRECTION (EACH OPRICINCY MUST BE PRECEDED BY PULL (EACH OPRICINCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D         PROVIDERS FLAN OF CORRECTION (EACH OPRICINCY MUST BE PRECEDED BY PULL (EACH OPRICINCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D           F 660         Continued From page 43 resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximu independence. Evaluate the resident's motivation to return to the community.         F 660         Including caregiver support and referrals to local contact agencies, as appropriate (adcharge location, adaptive equipment as needed, or any manual and the interdisciplinary team in developing the discharge heatest do gait or balance problems''. Interventions included Ensure that the resident is medications revealed he was taking the following medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Spiriva Respimat Aerosol, solution for wheezing or shortness of breath Diclofen			· · /			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           PINE ACRES CENTER FOR NURSING AND REHABILITATION         279 BRAN CENTER DRVE           (M) ID PREFIX         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX         PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         C           F 660         Continued From page 43 resident/family/caregivers the prognosis for independent or assisted living, Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence. Evaluate the resident's motivation to return to the community.         F 660           Additional review of Resident #241's care plan revealed a care plan for "Resident is (specify high, Moderate, Low) risk for falls related to gait or balance problems". Interventions included Ensure that the resident is wenging appropriate footwear when ambulating or mobilizing in wheelchair and for physical therapy to evaluate and treat as ordered or as needed.         F 660           Review of resident's medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Spiriva Respirat Aerosol, solution for the treatment of chornic obstructive pulmonary diseases (COPD) Albuterol Sulfate HFA Aerosol, solution for wheezing or shortness of breath Dicidefnac Sodium External Gel for pain management Venlafaxine HCI ER Oral Capsule Extended Release 24 Hour for the treatament of depression         Strate Aburson's addition and scharage usch as: care giver support, education, resident interests in any referrals made to local contact agency, post discharage needs such as nursing and			345011	B. WING		C 03/28/2024	
PINE ACRES CENTER FOR NURSING AND REHABILITATION         279 BRIAN CENTER DRIVE LEXINGTON, NC: 27292           (M) ID TKG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MATE NERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TKG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MATE NERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TKG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)         CONSENCEMENT AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         C           F 660         Continued From page 43 resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence. Evaluate the resident's motivation to return to the community.         F 660         including caregiver support and referrals to local contact agencies, as appropriate discharging from the resident and if applicable, the resident and if applicable, the resident rapresentative and the interdisciplinary team in developing the discharge plan to ensure a safe discharging form the facility. This will also include having knowledge of the discharge location, adaptive equipment as needed, ensuring basic needs (food, shelter, water) were met, location was identified, physician appointments, medications as needed.           Review of resident's medications revealed he was taking the following medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Arkinson's disease Spiriva Respimat Aerosol, solution for wheezing or shortness of breath Diciofenas Solution External Gel for pain management Venlafxine HCI ER Oral Capsule Extended Release 24 Hour for the treatment of depression         3/22/22.4.administrator Will meet weekly		ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/20/202	
IMAGE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)         IC           F 660         Continued From page 43 resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence. Evaluate the resident's motivation to return to the community.         F 660           Additional review of Resident #241's care plan revealed a care plan for "Resident is (specify high, Moderate, Low) risk for falls related to gait or balance problems". Interventions included Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair and for physical therapy to evaluate and treat as ordered or as needed.         F 660         including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident representative and threat as ordered or as needed.         F 660           Review of resident's medications revealed he was taking the following medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Spiriva Respimat Aerosol, solution for wheezing or shortness of breath Diciofena Codium External Cel for pain management Venlafaxine HCI ER Oral Capsule Extended Release 24 Hour for the treatment of depression         3/22/24 administrator agency, referrals made to local contact agency, post discharge needs such as nursing and			SING AND REHABILITATION		279 BRIAN CENTER DRIVE		
resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence. Evaluate the resident's motivation to return to the community. Additional review of Resident #241's care plan revealed a care plan for "Resident is (specify high, Moderate, Low) risk for falls related to gait or balance problems". Interventions included Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair and for physical therapy to evaluate and treat as ordered or as needed. Review of resident's medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Spiriva Respimat Aerosol, solution for wheezing or shortness of breath Diclofenac Sodium External Gel for pain management Venlafaxine HCI ER Oral Capsule Extended Release 24 Hour for the treatment of depression	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLE	
resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence. Evaluate the resident's motivation to return to the community. Additional review of Resident #241's care plan revealed a care plan for "Resident is (specify high, Moderate, Low) risk for falls related to gait or balance problems". Interventions included Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair and for physical therapy to evaluate and treat as ordered or as needed. Review of resident's medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Spiriva Respimat Aerosol, solution for wheezing or shortness of breath Diclofenac Sodium External Gel for pain management Venlafaxine HCI ER Oral Capsule Extended Release 24 Hour for the treatment of depression	F 660	Continued From pag	je 43	F 66	0		
disease Trazodone HCI Oral Tablet for the treatment of insomnia Propranolol HCI Oral Tablet for the treatment of hypertension Trilogy Ellipta Inhalation Aerosol Powder Breath Activated for the treatment of COPD Carbidopa-Levodopa ER Oral Tablet Extended Trilogy Ellipta Inhalation Aerosol Powder Breath Activated for the treatment of COPD Carbidopa-Levodopa ER Oral Tablet Extended The Administrator will be responsible for		resident/family/careg independent or assis and address limitation needs for maximum resident's motivation Additional review of revealed a care plan high, Moderate, Low or balance problems Ensure that the resid footwear when ambut wheelchair and for pland treat as ordered Review of resident's taking the following of Carbidopa-Levodop Release for the treat Spiriva Respimat Ae treatment of chronic disease (COPD) Albuterol Sulfate HF wheezing or shortne Diclofenac Sodium E management Venlafaxine HCI ER Release 24 Hour for Mirapex Tablet for the disease Trazodone HCI Oral insomnia Propranolol HCI Oral hypertension Trilogy Ellipta Inhala Activated for the treat	givers the prognosis for sted living. Identify, discuss, ons, risks, benefits, and independence. Evaluate the n to return to the community. Resident #241's care plan of or "Resident is (specify d) risk for falls related to gait ". Interventions included dent is wearing appropriate ulating or mobilizing in thysical therapy to evaluate d or as needed. medications revealed he was medications: a ER Oral Tablet Extended tment of Parkinson's disease trosol, solution for the obstructive pulmonary A Aerosol, solution for tess of breath External Gel for pain Oral Capsule Extended the treatment of Parkinson's Tablet for the treatment of a Tablet for the treatment of d Tablet for the treatment of tion Aerosol Powder Breath atment of COPD		<ul> <li>including caregiver support and refete to local contact agencies, as appropriate and involves the resident and if applicable, the resident representation and the interdisciplinary team in developing the discharge plan to errestate discharging from the facility. This within the aving knowledge of the discharge location, adaptive equiption needed, ensuring basic needs (foor shelter, water) were met, location with identified, physician appointments, medications as needed, and discharge safe and orderly. The Administ will educate newly hired social work and other newly hired IDT members orientation. Education completed 3/22/24. administrator also notified the interdisciplinary team they will mee weekly to review residents with goal discharge from the facility to identified address resident goals for care, treatment, preferences, barriers to discharge such as: care giver suppeducation, resident interests in any referrals made to local contact agel post discharge needs such as nurs therapy services, medical equipme modification to the home or activitie daily living assistance.</li> <li>The Administrator and IDT will review discharges x 8 weeks to ensure a stand orderly discharge process.</li> </ul>	priate, tive hsure a vill also ment as d, vas arge trator kers s in the t als to y and ort, ncy, ing and nt or es of ew all safe	

Facility ID: 923005

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						0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		345011	B. WING			C 1 <b>28/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACF	RES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 660	of hyperlipidemia Baclofen Tablet for the spasms Gabapentin Oral Car- nerve pain On 02/13/24 Resider bathroom with a fema- resident was reported down with her shirt p breasts. Review of Resident # revealed no notes or discharge planning p facility opened and b discharge summary. Review of Resident # revealed it was creat by the Social Worker summary indicated n referrals were comple- no durable medical e walker, bedside co	the treatment of muscle posule for the treatment of at #241 was found in a ale resident. The female dly undressed from the waist ulled up to below her #241's progress notes documentation related to rior to 02/13/24 when the egan to complete a #241's discharge summary ed on 02/13/24 at 10:50 PM . Resident #241's discharge o transitional services or eted or recommended, and equipment [wheelchair, mode, oxygen] was ordered. sment indicated Resident nt with his activities of daily ively intact. Physical therapy	F 660	Improvement committee x 2 conse meetings. The QAPI committee wi evaluate the effectiveness of the a plan and will make additional inter and recommendations based on th audits to ensure continued complia Date of Compliance: 4/23/24	ll bove ventions ne	

Facility ID: 923005

If continuation sheet Page 45 of 110

		MEDICAID SERVICES	0.00			10. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345011	B. WING		03/28/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2024
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	SING AND REHABILITATION		LEXINGTON, NC 27292		
(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	SHOULD BE	(X5) COMPLETIO DATE
				DEFICIENCY)		
F 000		45				
F 660			F 66	50		
		arged home, accompanied				
	by "agency" and was ambulatory at the time of					
		o durable medical equipment				
		ordered. The discharge				
	assessment was con	npleted on 02/14/24 and				
	signed by the Social	Worker, Nurse #8, Resident				
	#241.					
	Peview of Resident t	#241's functional abilities and				
	goals assessment co	•				
		241 required the use of a				
	walker prior to his ad	· · ·				
		ng assistance with toilet				
		s dependent on others for				
	-	and needed supervision with				
	walking 50 and 150 f	eet.				
	An interview with the	Social Worker on 03/22/24				
	at 1:32 PM revealed	Resident #241 had been				
	admitted to the facilit					
		rged on 02/14/24. She				
		g of 02/14/24, Resident #241				
		told her he wanted to leave				
		ked him if he would stay until				
	· ·	fe, and he reported that he				
		e was going to leave that				
		ker reported Resident #241				
	•	with his belongings packed.				
	She proceeded to try					
		tance in place as she could,				
		-				
		ut by the time she had al Director to notify him of the				
		•				
		nd returned from trying to				
		sician, Resident #241 had				
		y. She reported from the time				
		ted he wanted to leave until				
		s approximately 30 minutes				
		Vorker stated it was her				
	Lunderstanding that R	lesident #241 had arranged				

Facility ID: 923005

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345011	B. WING				C 28/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINE ACR	ES CENTER FOR NURS	NG AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	for a ride share driver facility. She stated sh Resident #241 had de previously mentioned spouse in a neighbori that was where he ha attempted to reach Re post discharge at the record, but was unsue she could not recall if planned on the dischar reported she had proo planned discharge be receiving pressure to were safe. She indica nature of Resident #2 should have been tread discharge against me planned, safe dischar there had been no ac to 02/13/24. Review of a progress #8 dated 02/14/24 at been discharged from writer reviewed dischar medications. No quest cart were released to explained/educated a in detail the times to s questions. Transportar resident to destination An interview with Nur AM revealed she rem Resident #241 on 2/1 seem like it was rushe not indicate who infor	to pick him up from the he had no knowledge where eparted to and that he had he would go to stay with his ng county and had assumed d gone. She reported she esident #241 via telephone number in his medical ccessful. She also stated she coded the discharge as arge summary. She cessed the discharge as a cause she had been ensure that all discharges ated that due to the hasty 41's discharge, it probably ated more as an unplanned dical advice, instead of a ge. She also indicated tive discharge planning prior note completed by Nurse 4:47 PM read "Resident has n facility, ambulating. [The] arge summary and tions asked. Medications on the resident and nd written on medicine card self-administer. No further tion driver transported	F	660			

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PRINTED: 04/19/2024

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	i	COMPLETED
					С
		345011	B. WING		03/28/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET TE APPROPRIATE DATE
F 660	Continued From page	e 47	F 66	0	
		as able to educate Resident			
		ons and when and how to			
	· · ·	rted he never mentioned to			
		d or being forced to leave			
		d he mentioned that he was			
		a friend's house or to the d the process was not			
		her planned discharges she			
		ith in the past. Nurse #8 also			
	stated that she codeo	-			
	transported to his dea	stination on her discharge			
	progress note by the	-			
		241 had set up his own			
		harge and since it was not as a transportation driver.			
	-	he did not recognize the			
	transportation driver.	-			
		harge Minimum Data Set			
		2/14/24 revealed he had a			
		om the facility back to the urn to the facility being			
	unanticipated.	and to the lacinty being			
		nducted with Resident #241			
		PM via telephone. Resident			
		ed to live at the facility and			
		n a homeless shelter. He he was accused of molesting			
	-	e facility on 02/13/24 and the			
		to leave after the incident.			
	Resident #241 was u	inable to provide the staff			
	member's name but	-			
		The physical description did			
		member as it corresponded			
	-	mbers. He described the dhe had to leave as a			
	Caucasian temale wi	th dark hair, approximately			

Facility ID: 923005

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						10. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		С
		345011	B. WING		0	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODI		0/20/2024
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO DATE
				DEFICIENCY)		
F 660	Continued From page		F 66	60		
	could not recall her n					
	-	ant to go to the shelter				
	because he thought he would be going to an					
		, but stated he was not given				
		241 reported he could not go				
	· ·	because they were estranged				
		ner to have to see him				
	deteriorate as his Par					
		cated he had not set up his				
	-	s he did not want to leave the				
		11 stated he had been at the				
		ce he was dropped off and				
	that he had not seen his physician since he left the facility. He explicitly stated that he did not feel					
		-				
	-	nat a week prior to this				
		rred at the shelter where				
	-	rown and he was pushed				
		eported he was fearful he				
		urt. When Resident #241				
		in pain, he stated "I hurt from				
		of ears." He indicated he				
		r because he had nowhere				
	else to go.					
	During a follow-up int	terview with Resident #241				
		PM, he reported prior to his				
		pital for hernia repair, he was				
		elter. He stated he was				
		ospital for hernia repair, and				
		ne facility for aftercare and				
		e believed the plan was for				
		ted living facility "down the				
	street" from the facilit					
		but they kicked him out				
		ppen. Resident #241 reported				
	on 2/14/24 he was tra					
		cle" driven by and African				
		dent #241 also indicated that				

Facility ID: 923005

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · · ·	E SURVEY IPLETED
			A. DOILDING			С
		345011	B. WING			3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	5/20/2024
10.002 01 1				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETIO DATE
F 660	Continued From pag	e 49	F 66	50		
	that it surprised him.					
		Transportation Driver #1,				
		nsportation driver employed atched the description				
		t #241 on 03/25/24 at 10:55				
		been at the facility since				
		vided transportation in the				
	facility's van for resid	ents. He stated he				
		nt #241 and stated he				
		sported him to and from "a				
		" during his admission.				
		r #1 reported he did not n services to Resident #241				
	at the time of his disc					
		Case Manager, who worked				
		ter where Resident #241				
		g at, was conducted on She reported Resident				
		e shelter approximately 2				
		he arrived there straight from				
		Manager reported when				
		d, he (Resident #241)				
	indicated he was uns	sure why the facility had				
		e shelter. She continued,				
	•	staff member (Shelter Staff				
		observed a facility labeled				
		op Resident #241 off at the igings and "a whole bunch of				
		ed the shelter staff were				
		1 with his medication				
		ted they needed to find him a				
		n he arrived, he did not have				
		difficulty ambulating without				
		also stated Resident #241				
		to stay at the shelter for 120				
	-	elter staff would have to				
	⊨reassess Resident #2	241 to determine if he would	1			

Facility ID: 923005

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						IO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED	
						С	
		345011	B. WING		<b>o</b> :	3/28/2024	
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE ACF	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 660	be allowed to stay lor stated that Resident a shelter through the da amount of money wh Manager also reporter receiving some assis daily living from other shoes and bathing as unable to assist him. another resident at th provide Resident #24 they had, and he was time when ambulating An interview with She 3:48 PM revealed he 02/14/24 from 5:00 P he did not see the ve arrived in but that wh had only a bag of me back. Shelter Staff # had no wheelchair or staff had to scramble because Resident #22 gait and the shelter s would fall and serious Staff #1 stated Reside walker the shelter pro- was ambulating. An interview with She at 8:23 AM revealed s shelter for approxima she was familiar with processed his intake She reported when R a box and a suitcase	nger. The Case Manger #241 was able to stay at the ay as he was paying a small lile he was there. The Case ed Resident #241 was tance with his activities of residents such as tying his the shelter staff were The Case Manager reported the shelter was able to 1 with an extra rolling walker currently using it all the g. elter Staff #1 on 03/27/24 at worked on the evening of M until 10:00 PM. He stated hicle that Resident #241 en Resident #241 arrived he dicine and the clothes on his 1 stated that Resident #241 walker and that the shelter	F 660				

Facility ID: 923005

If continuation sheet Page 51 of 110

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/19/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING				C 28/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			2	79 BRIAN CENTER DRIVE			
PINEACR	ES CENTER FOR NURSI	NG AND REHABILITATION	L	EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 660	facility had "dumped h Coordinator continued provide the care that indicated if "he was ne would have had to dis able to take care of hi information on the Re She stated that other helped him when pose	e 51 ed living facility, but the him here". The Shelter d, stating the shelter cannot Resident #241 needed and ot such a nice guy, we scharge him due to not being m." She did not provide sident #241's care needs. residents at the shelter sible. She also provided lent #241 was running out of	F 660				
	medication and the C #241 had reached our facility staff member v week and requested a The facility reported th resident, they could n The Shelter Coordina most likely have to be get treatment and me one medication he reac when he runs out, it w him to care for himsel	ase Manager and Resident t to the facility (no specific vas identified) the previous assistance and were denied. hat since he no longer was a ot do anything to assist him. tor stated Resident #241 will sent to the hospital soon to dication refills. She stated ceived was for tremors and vill become more difficult for f.					
	03/22/24 at 2:23 PM r mostly independent w living at the time of his he was walking more of a rolling walker. St #241 would require th ambulate long distance #241 needed the rollin ambulate long distance Director reported ther to him on 02/13/24, th She stated she was n planning process. She	Director of Therapy on revealed Resident #241 was with his activities of daily is discharge. She reported than 300 feet with the use he indicated that Resident e use of a rolling walker to ces. She indicated Resident mg walker in order to ces safely. The Therapy apy last provided services he day before he discharged. ot included in the discharge e reported she did not know ef wanted to leave or if he					

Facility ID: 923005

If continuation sheet Page 52 of 110

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345011	B. WING		0	C 3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	RES CENTER FOR NURS	ING AND REHABILITATION	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(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 660	was told to leave. Th reported she had no k Resident #241 discha had no knowledge if h he discharged but sta recommendation at th therapy. An interview with Unit 2:32 PM revealed she one with Resident #24 between him and and on 02-13-24. She rep 02/14/24, Resident #24 and stayed to himself day, Resident #241 w spent most of his day with other residents. he placed a few phon providing 1:1 supervis overhear what they w reported Resident #24 once on 02/14/24 tha She stated she could Resident #241 packir Manager #1 reported PM, Resident #241 et door and got into a ve she could not recall th model of vehicle Resi Manager #1 stated sh Resident #241 discha	te Director of Therapy knowledge of where arged to and indicated she he had a rolling walker when ated that was the he time of discharge from t Manager #1 on 03/22/24 at e was assigned to be one on 41 following an incident other resident at the facility borted the morning of 241 was quiet and reserved 5. She reported prior to that vas outgoing and friendly and rout in the facility visiting Unit Manager #1 reported he calls while she was sion, but she did not vere about. She also 41 had mentioned to her t he wanted to go home. not recall if she observed ng his belongings. Unit around 3:00 PM or 4:00 xited the facility via the front ehicle and left. She reported he type, color, make, or ident #241 left in. Unit he did not know where	F 66			
	03/24/24 at 3:12 PM Resident #241 one tir stated when he saw F a wheelchair as a wa					

Facility ID: 923005

If continuation sheet Page 53 of 110

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	IPLETED
		345011	B. WING			C 3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/20/2024
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 660	surgical aftercare. He involved in the dischar that he did not know y Resident #241 was a therapy. The Former Resident #241 had a would have needed a He also reported ther with Resident #241's his Parkinson's disea take his medications filled. An interview with the 03/23/24 at 2:34 PM the facility on the eve informed of an incide and another resident. Resident #241 inform discharge immediated belongings that the fa him in the medication Nursing reported she and encouraged him and the weather was #241 agreed to stay to was adamant the follo going to discharge. T reported Resident #2 accord on 02/14/24 a where he discharged needed, and whether safe and could meet Nursing indicated she	e reported he was not arge of Resident #241 and what the discharge goal for fter he completed his Medical Director stated that shuffling gait and that he a rolling walker to ambulate. The would be some concern involuntary movements from se worsening should he not or if they were unable to be Director of Nursing on revealed she had returned to ning of 02/13/24 after being int between Resident #241 . She reported at that time, hed her he wanted to by and requested some of his acility had been storing for a room. The Director of spoke with Resident #241 to stay since it was so late, cold. She stated Resident through the night but that he bwing morning that he was The Director of Nursing 41 discharged on his own ind she had no knowledge of to, if he had everything he the where he was going was his needs. The Director of e could not recall if she had	F 66	50		
	where he discharged needed, and whether safe and could meet Nursing indicated she contacted adult prote she did not call the M the Administrator had	to, if he had everything he where he was going was his needs. The Director of e could not recall if she had ctive services and stated ledical Director but thought				

Facility ID: 923005

If continuation sheet Page 54 of 110

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	IPLETED
						С
		345011	B. WING		0.	B/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0/20/2024
				279 BRIAN CENTER DRIVE	_	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETIO DATE
F 660	Continued From page	e 54	F 66	50		
		revealed she did not have a				
		arding Resident #241's				
	-	acility and that she felt they				
	did what they could to					
		ed her interdisciplinary team				
	typically set up disch					
	, , , , , , , , , , , , , , , , , , , ,	n residents stated they				
		She reported she was not				
		arge process for Resident				
	#241 and did not kno	w where he went. She was				
	unable to indicate wh	nat staff were involved with				
	Resident #241's disc	harge process. The				
		ed she was informed that				
		d he wanted to discharge				
		ed to return to his spouse.				
		ate who informed her or				
		ned. She stated it was her				
		alled a ride share company				
		l left on his own accord. She				
		n where she received this				
	•	e Administrator stated she				
	did not believe the fa					
		homeless shelter as they				
		arge transportation services.				
	-	at the facility's transportation				
		markings on it until 03/14/24 ve it wrapped in their facility's				
		ator reported there had been				
		Resident #241 and another				
		on the evening of 02/13/24				
		epartment had questioned				
		(Resident #241) that the				
		y wanted to press charges				
		that conversation may have				
		e him want to leave to avoid				
		ing Resident #241 being				
		rolling walker, she indicated				
		ely and provided equipment				

Facility ID: 923005

If continuation sheet Page 55 of 110

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
			A. BOILDIN			С
		345011	B. WING			3/28/2024
	ROVIDER OR SUPPLIER	040011		STREET ADDRESS, CITY, STATE, ZIP CO		3/28/2024
	NOVIDER ON SOLT EIER			279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE HE APPROPRIATE	COMPLETIO
F 660	Continued From page	<u>- 55</u>	F 6	60		
1 000				80		
		nent, or if needed equipment /e before the scheduled				
		Administrator reported she				
		for Resident #241 to take a				
		n had she been aware he				
	-	o reported that Resident				
		primary care physician and				
	-	all income each month and				
		e an urgent care physician if				
		ie could also afford to pay for				
	his own transportatio					
	on 03/23/24 at 2:04 F	terview with the Administrator PM, she reported during				
		our baseline care plan is desire to eventually				
		ited living facility when he				
		ministrator continued, stating				
		ad participated with therapy.				
		e incident between him and				
	-	3/24), he was informed that				
	he would have to rem					
		ed that at no time during				
		ission was he told he had to				
	leave. The Administr	ator stated the discharge				
		d on 02/13/24 because				
		ted that he wanted to leave				
	•	ial Worker began to prepare				
	him for discharge from	-				
	continued, stating the					
		nvince Resident #241 to stay				
	until they could set up	-				
		cility staff were under the				
		24 that Resident #241 had				
		safe and orderly discharge				
		ministrator reported the rocessed the discharge as				
		cal advice instead of a safe				
	neaving against medic	Lai auville ilistedu UI a Sale	1			1

Facility ID: 923005

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345011	B. WING				C 28/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE ACF	ES CENTER FOR NURS	ING AND REHABILITATION			79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(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 660	Social Worker on how on the discharge asse Administrator reporter include a resident bei to another facility, witi care needs and medie would include her inter would now include her inter would now include her inter would now include her inter would now include her inter mediate Jeopardy of The Administrator and Immediate Jeopardy of The facility provided to F660 Identify those recipier are likely to suffer, a se a result of the noncor The facility failed to d implement a discharg #241's needs would be ascertain how resider post discharge. The recommended adapti upon discharge. The after discharge to see were being met. The IDT team in the disch Administrator made m resident #241 by phot provided by surveyor voicemail box was ful be left. The administra notifying of attempt to full, inquiring if reside	v to better code discharges essment in the future. The d a safe discharge would ng prepared to go home or h education received on cations. A safe discharge erdisciplinary team and owing exactly where a arging to. d DON were notified of the on 03/22/24 at 5:22 PM. the following IJ removal plan: the following IJ removal plan: the following IJ removal plan: the swho have suffered, or serious adverse outcome as inpliance. evelop a discharge plan and the plan to ensure resident be met. The facility did not nt's needs would be met facility failed to ensure ve equipment was available facility did not follow up e if resident #241's needs facility failed to involve the arge process. The nultiple attempts to contact ne with phone number	F	660			

Facility ID: 923005

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PRINTED: 04/19/2024

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDIN	G		
		345011	B. WING			С
		345011	B. WING			3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIOI DATE
F 660	Continued From page	57		20		
1 000	e e i i i i i e i i e i i e i i e i e i		F 66	50		
		III. As of 3/24/2024 at 1:50				
	-	has not received any follow				
	_ · ·	from resident #241. In the 241 contacts administrator				
		inquire as to care needs of				
	current care needs.	to provide assistance with				
		g from the facility have				
		ed by the same deficient				
	practice.	d by the same delicient				
	On 3/22/24 the Direct	tor of Nursing reviewed the				
	last 30 days of planne	ed discharges to community				
	for development of a	discharge plan that				
		uipment, ensuring basic				
		water) were met, location				
		ian appointments and				
		nd orderly. There were no				
		ng this review, regulatory				
		safe discharge of all 13				
	residents reviewed. T					
		review, regulatory criteria				
		charge of all 13 residents				
		the Director of Nursing				
	reviewed the last 30 discharges to commu					
		inity for documentation to				
		revocation of all services				
		proper notice to implement a harge. There were no				
		ng this review, regulatory				
		unplanned discharge of all 2				
	residents reviewed. C					
		the interdisciplinary team of				
		planned discharges daily in				
	morning meetings to					
		been followed and resident				
		s are addressed prior to final				
	-	vide the medical director with				
		upcoming discharges to				

Facility ID: 923005

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						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
			AL DOILDIN	S		С
		345011	B. WING		0	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODI	1	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
				LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 660	Continued From page	e 58	F 6	60		
		and discharge paperwork e administrator also notified				
		eam they will meet weekly to				
		goals to discharge from the				
		address resident goals for				
	care, treatment, prefe					
	discharge such as: ca	are giver support, education,				
	resident interests in a	any referrals made to local				
		discharge needs such as				
		services, medical equipment				
		home or activities of daily				
	living assistance.					
	Specify the action the	e entity will take to alter the				
		ilure to prevent a serious				
		m occurring or recurring, and				
	when the action will b	pe complete:				
	On 3/22/2024 the Ad	ministrator completed				
	education with the inf	terdisciplinary team.				
	Education included: t	he discharge planning				
		initiated and resident				
	-	determining when safe				
		attainable and/or unsafe				
		edical advice. Education also				
	included understandi					
	requirements for the					
	660, to ensure the inf	te Operations Manual for F				
		nt of the regulation as follows				
		anning processes in place				
		planned discharges. The				
		rocess will address each				
	resident's discharge	goals and needs including				
		d referrals to local contact				
		riate, and involves the				
	resident and if applic					
		e interdisciplinary team in				
	developing the discha	arde high to ensure a safe	1	1		1

Facility ID: 923005

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	
		345011	B. WING				28/2024
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 660	the facility. This will a knowledge of the disc equipment as needed (food, shelter, water) identified, physician a as needed, and disch The Administrator will workers and other ne orientation. Educatio Effective 3/22/24 the responsible for ensur- immediate jeopardy re non-compliance.	esidents discharging from lso include having charge location, adaptive l, ensuring basic needs were met, location was appointments, medications arge was safe and orderly. educate newly hired social wly hired IDT members in n completed 3/22/24. Administrator will be ing implementation of this emoval for the alleged moval: 3/24/2024	F	660			
F 684 SS=K	Jeopardy removal wa verification through fa record review. The ir disciplines included n therapy. The intervie received in-service tra and processes and w orderly discharge. Th previous discharges f other residents had p facility's alleged Imme date of 03/24/24 was Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatmen	acility staff interviews and interviewed staff across ursing, administration, and wed staff indicated they had aining on discharge planning hat constituted a safe and e facility also reviewed for the past 30 days to see if ossibly been affected. The ediate Jeopardy removal validated.	F	584			4/23/24

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PRINTED: 04/19/2024

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			IPLETED
			AL BOILDING			С
		345011	B. WING		0:	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
F 684	Continued From page	e 60	F 68	4		
	assessment of a resi	dent, the facility must ensure				
		e treatment and care in				
		essional standards of				
		nensive person-centered				
	care plan, and the re-					
	by:	Γ is not met as evidenced				
		iew, staff, family, Emergency		F684		
		<i>IS</i> ) personnel, Infectious		Resident #244 was discharge	d from the	
	Disease Nurse Pract			facility on 7/24/23. Seen in the		
	Practitioner #2, and M	Medical Director interviews		7/26/23 and his access was re	estored.	
		end Resident #244 to the		On 03/27/2024, the Director o	-	
	Emergency Room (E			assessed all current residents		
		fice on 07/14/23 to have his		antibiotics for: IV access place		
		ess restored and to resume ibed IV antibiotics. Resident		patency/function, and orders f administration of IV antibiotic		
		iserted central catheter		course, to ensure residents ar		
		dislodged on 07/11/23 and		their antibiotics as ordered by		
		10 was notified by the		physician, and do not require		
	Infectious Disease of	fice to send Resident #244		level of care to meet resident	current	
	to the ER to have his	PICC line reinserted so that		needs.		
		antibiotics as ordered and		On 03/27/2024, the Director o		
		end him to the ER. Resident		educated licensed nurses on o	•	
	-	from the facility on 07/24/23		residents to a higher level of c needs of the resident cannot b		
	-	e Infectious Disease office IV access restored and his		facility to avoid serious harm of		
		d at an outpatient infusion		impairment. 03/27/2024, the D		
		practice affected 1 of 2		Nursing educated licenses nu		
		or significant medication		include agency) on following f		
	errors.			provider orders (to include cor	nsulting	
				physicians and notification of	-	
		began on 07/14/23 when the		provider/consulting physicians		
		fice instructed the facility		realm of practice) and docume		
		It #244 to the ER to have his that he could resume his IV		barriers to IV antibiotic admini 03/27/2024, the Director of Nu		
	antibiotics and the fa			educated all certified nursing a	-	
		was removed on 03/28/24		on reporting changes in reside		
	when the facility impl			new acute observations; to inc		
		ate jeopardy removal. The		observed IV issues. On 03/27		

Event ID:9BNO11

Facility ID: 923005

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STATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
			A. BUILDING			C
		345011	B. WING			3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 684	Continued From page	e 61	F 68	4		
	facility will remain out scope and severity of potential for more tha immediate jeopardy) education and monito The finding included: Review of Resident # from the local hospita part, chronic left hum vehicle accident in 20 hardware and recurred due to methicillin sens (MSSA) status post re weeks ago. The disch indicated severe thora cord flattening, poster abnormal marrow sig osteomyelitis. Infection antibiotics were switc ciprofloxacin to comp regimen. Resident #2 included: Daptomycin (mg) intravenously (IN (antibiotic) 750 mg by were to be given for a to be discontinued on Resident #244 was an 06/29/23 and was dis Resident #244's diago osteomyelitis with spi extremity amputation. Review of physician of Ciprofloxacin 750 mg	<ul> <li>a of compliance at lower</li> <li>a D (no actual harm with an minimal harm that is not to ensure the completion of oring system are in place.</li> <li>a dated 06/29/23 read in eral fracture from a motor 018 with fixation with ent infection/osteomyelitis sitive staphylococcus aureus ecent left arm amputation 2 harge summary further acic spinal stenosis with rior disc bulging, vertebral nal intensity possible bus disease on board and hed to daptomycin and lete 8 weeks of antibiotic 244's discharge medications a (antibiotic) 500 milligrams //) daily and Ciprofloxacin // mouth twice daily. Both a total of 8 weeks and were 0 08/19/23.</li> <li>dmitted to the facility on ccharged on 07/24/23. noses included thoracic nal stenosis and left upper</li> </ul>		orders for administra therapy course; to er receiving their antibio	V antibiotics for: IV atency/ function, and tion of IV antibiotic neure residents are obics as ordered by o not require a higher resident current of Nursing will licensed nurses and cation completed ing or designee will receiving IV re IV access and according to orders. Inducted twice weekly e-time weekly x ing will bring the IV the Quality nce Improvement ecutive months. The evaluate the above plan and will ventions and ased on the audits to mpliance.	

If continuation sheet Page 62 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/19/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345011	B. WING				C 28/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				279	9 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURSI	NG AND REHABILITATION		LE	EXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
			1				
F 684	Continued From page	962	F 68	34			
	Review of the Medica	tion Administration Record					
	(MAR) dated July 202	23 revealed that Resident					
	#244's Ciprofloxacin v	was administered as					
	prescribed during his	time in the facility. The MAR					
	further revealed that t	he Daptomycin was not					
	given from 07/11/23 tl	hrough 07/24/23.					
		ion Minimum Data Set					
		3 revealed that Resident					
		intact with no rejection of					
		r indicated he received IV					
		ys of antibiotic during the					
	assessment reference	e period.					
		7/44/00 at 7:04 DM madin					
		07/11/23 at 7:24 PM read in nom to check on resident					
	-						
		sident was digging in closet t was wrong and he stated					
		ut and PICC line noted on					
		urse requested resident to					
		pressure dressing on site					
		and stated it was fine. Nurse					
	attempted to educate						
	-	d resident started cussing					
		e. Resident told this nurse					
	not to return to his roo						
		ding noted at the PICC line					
	•	e note was written by Nurse					
	#3.						
		order dated 07/12/23 read					
		to place new line. PICC line					
		hird party. Medication to be					
		serted. The order was					
		The order was a verbal					
	order from the Medica	al Director (MD).					
	Deview of a come of	initiated on 00/20/20					
	Review of a care plan	initiated on 06/30/23 read,					

Facility ID: 923005

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	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED
						С
		345011	B. WING		03	8/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION	:			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	am receiving IV antib otherwise specified th of 08/22/23." The goa free from complicatio through the review da included, administer a follow facility policy a summarizing and rep universal precautions monitor temperature/ and report signs of da Review of a documer company dated 07/13 large red area to the patient pulled out at I more. Right cephalic with good blood retur insert catheter) only v brachial vein (anothe good blood return by Not a candidate for fu	discitis of the vertebra and iotic therapy, unless his event will be resolved as al read, "The resident will be ns related to infection ate." The interventions antibiotics as per MD order, nd procedures for line listing orting infections, maintain a when providing care, pulse as ordered, monitor elirium." ht from a third-party 8/23 at 1:00 PM read in part, inner side of right arm, east 2 lines already maybe vein (superficial vein in arm) n but the guide wire (used to went up 8 centimeters. Right r superficial vein in arm) would not thread guidewire. uture PICC or midline s signed by the technician	F 684			
	Infectious Disease of PM read, had a call to stated that Resident a had someone to com and they could not ge down there and talke today" {Nurse #10} "a given any orders for I him the cipro. I told h the ER and get the P	communication from the fice dated 07/14/23 at 2:01 oday from {Unit Manager} #244's "picc line was out that e there and try to put it in et it in. I called back and d to the nurse with him and she said she was not V antibiotics. She was giving er she needed to take him to ICC line put back in. I told been out it was 2 days he				

Facility ID: 923005

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345011	B. WING _				C 28/2024
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	NG AND REHABILITATION			79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	3:45 PM, she stated t facility for 9 months. S calling Infectious Dise #244 and did not reca with the Resident #24 Review of intraoffice of Infectious Disease off called the nursing hor	s interviewed on 03/20/24 at hat she had worked at the She stated she did not recall ease regarding Resident all having any involvement 4 or the situation. communication from the fice dated 07/17/23 read, I me and spoke with {Nurse	F 6	684			
	have PICC line put in	ok him to the hospital to . she said no they had t there. They could not get it oo sore."					
	at 3:05 PM. Nurse #1 in report that Residen and he missed doses that she had called th and made them awar line came out and that it was unsuccessful. S gave her report that d the Infectious Disease me any orders, or I w notes. Nurse #11 stat	ewed via phone on 03/20/24 stated that she had received t #244's PICC line was out, of his antibiotic. She stated e Infectious Disease office e that Resident #244's PICC t they tried to re-insert it and She could not recall who ay or who she spoke to at e office, but they did not give ould have put them in my ed she did recall speaking regarding Resident #244's on.					
	on 03/20/24 at 4:41 P	ice and continued his					

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PRINTED: 04/19/2024

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	IO. 0938-03 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	IPLETED
		345011	B. WING			С
	ROVIDER OR SUPPLIER	545011	D. WING	STREET ADDRESS, CITY, STATE, ZIP COL		3/28/2024
NAME OF FI	CONDER OR SOFFLIER			279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	<u>- 65</u>	F 68	4		
1 004		She stated that it had been	F 00	4		
		worked at the facility. She				
		did not recall Resident				
		that she came to work one				
	•	d not have an IV line so she				
		the IV antibiotic. It rings a ed to have the line replaced				
	•	d not make a note about it."				
		e called the provider and				
	told them that he did	not have IV access and then				
	•	ders they gave. If they would				
		Resident #244 to the				
	unacceptable to skip	done so because "it is an antibiotic."				
	A follow up interview	was conducted with Nurse				
	#10 on 03/21/24 at 3					
		d not receive a call with				
		Resident #244 to the ER. If would put the order into the				
		gency Medical Services				
		e management team.				
		documented in the medical				
	record the situation."					
	Nurse #6 was intervie	ewed via phone on 03/22/24				
		ted that she had not worked				
	at the facility for 6 mc	onths. She stated that she				
		any orders from Infectious				
		providers regarding Resident				
		t she was not able to give because he did not have a				
		he stated she believed the				
		to the ER and when EMS				
		that the ER would not place				
		ed that EMS had called the				
		told them no they could not Nurse #6 stated that most of				

Facility ID: 923005

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			0.0			O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING			С
		345011	B. WING		03	S/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (		(X5)
PRÉFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETIO
F 684	Continued From page	e 66	F 68	84		
	the PICC line, and sh					
	contacted to come ar					
	An interview was con	ducted with EMS personnel				
		M and they had no record of				
		esident #244 at the facility				
	from 07/11/23 throug	h 07/24/23.				
	The DON was intervi	ewed on 03/20/24 at 5:07				
	-	ecalled Resident #244 as he				
	only had one arm and	d he pulled his PICC line out.				
		fused to have it reinserted				
	-	ome. The DON stated that				
		office was notified on was out, and he had missed				
		bmycin. When asked why				
	she did not send Res					
	Emergency Room (E	R) for assistance in getting a				
		e inserted for the antibiotic				
		nnot get a line the ER cannot				
	-	annot put a PICC line in				
	there to do it. The AT	have access people over				
		ent with Infection Disease.				
		o not when the appointment				
		a year ago." "He only had				
	one arm and if we co	uld not get a line the ER				
		She added that she had no				
		s Disease office during this				
	IV antibiotic could not	d that with no IV access the				
	The Infectious Diseas	se Nurse Practitioner (NP)				
	was interviewed via p	phone on 03/20/24 at 12;15				
		Resident #244's PICC line				
	-	did not have access and				
		be obtained then he should				
		ely sent to the ER so we his access. She explained				
	could have restored r	ils access. She explained				1

Facility ID: 923005

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	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	): 04/19/2024 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING			03/2	C 28/2024
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
PINE ACR	RES CENTER FOR NURS	NG AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(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
F 684	that there were nume access that they could #244 including a cent line in the groin. The reasonable to not rec- of time due to access skilled nursing facility attempts to reinsert fa- been directed to high well and not give for 2 the facility could not fi through the access is them." She added that thoracic spinal osteor and staphylococcus b could lead to loss of li already a left upper et stated that Resident # 2 days after dischargi 07/26/23 and his acce resumed his IV antibio center and extended the missed doses at t The MD was interview at 1:26 PM. He stated made aware that his I he had missed 14 dos MD stated had he bea reinsert the PICC line would have directed t #244 to the ER to hav stated, "it was very co doses of antibiotic." The facility NP #2 was 03/20/24 at 4:47 PM, Resident #244 but stated	rous other types of line d have done for Resident ral line or tunneled PICC NP stated, "it is not eive antibiotics for a portion " issues. "It is prudent of any if the PICC line is out and iiled, then he should have er level of care, not say oh 2 weeks." The NP added, "if gure out how to work sues we could have helped it Resident #244 "had nyelitis with spinal stenosis facteremia and untreated mb function and he was atremity amputee." The NP #244 was seen in the office ng from the facility on ess was restored, and we obtic at an outpatient infusion the duration to make up for	F 684				

Facility ID: 923005

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-				PRINTED: 04/19/202 FORM APPROVED OMB NO. 0938-039
ER/SUPPLIER/CLIA	. ,			(X3) DATE SURVEY COMPLETED
345011	B. WING		_	C 03/28/2024
	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	
HABILITATION				
ECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA	
s during this time she would have nt #244 to the f immediate g immediate g immediate re suffered, or erse outcome as th #244 to the access (IV) nserted central lirected by the 7/14/2023. of the IV ed from the antibiotic course There was a high airment when o a high level of ore his IV access ursing assessed antibiotics for: IV ction, and orders therapy course, their antibiotics d o not require a	F 684			
	SERVICES SERVICES SERVICES ERSUPPLIER/CLIA ICATION NUMBER: 345011 CHABILITATION CEFICIENCIES RECEDED BY FULL ING INFORMATION) DEFICIENCIES RECEDED BY FULL ING INFORMATION) The d that she was as during this time as he would have ant #244 to the f immediate g immediate g immediate g immediate g immediate f esse outcome as th #244 to the access (IV) nserted central directed by the 7/14/2023. of the IV ed from the 7 antibiotic course There was a high pairment when o a high level of ore his IV access courses therapy course, g their antibiotics d on ot require a dent current	SERVICES         ICATION NUMBER:       (X2) MULTIPLE         345011       B. WING         345011       B. WING         SEHABILITATION       ID         DEFICIENCIES       ID         RECEDED BY FULL       PREFIX         ING INFORMATION)       F 684         ned that she was       ID         s during this time       she would have         int #244 to the       ID         f immediate       ID         g immediate       ID         /ve suffered, or       rerse outcome as         nt #244 to the       Interest of the IV         inected by the       7/14/2023.         of the IV       of the IV         ued from the       or a high level of or         ore his IV access       Intibiotics for: IV         ction, and orders       therapy course, or         g their antibiotics       do not require a	SERVICES         IER/SUPPLIER/CLIA ICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         345011       B. WING         ID       STREET ADDRESS, CITY, ST 279 BRIAN CENTER DRIVI LEXINGTON, NC 27292         DEFICIENCIES       ID         PREFIX       (EAACH CORRE CROSS-REFERE ID         ING INFORMATION)       PREFIX TAG         ING INFORMATION)       PREFIX TAG         F 684         Index that she was is during this time is she would have int #244 to the         f immediate         g immediate         de suffered, or therese outcome as         Int #244 to the access (IV) inserted central tirected by the 7/14/2023. of the IV ged from the // antibiotic course There was a high mairment when o a high level of ore his IV access         Aursing assessed antibiotics for: IV ction, and orders therapy course, g their antibiotics         Aursing assessed antibiotics	SERVICES         ERRUPPUERCLA (CATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         345011       B. WING         B. WING

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	IO. 0938-039
nd plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	<b>MPLETED</b>
		345011	B. WING		C 03/28/2024	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD		5/20/2024
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 69	F 684			
Specify the action the process or system fa		entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete:				
	licensed nurses on di level of care, if the ne be met in the facility t impairment. 03/27/20 educated licenses nu following facility provi consulting physicians provider/consulting ph practice) and docume antibiotic administration Director of Nursing ed assistants on reporting baseline, new acute of observed IV issues. Of of Nursing reviewed a receiving IV antibiotic patency/ function, and IV antibiotic therapy of are receiving their and physician, and do not care to meet resident	and notification of facility hysicians within the realm of enting any barriers to IV on. On 03/27/2024, the ducated all certified nursing g changes in resident observations; to include On 03/27/2024, the Director all current residents s for: IV access placement/ d orders for administration of course; to ensure residents tibiotics as ordered by the require a higher level of				
	Effective 3/28/24 the for ensuring implement	Director will be responsible ntation of this immediate the alleged non-compliance.				
	Alleged Date of IJ Re	moval: 3/28/24				
	On 03/28/24 an onsite	e credible allegation				

Facility ID: 923005

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/19/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345011	B. WING		_		C 28/2024
NAME OF P	ROVIDER OR SUPPLIER		· · ·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
				279 BRIAN CENTER DRIVE	E		
PINE ACR	ES CENTER FOR NURSI	NG AND REHABILITATION		LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684 F 697 SS=G	and revealed two resilor orders, administration duration of medication issues were identified staff revealed that the identifying and report status or barriers to m the medical provider a received and the ensu- in the medical record. transferring the residen the staff were able to transferring a residen The IJ removal date of Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensu- provided to residents consistent with profess the comprehensive per and the residents' goa This REQUIREMENT by: Based on record revi staff, Wound Nurse P Nurse Practitioner inte stop incontinent care #35) experienced pain to report to the nurse pain could be address reviewed for pain man stated that during inco	antibiotics was reviewed dents. Those two residents' record, dressings, and n were all verified, and no . Interviews with all nursing y had been educated on ng any changes in resident redication administration to and carrying out any orders uring that it was documented If the new orders entailed ent to a higher level of care verbalize the process for t to the ER for treatment. of 03/28/24 was validated.	F 684	F697 Resident #35 was facility on 3/22/24. The Regional Nurs care nurse and uni 100% pain assess residents who rece and required turnin and 4/5/24. Any re- identified, the phys medication adjuste	vive incontinent care ng by staff on 4/4/24 sident with issued ician was notified, an	d a nd	4/23/24

Event ID:9BNO11

Facility ID: 923005

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345011	B. WING		C 03/28/2024	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/20/2024	
			27	79 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	SING AND REHABILITATION	L	EXINGTON, NC 27292		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE	
F 697	Continued From pag	e 71	F 697			
	The findings include			4/5/24.		
				The Director of Nursing initiated an		
	Resident #35 was ad	dmitted to the facility on		in-service for all licensed nurses and		
		oses that included: diabetes		certified nursing assistants (CNA) on		
		structive pulmonary disease,		management while turning or receivin	-	
		pressure ulcer to left lower		incontinent care. This in-service inclu	ded	
	leg, and a pressure i	ulcer to the right lower leg.		stopping care and getting resident		
	Peview of a pain car	e plan for Resident #35		assistance for pain management. This in-service was completed on 4/22/24.		
		read in part, "I am on pain		licensed nurse or CNA who did not	Ally	
		elated to wound to lower		complete this in-service by 4/22/24, w	vill 👘	
		al read, "The resident will be		not be allowed to work until complete.		
	free of any discomfo	rt or adverse side effects		Director of Nursing added this to the r	new	
		n through the review date,"		hire orientation on 4/12/24.		
		s included: administer		The Director of Nursing or designee w		
	analgesic (pain medi			audit 5 residents weekly x 2 months for		
		s needed adverse reactions and review pain medication		incontinent care and/turning by staff for pain management.		
	for effectiveness.	and review pair medication		The Director of Nursing will be		
				responsible for bringing the pain		
	Review of a physicia	n's order dated 03/21/23		management audit to the Quality		
	read, Hydrocodone/A	Acetaminophen (controlled		Assurance Performance Improvemen	t	
	. ,	25 milligrams (mg) by mouth		committee x 2 consecutive meetings.	The	
		eded for pain. Tylenol Extra		QAPI committee will evaluate the		
	8 hours as needed for	e two tables by mouth every		effectiveness of the above plan and w make additional interventions and	/111	
				recommendations based on the audit	s to	
	Review of the annua	l Minimum Data Set (MDS)		ensure continued compliance.		
		aled that Resident #35 was		Date of Compliance: 4/23/24		
	cognitively intact and	had no rejection of care.				
		ed pain occasionally on a				
	· ·	e MDS also indicated that				
		oisture associated skin				
	received opioid medi	venous ulcers. Resident #35				
	assessment reference					
	Review of the MAR of	dated March 2024 revealed				
	Review of the MAR of on 03/18/24 no as ne					
		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVEI NO. 0938-039
--------------------------	---	--	---------------------	--	--------------------------------	-----------------------------
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED C
		345011	B. WING		0	3/28/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
		ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
	LO CENTERTOR NORS			LEXINGTON, NC 27292		
(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 TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 697	Continued From page	e 72	F 6	97		
	Hydrocodone/Acetan Strength were admini revealed Resident #3 pain scale of 5-6 at le month of March exce 03/18/24. Some days of the Hydrocodone/A administered. An observation and in with Resident #35 on Resident #35 was res had a very flat affect, tone almost a whispe two Nurse Aides (NA bath, the one with shi the one with long hai #35 was asked to des she stated that the lo NA #2 was giving her washing with a rag th the short haired NA ic and they turned me of much pain" from the Resident #35 stated to hollering out in pain a "we are sorry" but jus Resident #35 stated to at 8 at the time, once her back onto her bac better than before "m added that could not time that NA #2 and I	ninophen or Tylenol Extra istered. The MAR also 35 had reported pain on a east every day during the pt for 03/13/24 and a there were multiple doses Acetaminophen nterview were conducted 03/18/24 at 12:01 PM. sting in bed on her back and her voice was very soft in rr. Resident #35 stated that ) had just given her a bed ort hair was very nice and r was very rough. Resident scribe what rough meant, ng-haired NA, identified as a bed bath and she was that was very rough and then dentified as NA #3 came in onto my side and "I was in so wounds on my bottom. that she was crying and and both NAs kept saying at kept on "wiping me." that she would rate her pain the staff were done and got ck, she stated her pain was aybe down to a 5." She recall if this was the first NA #3 had taken care of her				
	on her bottom before added that NA #2 and	It some cream on her sores they finished with her. She d NA #3 were talking to each ds on my bottom but not to				

If continuation sheet Page 73 of 110

						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		E SURVEY IPLETED
			A. BOILDING			С
		345011	B. WING		0	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
				LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 697	Continued From page	e 73	F 697	,		
		mitted to the facility on				
	Review of the quarterly MDS dated 01/19/24 revealed that Resident #10 was cognitively intact.					
	(Resident #10) was of 12:06 PM, she stated Resident #35 she was bath and got the basis went to Resident #35 bath. She stated she but she heard the em provided to her room that she could hear N #35 and heard Resid she was scrubbing he had completed wash she went and got NA wash her back side. I during the process be talking to themselves indicated they were r of Resident #35's sor not talking to Residen time NA #2 and NA # Resident #35 was cry hurt. She did overhea "I am sorry," and NA	sident #35's roommate conducted on 03/18/24 at d NA #2 came in and told is going to give her a bed in and filled it with water and b's bedside to begin her bed did pull the privacy curtain, tire exchange of care being mate. Resident #10 stated IA #2 scrubbing Resident ent #35 state to NA #2 that er too hard. When NA #2 ing the front of Resident #35 #3 to help turn her and Resident #10 stated that oth NA #2 and NA #3 were a about how bad it was, and eferring to the size and color res on her bottom were but nt #35. She stated the whole i3 were washing her ying and screaming saying it ar NA #2 say to Resident #35 #3 apologized a couple of ot stop and get the nurse. NA #2 and NA #3 were the room Resident #35 did				
	she stated she had b	ed on 03/18/24 at 2:23 PM, een coming to the facility for iff. NA #2 confirmed she had				

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/19/2024 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		345011	B. WING			C 03/2	8/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	NG AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 697	especially when she r NA #2 stated, "She is her back side." NA #3 Resident #35 onto he side. She stated Resi deep, and she had put them. NA #2 explaine #35's other body parts complaints of pain, bu her peri area and her but did not see real te and saying that it hurt reported the interaction aware if Resident #35 not. She added that e crying and fussing was that was why she had NA #2 stated, "If you a referring to Resident a that when she entered was resting on her bas dried her front side ar onto her side to wash side. She stated when over, she was moanin one point put her han she knew Resident #3 never asked us to sto normal behavior for h not let the nurse know hurting. Nurse #9 was interview	435 "was in pain and crying" rolled her over to her side. raw in her peri area and on a came in and helped turn r side to help wash her back dent #35's wounds were not at cream (barrier cream) on d while washing Resident s she was fine and had no at when she started washing back side, she began to cry ears, but she was moaning NA #2 stated she had not on to the nurse and was not b had anything for pain or veryone told me that her is her usual behavior and I not reported it to the nurse. see it you will understand," #35's peri area and bottom. d on 03/18/24 at 2:56 PM ssisted NA #2 with #35's bed bath. She stated d the room Resident #35 ck, NA #2 had washed and not they turned Resident #35 her peri area and her back in they turned Resident #35 ing and saying ouch and at ds over her face. She stated 35 was hurting but she	F 69	7			

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURV	<u>38-03</u>
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	COMPLETE	
					С	
		345011	B. WING		03/28/20	024
NAME OF PF	OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
		ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
	ES CENTER FOR NORS	ING AND REPABLEMATION		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CON	(X5) MPLETIO DATE
F 697	Continued From page	a 75	F 69	7		
1 037			FOE			
	her something for pai	ids, and they definitely gave				
	• .	stated outside of wound care				
		Resident #35 requested				
		he explained the resident				
	÷ .	edication once a shift and				
		or a day or so. Nurse #9				
	stated Resident #35 I	has pain when she is moved				
	and there were times	where she would refuse to				
		o bad. Nurse #9 stated she				
		5 that she can have her pain				
		he still has to get changed				
		ion is effective until we move				
		se #9 does assess Resident				
	#35's pain she explai	her bottom and sometimes				
		. If she was resistive to care				
	•	and get me but nothing was				
		rday regarding Resident				
		ontinent care. Nurse #9 also				
		ot given Resident #35				
	anything for pain on (	03/18/24.				
		nterviewed via phone on				
		she stated the nurse had				
		on 03/19/24 and she was				
		sident #35's pain medication.				
	She stated that recer	ally the pain medication was				
		hanges. The NP explained				
		ent #35's legs had been				
		nd were likely not going to				
		although Resident #35 was				
	starting to use her pa					
		t think that she would need				
		h incontinent care. She				
	added that abo was in	n ana a aim a' la an Lluvalna a a al ama	1	1		
		ncreasing her Hydrocodone urs, but everything was a fine				

Facility ID: 923005

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	S FOR MEDICARE & PF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		TE SURVEY MPLETED
		345011	B. WING		C 03/28/2024	
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD		0.20.2021
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	that Resident #35's b she will have spots th bigger. She stated sh #35 first thing in the r usually more irritated the night. and there w allow me to look at he it hurt to turn over. Th when she first started recommend starting s	actitioner (NP) was /24 at 8:47 AM. She stated ottom waxes and wanes, hat open and then get a little be generally saw Resident norning, and she was from being wet throughout were times she would not ber bottom because she said he Wound NP stated that	F 697			
F 757 SS=D	her participation. The Director of Nursin on 03/21/24 at 10:28 Resident #35 was ver things. She stated the Resident #35's pain r 03/19/24. If Resident staff should have give would expect the pain ahead of the pain. Drug Regimen is Free CFR(s): 483.45(d)(1):	ng (DON) was interviewed AM, she stated that rbal when she needed e NP had increased nedication to 7.5 mg on t #35 was in pain, then the en her pain medication and n medication to be given e from Unnecessary Drugs -(6) sary Drugs-General.	F 757			4/23/24
	unnecessary drugs. drug when used-					

Event ID:9BNO11

Facility ID: 923005

If continuation sheet Page 77 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/19/2024 RM APPROVED IO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345011	B. WING _		0	3/28/2024		
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			79 BRIAN CENTER DRIVE EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	Continued From page	9 77	F	757				
	§483.45(d)(3) Withou	t adequate monitoring; or						
	§483.45(d)(4) Withou use; or	t adequate indications for its						
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be						
	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced							
	interviews the facility from being given mor	iew and staff and Physician failed to prevent a vaccine e than once when it was e dose for 1 of 5 residents ved for unnecessary			F757 Resident #71 was assessed by the N Practitioner on 3/22/24, and no adver effects were identified. The Director of Nursing reviewed 100 all in house residents on 4/1/24 for additional doses of RSV vaccine. No	rse 0% of		
	Findings included: According to Arexvy.o administration inform a single dose (0.5 mL intramuscular injectio	ation indicated, "Administer .) of AREXVY as an			residents were identified during this a The Director of Nursing initiated an in-service on 4/1/24 to all licensed nu on immunization schedules. This in-service was completed on 4/22/24 licensed nurse who did not receive th	udit. Irses . Any		
	3/8/2023 with diagnost respiratory disease.	mitted to the facility on ses of stroke and chronic			in-service will not be allowed to work this in-service has been completed. A new hired employees will be provided orientation/education on vaccines/immunizations and accurac	All J y of		
	dated 1/11/2024 indic severely cognitively in				giving them as requested to the resid and as per MD order. The Director of Nursing or designee v review all new admission RSV orders	will		
	A Physician's Order of Resident #71 should	lated 3/4/2024 indicated receive Arexvy			weekly x 3 months ensuring RSV immunizations have been documente	ed		

Facility ID: 923005

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
		345011	B. WING		С
	ROVIDER OR SUPPLIER	345011	B. WING	STREET ADDRESS, CITY, STATE, Z	03/28/2024
NAME OF F	ROVIDER OR SUFFLIER			279 BRIAN CENTER DRIVE	IF CODE
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292	
(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 DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 757	Continued From page	e 78	F 7	57	
	Intramuscular Susper intramuscularly one ti vaccination. During a review of Re medical record a revi Administration Recor- and it indicated Resic doses (on 3/4/2024, 3 the vaccine Arexvy In (RSV Vaccine). The vaccine should be giv vaccine beginning on indicated the vaccine 3/19/2024. Nurse #14 was interv 3/21/2024 at 1:57 pm Resident #71 the RST because it was ordered stated she did not kno on the two other occa An interview was con	nsion Vaccine 0.5 milliliters ime a day for RSV esident #71's electronic ew was done of Medication d (MAR) for March 2024, dent #71 received three 3/7/2024, and 3/15/2024) of thramuscular Suspension MAR further indicated the ven one time a day for RSV a 3/4/2024. The MAR was discontinued on riewed by phone on and she stated she gave V vaccination on 3/4/2024 ed to be given that day. She ow why it was given again		and discontinued as ord The Director of Nursing immunization audit to th Assurance Performance committee x 3 consecut QAPI committee will eva effectiveness of the abo make additional interver recommendations based ensure continued compl Date of Compliance: 4/2	will bring the RSV e Quality e Improvement ive meetings. The aluate the ve plan and will ntions and d on the audits to liance.
	stated she document 3/7/2024 and 3/15/20 vaccination on 3/7/20 have documented it of Nurse #3 indicated th transcribed into the e	ot as a continuous once a			
	3/22/2024 at 9:00 am should have received	n she stated Resident #71 I only one dose of the RSV vould not have suffered any			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/20 FORM APPROVI OMB NO. 0938-03
ATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345011	B. WING		C 03/28/2024
NAME OF PF	ROVIDER OR SUPPLIER	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		79 BRIAN CENTER DRIVE EXINGTON, NC 27292	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 757	Continued From page	e 79	F 757		
		ira dose.The Physician corred every shift by nursing ere reported.			
	3/22/2024 at 9:30 am vaccination was orde dose, but the order w day. Since the Phys transcribed in the elec the nurses gave it mo Medication Administra- been corrected in the after the first dose it w indicate it needed to On 3/22/2024 at 12:3 interviewed and state received the RSV vac physician and the elec Administration Recorr to ensure the vaccine Residents are Free o CFR(s): 483.45(f)(2)	ctronic record as once a day ore than one time. The ation Record should have e electronic record so that would not have continued to be given. 2 pm the Administrator was ad Resident #71 should have cine as ordered by the ctronic Medication d should have been correct e was not given in error. f Significant Med Errors	F 760		4/23/24
	medication errors. This REQUIREMENT by: Based on record rev Disease Nurse Practi Practitioner #2, and N the facility failed to pr medication error whe 14 ordered doses of i from 07/11/23 to 07/2	nts are free of any significant is not met as evidenced iew, staff, family, Infectious tioner, facility Nurse Medical Director interviews		F760 Resident # 244 was discharged from t facility on 7/24/23. On 03/27/2024 the Director of Nursing reviewed all current residents receivin antibiotics for IV access placement/ patency/ function, orders for administration of IV antibiotic therapy	1

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Event ID:9BNO11

Facility ID: 923005

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 09 (X3) DATE SUR	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLET	
					с	
		345011	B. WING		03/28/2	2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
	LO CENTERTOR NORS		LEXINGTON, NC 27292			
(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 CO	(X5) OMPLETIO DATE
F 760	Continued From page	e 80	F 76	0		
		of 2 residents reviewed for		course to ensure residents are re	eceiving	
		n error (Resident #244).		their antibiotics as ordered by the	•	
	-	ction if left untreated could		physician and do not require a h		
	lead to loss of limb fu	inction.		of care to meet resident current	•	
	Immediate jeopardy t	began on 07/14/23 when		On 03/27/2024 the Director of Nu	ursing	
		C line become dislodged,		educated all licensed nurses on		
	and the facility failed	to direct him to higher level		residents to a higher level of care	e if the	
	of care to ensure he	received the IV antibiotic he		needs of the resident cannot be	met in the	
		jeopardy was removed on		facility to avoid serious harm or		
		cility implemented an		impairment/ neglect of services r		
	-	allegation of immediate		On 03/27/2024, the Director of N	-	
		e facility will remain out of		educated all licenses nurses on		
		r scope and severity of D potential for more than		physician orders, notification of p and documenting any barriers to	-	
		not immediate jeopardy) to		antibiotic administration. On 03/2		
	ensure the completio			the Director of Nursing educated		
	monitoring system ar			certified nursing assistants on re		
				changes in resident baseline, an		
	The findings included	l:		new acute observations to includ		
				observed IV issues. On 03/27/20	24 the	
	Review of Resident #	244's discharge summary		Director of Nursing educated all	staff on	
	-	al dated 06/29/23 read in		heightened awareness of the de		
	1 • ·	eral fracture from a motor		neglect, what constitutes neglect		
	vehicle accident in 20			to provide necessary care and se		
		ent infection/osteomyelitis		the residents to ensure resident		
		sitive staphylococcus aureus		appropriate goods and services.		
		ecent left arm amputation 2 harge summary further		03/27/2024, the Director of Nursi reviewed all current residents red		
		acic spinal stenosis with		antibiotics for IV access		
		rior disc bulging, vertebral		placement/patency/ function, ord	ers for	
	abnormal marrow sig			administration of IV antibiotic the		
		bus disease on board and		course to ensure residents are re		
	•	hed to daptomycin and		their antibiotics as ordered by the	e -	
		lete 8 weeks of antibiotic		physician and do not require a h		
		244's discharge medications		of care to meet resident current i		
		n (antibiotic) 500 milligrams		The Director of Nursing will educ	-	
		V) daily and Ciprofloxacin		hired licensed nurses. Education		
	(antibiotic) 750 mg by	y mouth twice daily. Both		completed 3/27/24.		

Facility ID: 923005

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					NO. 0938-039	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	ATE SURVEY OMPLETED	
					С	
	345011	B. WING			03/28/2024	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	l .		
ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
Continued From page	e 81	F 76	0			
were to be given for a to be discontinued or Resident #244 was a 06/29/23 and was dis Resident #244's diag osteomyelitis with spi extremity amputation Review of physician of Ciprofloxacin 750 mg 08/19/23. Daptomycin 08/19/23. Review of the admiss (MDS) dated 07/06/2 #244 was cognitively care. The MDS further medications and 7 dated 1000000000000000000000000000000000000	a total of 8 weeks and were n 08/19/23. dmitted to the facility on scharged on 07/24/23. noses included thoracic inal stenosis and left upper orders dated 06/30/23 read, by mouth twice a day until n 500 mg IV every day until sion Minimum Data Set 3 revealed that Resident intact with no rejection of er indicated he received IV ays of antibiotic during the		review all residents receiving I medications to ensure IV acce medication delivery according This audit will be conducted tw x 2 months, then one-time wee month. The Director of Nursing will bri medication audits to the Qualit Assurance Performance Impro- Committee x 3 consecutive mo- QAPI committee will evaluate effectiveness of the above plan make additional interventions a	V ss and to orders. vice weekly ekly x ng the IV cy ovement onths. The the n and will and		
dated July 2023 reve not receive Daptomy	aled that Resident #244 did cin 500 mg IV from 07/11/23					
part, nurse entered ro and his PICC line. Re and nurse asked wha his PICC line came o bedside table. This n allow nurse to place p and resident refused attempted to educate	bom to check on resident esident was digging in closet at was wrong and he stated ut and PICC line noted on urse requested resident to pressure dressing on site and stated it was fine. Nurse e resident on need for					
	Review of the admiss (MDS) dated 07/06/2 #244 was cognitively care. The MDS further medications and 7 da assessment reference Review of the Medica dated July 2023 reve not receive Daptomy through his discharge A nurses note dated part, nurse entered ro and nurse to place p and resident refused attempted to educate pressure dressing an	OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345011         ROVIDER OR SUPPLIER       345011         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 81       were to be given for a total of 8 weeks and were to be discontinued on 08/19/23.         Resident #244 was admitted to the facility on 06/29/23 and was discharged on 07/24/23.         Resident #244's diagnoses included thoracic osteomyelitis with spinal stenosis and left upper extremity amputation.         Review of physician orders dated 06/30/23 read, Ciprofloxacin 750 mg by mouth twice a day until 08/19/23.         Review of the admission Minimum Data Set (MDS) dated 07/06/23 revealed that Resident #244 was cognitively intact with no rejection of care. The MDS further indicated he received IV medications and 7 days of antibiotic during the assessment reference period.         Review of the Medication Administration Record dated July 2023 revealed that Resident #244 did not receive Daptomycin 500 mg IV from 07/11/23 through his discharge on 07/24/23.         A nurses note dated 07/11/23 at 7:24 PM read in part, nurse entered room to check on resident and his PICC line. Resident was digging in closet and nurse asked what was wrong and he stated his PICC line came out and PICC line noted on bedside table. This nurse requested resident to allow nurse to place pressure dressing on site and resident refused and stated it was fine. Nurse attempted to educate resident on need for pressure dressing and resident started cussing	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         A BUILDING       345011       B. WING         ROVIDER OR SUPPLIER       ES CENTER FOR NURSING AND REHABILITATION       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 81       F 76         were to be given for a total of 8 weeks and were to be discontinued on 08/19/23.       F 76         Resident #244 was admitted to the facility on 06/29/23 and was discharged on 07/24/23.       F 76         Resident #244's diagnoses included thoracic osteomyelitis with spinal stenosis and left upper extremity amputation.       F         Review of physician orders dated 06/30/23 read, Ciprofloxacin 750 mg by mouth twice a day until 08/19/23.       Review of the admission Minimum Data Set (MDS) dated 07/06/23 revealed that Resident #244 was cognitively intact with no rejection of care. The MDS further indicated he received IV medications and 7 days of antibiotic during the assessment reference period.         Review of the Medication Administration Record dated July 2023 revealed that Resident #244 did not receive Daptomycin 500 mg IV from 07/11/23 through his discharge on 07/24/23.         A nurses note dated 07/11/23 at 7:24 PM read in part, nurse entered room to check on resident and nurse asked what was wrong and he stated in part, nurse entered room to check on resident and nurse asked what was wrong and he stated and nurse to place pressure dressing on site and resident refused and stated it was fine. Nurse attempted to educate resident on need for p	protenceucies correction       (x1) PROVIDER/SUPPLIERCLUA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING         SUMDREY STEMET FOR NURSING AND REHABILITATION         STREET ADDRESS, CITY, STATE, 2IP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292         SUMMARY STATEMENT OF DEPICIENCIES (EAD PERCIEXY MUTE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       precessor PRECIEXY MUTE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       precessor PRECIEXY PRECIEXY AND FOR (EAD CORRECTIVE ACTION CONTINUED TO BE PRICE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       precessor PRECIEXY PRECIEXY CONTINUED TO BE PRICE PRECEDED FOR FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       precessor PRECIEXY PRECIEXY TAG       precessor PRECIEXY PRECIE	FEBRICENCIES CORRECTION       (X1) PROVIDER VERUPUENCUA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BULDING       (X3) D A BULDING         345011       B. WING         STREET ADDRESS, CITY: STATE, 2IP CODE 279 BRIAN CENTER FOR NURSING AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES RECULATORY OR LSC. (DENTIFYING INFORMATION)         Resident #244 was admitted to the facility on 00/29/23 and was discharged on 07/24/23.       p PRETIX TAG       PRETIX TAG         Resident #244 was admitted to the facility on 00/29/23 and was discharged on 07/24/23.       F 760         Review of the admission Minimum Data Set (MDS) dated 07/06/23 revealed that Resident 4244 was continued on 07/11/23 through his discharge on 07/24/23.       F 760         Review of the admission Minimum Data Set (MDS) dated 07/06/23 revealed that Resident 4244 was continued and Table of curring the assessment reference period.       F 760         Review of the Medication Administration core coice Dations for 0 mg IV every day until 08/19/23.       The Director of Nursing will bring the IV medications admitted to the received IV medications admitted to the received IV medication admits to the Coulity Assurance Performance Improvement Committee x3 consecutive months. The OAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and receive Datomyonis 500 mg IV from 07/11/23 through his discharge on 07/24/23.         A nurses note dated 07/11/23 at 7:24 PM read in part, nurse entered room to check on resident and his PICC line. Resident #244 did not receive Datomyonis 500 mg IV from 07/11/23 through his disch	

If continuation sheet Page 82 of 110

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345011	B. WING				C 28/2024
NAME OF PF	ROVIDER OR SUPPLIER		<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	<ul> <li>#3.</li> <li>Review of a physician pulled IV out, unable to be put in place by theld until PICC line in entered by Nurse #4.</li> <li>order from the Medication 07/11/23 at 8:26 PM to 500 mg every 24 hour pending PICC replace</li> <li>Review of a Medication 07/12/23 at 9:48 PM to PICC line unsuccessfor Nurse #5.</li> <li>Review of a document company dated 07/13 large red area to the in patient pulled out at lemore. Right cephalic for with good blood return insert the catheter) or Right brachial vein (at blood return by would candidate for future P form was signed by the to reinsert the PICC line this shift we was written by Nurse</li> </ul>	e note was written by Nurse a order dated 07/12/23 read to place new line. PICC line hird party. Medication to be userted. The order was The order was a verbal al Director (MD). on Administration Note dated by Nurse #3, Daptomycin rs until 08/19/23 hold ement. on Administration Note dated read in part, placement of ful. The note was written by At from a third-party 8/23 at 1:00 PM read in part, nner side of right arm, east 2 lines already maybe vein (superficial vein in arm) n but the guide wire (used to hy went up 8 centimeters. nother superficial vein) good 1 not thread guidewire. Not a PICC or midline access. The he technician that attempted ne. on Administration Note dated read, attempts to replace ere unsuccessful. The note #5.	F	760			
	Review of intraoffice of	communication from the					

Facility ID: 923005

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	MENT OF HEALTH AN					FORM	D: 04/19/2024 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345011	B. WING				C 28/2024
NAME OF P	ROVIDER OR SUPPLIER		- -	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACF	RES CENTER FOR NURS	NG AND REHABILITATION			BRIAN CENTER DRIVE XINGTON, NC 27292		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Infectious Disease off PM read, had a call to stated that Resident # had someone to come and they could not ge down there and talked today" {Nurse #10} "a given any orders for I' him the cipro. I told he the ER and get the PI her if PICC line had b has gone without his Review of a Medicatio 07/14/23 at 7:50 PM r replaced. The note was Review of a Medicatio 07/15/23 at 9:52 PM r mg every 24 hours ur note was signed by N Review of a Medicatio 07/16/23 at 8:08 PM r mg every 24 hours ur line placed. The note Review of intraoffice of Infectious Disease off called the nursing hor #11} "to see if they to have PICC line put in someone to come out in. Said his arm was t Review of a Medicatio 07/17/23 at 8:36 PM r	ice dated 07/14/23 at 2:01 oday from {Unit Manager} ź244's "picc line was out that e there and try to put it in t it in. I called back and d to the nurse with him nd she said she was not V antibiotics. She was giving er she needed to take him to CC line put back in. I told een out it was 2 days he medication." On Administration Note dated read, PICC line to be as written by Nurse #2. On Administration Note dated read in part, Daptomycin 500 ntil 08/19/23, no access. The urse #6. On Administration Note dated read in part, Daptomycin 500 ntil 08/19/23, held until PICC was signed by Nurse #7. Communication from the fice dated 07/17/23 read, I me and spoke with {Nurse ok him to the hospital to . she said no they had t there. They could not get it oo sore."	F 76	60			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345011	B. WING			CORRECTION (X5) FION SHOULD BE COMPLETION THE APPROPRIATE DATE	-
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	INE ACRES CENTER FOR NURSING AND REHABILITATION 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION
F 760	placement. The note Review of a nurses m AM read in part, resid antibiotic on hold due to multiple attempts w lines out. On oral anti when complete. The n Director of Nursing (D Nurse #3 was intervie who stated that she re rolled over in bed and She stated she found Nurse #3 stated that he allow the area to be d at Nurse #3. She stat an order for reinsertio antibiotic pending rein Resident #244's famil on 03/20/24 at 4:41 P stated that after Resid from the facility he ha Infectious Disease off antibiotic treatment. The DON was intervie PM who stated she re only had one arm and She stated that he rei as he wanted to go he the Infection Disease 07/17/24 that his line doses of the IV Dapto she did not send Res Emergency Room (El PICC line or other line	was signed by Nurse #3. ote dated 07/18/23 at 9:37 lent continues on therapy, IV to unable to obtain line due <i>v</i> ith resident pulling PICC biotic to discharge home note was signed by the DON). weed on 03/20/24 at 3:21 PM ecalled Resident #244 had I pulled his PICC line out. it on his bedside table. Resident #244 would not lressed and began cursing ed she had called and got on and to hold the IV hsertion. IV was interviewed via phone M. The family member dent #244 was discharged d followed up at the fice and continued his ewed on 03/20/24 at 5:07 ecalled Resident #244 as he d he pulled his PICC line out. fused to have it reinserted ome. The DON stated that office was notified on was out, and he had missed omycin. When asked why	F	760			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345011	B. WING				C 28/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINE ACR	ES CENTER FOR NURS	NG AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	get a line." The ER ca because they do not it there to do it. The ATI pending an appointme The DON stated, "I do appointment was it ha "He only had one arm line the ER could not she had no contact w during this time. The access the IV antibiot administered. Nurse #2 was intervie at 9:58 AM. Nurse #2 units and did not reca situation, she stated " Nurse #6 was intervie at 10:43 AM, she stat the facility for the last was not able to admir Daptomycin because She stated she thoug pharmacy to request but after that she did Resident #244 again. Nurse #7 was intervie at 11:00 AM. Nurse # at the facility anymore approximately 2 mont recalled Resident #24 his PICC line dressing else about Resident #244 or the PICC line was out we	annot put a PICC line in nave access people over 3 was placed on hold ent with Infection Disease. o not know when the as been over a year ago." and if we could not get a get a line." She added that ith Infectious Disease office e DON stated that with no IV ic could not be ewed via phone on 03/22/24 stated she worked all the II Resident #244's name or I see some of everyone." ewed via phone on 03/22/24 ed she no longer worked at 6 months. She stated she nister Resident #244's IV he did not have a PICC line. ht they had called the a new PICC line be placed not recall working with ewed via phone on 03/22/24 7 stated that he did not work e and had been gone for hs. He stated that he i4 was very particular about g but did not recall much situation. He stated if his should have held the ed the Medical Director (MD)	F	760			

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	S FOR MEDICARE &					O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
	OUTILE HON	DENTIFICATION NUMBER.	A. BUILDING	3		
						С
		345011	B. WING			8/28/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
		ING AND REHABILITATION		279 BRIAN CENTER DRIVE		
	ES CENTER FOR NORS	ING AND REPABLEMATION		LEXINGTON, NC 27292		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	EAPPROPRIATE	COMPLETION
F 760	Continued From page 86		F 76	60		
		ewed via phone on 03/24/24				
		ted she had not worked at				
	the facility for almost					
	Resident #244 of any	ything about the situation.				
	An attempt to speak	to Nurse #5 via phone was				
	made on $03/24/24$ at					
	unsuccessful.					
	The Infectious Disea	se Nurse Practitioner (NP)				
	was interviewed via p	ohone on 03/20/24 at 12;15				
	PM who stated that it	f Resident #244's PICC line				
	-	did not have access and				
		o be obtained then he should				
		ely sent to the ER so we				
		his access. She explained				
		erous other types of line				
		Id have done for Resident				
	line in the groin. The	tral line or tunneled PICC				
	•	ceive antibiotics for a portion				
		s" issues. "It is prudent of any				
		/ if the PICC line is out and				
	• •	ailed, then he should have				
		her level of care, not say Oh				
		2 weeks." The NP added, "if				
	-	figure out how to work				
		ssues we could have helped				
		at Resident #244 "had				
		myelitis with spinal stenosis				
	•	a and untreated could lead to				
		and he was already a left				
		utee." The NP stated that				
		seen in the office 2 days after				
		facility on 07/26/23 and his				
		, and we resumed his IV				
1		tient infusion center and				

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345011	B. WING				C /28/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	doses at the facility. The MD was interview at 1:26 PM. He stated made aware that his he had missed 14 dos MD stated had he ber reinsert the PICC line would have directed t #244 to the ER to hav stated, "it was very co doses of antibiotic." The facility NP #2 wa 03/20/24 at 4:47 PM, Resident #244 but stat issues with his PICC scheduled antibiotic. out of state on persor but had someone cor directed the staff to so ER.	wed via phone on 03/20/24 d that he did not recall being PICC line was out and that ses of the IV antibiotic. The en aware that an attempt to a was unsuccessful, he he staff to send Resident ve access regained. The MD oncerning that he missed 14 s interviewed via phone on she stated she recalled ated she did not recall any line or missing doses of his She explained that she was hal business during this time thatched her, she would have end Resident #244 to the s notified of the Immediate 4 at 10:10 AM. e following credible	F	760			
	Identify those recipier are likely to suffer, a a result of the noncor	nts who have suffered, or serious adverse outcome as npliance.					
	(IV) antibiotic for 14 d peripherally inserted d dislodged in 07/11/20 Resident #244 was d						

Facility ID: 923005

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345011	ILITATION     STREET ADDRESS, CITY, STATE, ZIP CODE       279 BRIAN CENTER DRIVE     LEXINGTON, NC 27292       ENCIES     ID     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE FORMATION)       FORMATION)     PREFIX TAG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)       d his IV high oose the extremity rdered. On ssessed all tics for IV orders for course to intibiotics as require a current     F 760		C / <b>28/2024</b>		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		L	LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
F 760	07/26/2023, access w antibiotic was resume likelihood that Reside function of his one ret without having the IV 03/27/2024 the Direct current residents rece access placement/ pa administration of IV a ensure residents are ordered by the physic higher level of care to needs. Specify the action the process or system fai adverse outcome fror when the action will b On 03/27/2024 the Dir licensed nurses on di level of care if the nee be met in the facility t impairment. On 03/27 Nursing educated me to licensed nurses an to resident care that r a licensed nurses to av impairment. 03/27/2 educated licenses nu orders and notification documenting any bar administration. 03/27/ educated medication orders and notification barriers to medication 03/27/2024 the Direct current residents rece	vas restored, and his IV ed. There was a high nt #244 would lose the maining upper extremity antibiotics as ordered. On tor of Nursing assessed all eiving IV antibiotics for IV atency/ function, orders for ntibiotic therapy course to receiving their antibiotics as cian and do not require a meet resident current e entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete: rector of Nursing educated recting residents to a higher eds of the resident cannot o avoid serious harm or 7/2024 the Director of dication aides on reporting y observations of adversities may indicate assessment by void serious harm or 024 the Director of Nursing rses on following physician n of physician and riers to medication (2024 the Director of Nursing aides on following physician n to a licensed nurse any	F	760			

Facility ID: 923005

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		ID HUMAN SERVICES			FO	ED: 04/19/202
TATEMENT C	S FOR MEDICARE & of deficiencies correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345011	B. WING			C 3/28/2024
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	
				279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 760 F 761 SS=D	ensure residents are ordered by the physic higher level of care to needs. The Director newly hired licensed aides. Education cor Effective 3/28/24 the for ensuring impleme jeopardy removal for Alleged Date of IJ Re On 03/28/24 an onsit validation was condu house residents on IV and revealed two res orders, administration duration of medicatio issues were identified staff revealed that the identifying and report status or barriers to n the medical provider received and the ens in the medical record transferring the reside the staff were able to transferring a residen The IJ removal date of Label/Store Drugs an	ntibiotic therapy course to receiving their antibiotics as cian and do not require a o meet resident current of Nursing will educate nurses and medication npleted 3/27/24. Director will be responsible ntation of this immediate the alleged non-compliance. moval: 3/28/24 e credible allegation cted. The audit of all in / antibiotics was reviewed idents. Those two residents' n record, dressings, and n were all verified, and no d. Interviews with all nursing ey had been educated on ing any changes in resident nedication administration to and carrying out any orders uring that it was documented . If the new orders entailed ent to a higher level of care verbalize the process for t to the ER for treatment. of 03/28/24 was validated. d Biologicals	F 76			4/23/24
	Drugs and biologicals	of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the				

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 0	PROVE
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345011	B. WING		C 03/28/2	2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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 APPR DEFICIENCY)	ULD BE C	(X5) OMPLETION DATE
F 761	§483.45(h)(1) In acco Federal laws, the fact biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fact locked, permanently storage of controlled the Comprehensive II Control Act of 1976 at abuse, except when the package drug distribut quantity stored is min- be readily detected. This REQUIREMENT by: Based on observation facility failed to label medications that had medications carts (100 observed for storage Findings included: During an observation cart on 3/20/2024 at medications were found dated: Pro-stat (a concentral	y and cautionary expiration date when of Drugs and Biologicals ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ation systems in which the simal and a missing dose can <sup>-</sup> is not met as evidenced an and staff interviews the and date four liquid been opened in 1 of 3 00-hall medication cart) and labeling of medications.	F 76	F761 Pro-stat, Chlorhexidine Gluconate Valproic Acid, and Dextromethorphan/Guaifenesin th opened and undated were remove the medication □s carts on 3/20/24 removed the same day by the Dire Nursing. All medication carts and medicatio rooms were audited on 4/5/24 by t Pharmacy consultant. Any medicatio found opened and undated were r immediately. The Director of Nursing initiated and	at were ed from were ector of ons the tions emoved	
		ounce was found opened bel indicated the medication		in-service to all licensed nurses ar medication aides on dating medica		

Event ID:9BNO11

Facility ID: 923005

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							NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>			` '	ATE SURVEY MPLETED
		345011	B. WING				C 03/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREETADDRES	SS, CITY, STATE, ZIP CODE	<u> </u>	012012024
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CEN LEXINGTON, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHOL SS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 761	Continued From page	91	F 7	51			
	should be discarded antiseptic mouthwash undated. There were regarding when it sho opening.	3 months after opening. line Gluconate 0.12% (an n) was found open and e no instructions on the bottle buld be discarded after polution 250 milligrams in 5		with no da was comp nurse or n receive th be allowed been com added this all new hin	ened and if found to be op ate, to discard. This in-se- pleted on 4/22/24. Any lic- medication aide who did r his in-service by 4/22/24 w d to work until the in-serv pleted. The Director of N is to the new hire orientation res on 4/12/24. ctor of Nursing or designe	rvice ensed not <i>i</i> ill not ice has ursing on for	
<ul> <li>milliliters (an antiseizure medication) was found opened and undated. There were no instructions on the bottle regarding when it should be discarded after opening.</li> <li>Dextromethorphan/Guaifenesin (an over-the-counter cough suppressant medication) 2 milligrams/200 milligrams in 10 milliliters liquid was found open and undated. There were no instructions on the label regarding when they should be discarded after opening.</li> <li>On 3/20/2024 at 10:42 am Nurse #8 was interviewed, and she stated she normally worked on the 100-hall. Nurse #8 stated all medications that were opened and stored in the medication carts should be labeled with the date they were opened. She stated she had an in-service education recently and understood the medications should be dated as soon as they were opened, and she did not know who had put the unlabeled medications in the medication cart.</li> </ul>	There were no instructions g when it should be ng. uaifenesin (an gh suppressant medication) grams in 10 milliliters liquid undated. There were no bel regarding when they		conduct m medicatio times wee week x 4 consultan carts "una practice d The Direc responsib cart and m	nedication audits to includ n carts and medication ro ekly for 4 weeks, then 1 ti weeks. The pharmacy t will be reviewing medica announced" ensuring defi loes not reoccur. etor of Nursing will be to for bringing the medica nedication room audits to ssurance Performance	de boms 3 me a ation cient ation		
	interviewed, and she on the 100-hall. Nur that were opened and carts should be labele opened. She stated s education recently an medications should b were opened, and sh	stated she normally worked se #8 stated all medications d stored in the medication ed with the date they were she had an in-service id understood the e dated as soon as they e did not know who had put		meetings. evaluate t plan and v and recon audits to e	nent committee for 2 cons The QAPI committee wil the effectiveness of the al will make additional interv nmendations based on th ensure continued complia ompliance: 4/23/24	l bove ventions ie	
	on 3/21/2024 at 1:34 staff had been education any medications that the medication cart. have ensured the me	ng (DON) was interviewed pm and stated the nursing ted on labeling and dating were opened and placed in She stated Nurse #8 should dications were labeled with pened and discarded them if					

Facility ID: 923005

If continuation sheet Page 92 of 110

				E CONSTRUCTION		0.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY PLETED
			A BOILDING			С
		345011	B. WING		03	/28/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	RES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 761	Continued From page they were not labeled opened.	e 92 I with the date they were	F 76	1		
F 867 SS=G	During an interview w 3/21/2024 at 3:29 pm should be labeled wit before they were plac QAPI/QAA Improvem		F 86	7		4/23/24
	monitoring. A facility must establi policies and procedur collections systems, a adverse event monito	eedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the				
	systems to obtain and from direct care staff, resident representativ information will be us	maintenance of effective d use of feedback and input other staff, residents, and ves, including how such ed to identify problems that ume, or problem-prone, and ovement.				
	systems to identify, c information from all d not limited to the facil §483.70(e) and include	maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance				
	and evaluation of per	development, monitoring, formance indicators, ology and frequency for such				

If continuation sheet Page 93 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	
		345011	B. WING				
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	including the methods systematically identify analyze and use data adverse events in the facility will use the da prevent adverse even §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ac (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance im- ensure that improvem §483.75(e)(1) The fac geformance improve high-risk, high-volume	ring, and evaluation. adverse event monitoring, s by which the facility will y, report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after actions, measure its success, e to ensure that alized and sustained. cility will develop and ddressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to hents are sustained.	F	867			
		e, providendo, una doventy					

	-	D HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/19/2024 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DA	E SURVEY IPLETED
		345011	B. WING			o	C 3/28/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURSI	NG AND REHABILITATION			279 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 867	outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance i number and frequenc conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sect §483.75(g)(2) The qu assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple	areas; and affect health afety, resident autonomy, quality of care. hance improvement hedical errors and adverse vze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's seignated person(s) ming body regarding its uplementation of the QAPI er paragraphs (a) through e committee must:	F	867			
		ified quality deficiencies; and analyze data, including					

If continuation sheet Page 95 of 110

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
			D 14/11/0			С
		345011	B. WING			3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
PINE ACR	ES CENTER FOR NURS	SING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 867	Continued From pag	e 95	F 86	7		
		the QAPI program and data				
		egimen reviews, and act on				
	available data to mal					
	This REQUIREMEN	T is not met as evidenced				
	by:					
		view, resident, shelter staff,		F867		
		views the facility's Quality		The facility's Quality Asses		
		surance (QAA) Committee		Assurance (QAA) Committ		
	-	plemented procedures and entions that the committee		maintain implemented proc monitor these interventions		
		ng the 9/23/2021 Complaint		committee put into place for		
		and the 3/8/2022 Complaint		9/23/2021 Complaint Inves		
		During the 3/8/2022		and the 3/8/2022 Complain	• •	
		ion Survey the facility was		Survey During the 3/8/202	•	
		ghts (F550) and during the		Investigation Survey the fa		
	9/23/2021 Complaint	Investigation Survey the		for Resident Rights (F550)	and during	
		Discharge Planning Process		the9/23/2021 Complaint In		
		encies were recited again on		Survey the facility was cite	•	
		ation Survey and Complaint		Planning Process(F660). T		
		of 3/28/2024. The continued		deficiencies were recited a	•	
	-	o ensure compliance in the		current Recertification Sur	-	
		ent areas showed a pattern ty to sustain an effective		Complaint Investigation Su 3/28/2024.The continued fa		
		and Assurance program.		facility to ensure compliand		
				previously deficient areas		
	Findings included:			pattern of the facility's inab		
	5			an effective Quality Assess		
	This tag is cross refe	renced to:		Assurance program.		
				The Administrator initiated	an in-service to	
		rd review, resident, facility		all administrative staff on 3		
		ff interview the facility failed		regarding Quality Assurance		
		ment an effective discharge		Improvement (QAPI) proce		
		ensure discharge needs and		identifying and prioritizing		
	-	with the resident and the n (IDT) as active participants		deficiencies, systemically a causes of quality deficienc		
	-	in order to prepare the		and implementing correctiv		
	resident for an effect			performance improvement		
			1			1
	post-discharge care	for a resident who was a		in-service included accurate	cv of audits	

Facility ID: 923005

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(X3) DATE SURVEY
COMPLETED
C 03/28/2024
CODE
F CORRECTION (X5) TION SHOULD BE COMPLET THE APPROPRIATE DATE CY)
n/performance
evaluate the and revise, as administrative priate education ninistrative staff appropriate
mittee will dits to evaluate e committee will <sup>c</sup> any d and
rection for ocess will as achieved t compliance. responsible for
24
-

If continuation sheet Page 97 of 110

SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; an- available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	essment and Assurance ne department managers	· ,	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION (X5) SHOULD BE COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; and available for the quart stated she understood had failed since they h for Resident Rights ar Process and the faciliti mprove their process	NG AND REHABILITATION ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 97 essment and Assurance he department managers d the Pharmacist is erly QAA meetings. She d the facility's QAA process had repeated the two tags had Discharge Planning	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292 PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	RRECTION (X5) SHOULD BE COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; and available for the quart stated she understood had failed since they h for Resident Rights ar Process and the faciliti mprove their process	NG AND REHABILITATION ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 97 essment and Assurance he department managers d the Pharmacist is erly QAA meetings. She d the facility's QAA process had repeated the two tags had Discharge Planning	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION (X5) SHOULD BE COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; and available for the quart stated she understood had failed since they h for Resident Rights ar Process and the faciliti mprove their process	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 97 essment and Assurance he department managers d the Pharmacist is lerly QAA meetings. She d the facility's QAA process had repeated the two tags hd Discharge Planning	PREFIX	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION (X5) SHOULD BE COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; an- available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 97 essment and Assurance he department managers d the Pharmacist is lerly QAA meetings. She d the facility's QAA process had repeated the two tags hd Discharge Planning	PREFIX	LEXINGTON, NC 27292 PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; an- available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 97 essment and Assurance he department managers d the Pharmacist is lerly QAA meetings. She d the facility's QAA process had repeated the two tags hd Discharge Planning	PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
(EACH DEFICIENCY REGULATORY OR L Continued From page a monthly Quality Ass (QAA) meeting with th and the Physician; and available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	e MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) essment and Assurance he department managers d the Pharmacist is erly QAA meetings. She d the facility's QAA process had repeated the two tags and Discharge Planning	PREFIX	( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
a monthly Quality Ass (QAA) meeting with th and the Physician; an available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	essment and Assurance ne department managers d the Pharmacist is erly QAA meetings. She d the facility's QAA process nad repeated the two tags nd Discharge Planning	F 8	367	
a monthly Quality Ass (QAA) meeting with th and the Physician; an available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	essment and Assurance ne department managers d the Pharmacist is erly QAA meetings. She d the facility's QAA process nad repeated the two tags nd Discharge Planning			
(QAA) meeting with th and the Physician; and available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	ne department managers d the Pharmacist is erly QAA meetings. She d the facility's QAA process nad repeated the two tags nd Discharge Planning			
and the Physician; and available for the quart stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	d the Pharmacist is erly QAA meetings. She d the facility's QAA process nad repeated the two tags nd Discharge Planning			
stated she understood had failed since they h for Resident Rights ar Process and the facilit mprove their process	d the facility's QAA process nad repeated the two tags nd Discharge Planning			
nad failed since they h for Resident Rights ar Process and the facilit mprove their process	nad repeated the two tags nd Discharge Planning			
or Resident Rights ar Process and the facilit mprove their process	nd Discharge Planning			
Process and the facilit	÷ ÷			
mprove their process				
883 Influenza and Pneumococcal Immunizations	F 8	383		
CFR(s): 483.80(d)(1)(	2)			
§483.80(d) Influenza a	and pneumococcal			
mmunizations				
	za. The facility must develop			
•				
	0			
	•			
	5			
•	•			
	•			
	dicates, at a minimum, the			
-	ar regident's representative			
•				
mmunization; and				
	nedical contraindications or			
Societa con (i na con (i na con (i na con	483.80(d)(1) Influenz olicies and procedur ) Before offering the ach resident or the re- eceives education re- otential side effects of i) Each resident is of nmunization October nnually, unless the ir pontraindicated or the munized during this ii) The resident or the as the opportunity to v)The resident's met occumentation that in pollowing: A) That the resident of nmunization; and B) That the resident of nmunization or did n	<ul> <li>483.80(d)(1) Influenza. The facility must develop olicies and procedures to ensure that-</li> <li>before offering the influenza immunization, ach resident or the resident's representative eccives education regarding the benefits and otential side effects of the immunization;</li> <li>i) Each resident is offered an influenza munization October 1 through March 31 nnually, unless the immunization is medically contraindicated or the resident has already been munized during this time period;</li> <li>ii) The resident or the resident's representative as the opportunity to refuse immunization; and v)The resident or resident's representative as provided education regarding the benefits and potential side effects of influenza munization; and</li> <li>a) That the resident or resident's representative as provided education regarding the benefits and potential side effects of influenza munization; and</li> <li>b) That the resident either received the influenza munization or did not receive the influenza munization due to medical contraindications or</li> </ul>	<ul> <li>483.80(d)(1) Influenza. The facility must develop olicies and procedures to ensure that-</li> <li>b) Before offering the influenza immunization, ach resident or the resident's representative eccives education regarding the benefits and otential side effects of the immunization;</li> <li>ii) Each resident is offered an influenza munization October 1 through March 31 nnually, unless the immunization is medically contraindicated or the resident has already been munized during this time period;</li> <li>iii) The resident or the resident's representative as the opportunity to refuse immunization; and v)The resident or resident's representative as provided education regarding the benefits and potential side effects of influenza munization; and</li> <li>a) That the resident or resident's representative as provided education regarding the benefits and potential side effects of influenza munization; and</li> <li>b) That the resident either received the influenza munization or did not receive the influenza munization due to medical contraindications or</li> </ul>	483.80(d)(1) Influenza. The facility must develop olicies and procedures to ensure that- ) Before offering the influenza immunization, ach resident or the resident's representative accives education regarding the benefits and otential side effects of the immunization; i) Each resident is offered an influenza nmunization October 1 through March 31 nnually, unless the immunization is medically ontraindicated or the resident has already been nmunized during this time period; ii) The resident or the resident's representative as the opportunity to refuse immunization; and v)The resident's medical record includes occumentation that indicates, at a minimum, the soccumentation that indicates, at a minimum, the soccumentation regarding the benefits and potential side effects of influenza nmunization; and 3) That the resident either received the influenza nmunization or did not receive the influenza nmunization or did not receive the influenza nmunization due to medical contraindications or

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/19/2024 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2024	
		345011	B. WING _				
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			9 BRIAN CENTER DRIVE XINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION DATE
F 883	Continued From page	98	F٤	383			
	must develop policies that- (i) Before offering the immunization, each re- representative receive benefits and potential immunization; (ii) Each resident is o immunization, unless medically contraindic already been immunit (iii) The resident or the has the opportunity to (iv)The resident or the has the opportunity to (iv)The resident's me documentation that in following: (A) That the resident was provided educati and potential side effe- immunization; and (B) That the resident pneumococcal immu- the pneumococcal immu- the pneumococcal immu- the pneumococcal immu- the pneumococcal im- contraindication or re This REQUIREMENT by: Based on record rev facility failed to includ medical record of edu- benefits and potential and Pneumococcal in residents reviewed (F Resident #34, Reside The findings included	esident or the resident's es education regarding the I side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; the resident's representative or refuse immunization; and dical record includes ndicates, at a minimum, the or resident's representative on regarding the benefits ects of pneumococcal either received the nization or did not receive immunization due to medical fusal. T is not met as evidenced iew and staff interviews the led documentation in the ucation regarding the I side effects of the Influenza nmunization for 5 of 5 Resident #10, Resident #21, ent #35, and Resident #41.)			Past noncompliance: no plan of correction required.		

Facility ID: 923005

If continuation sheet Page 99 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
				_			C
		345011	B. WING			03/	28/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	NG AND REHABILITATION			LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page 02/07/23.	99	F	383			
	dated 01/19/24 revea cognitively intact and immunization in the fa	ly Minimum Data Set (MDS) led Resident #10 was received the Influenza acility on 10/16/23 and mococcal immunization was					
	medical record that th representative was pr	as no information in the ne Resident or their legal rovided education regarding ntial side effects of the					
	b. Resident #21 wa 09/24/18.	s admitted to the facility on					
	revealed that Resider impaired and had rec immunization in the fa	ly MDS dated 03/14/24 ht #21 severely cognitively eived the Influenza acility on 09/29/23 and his hization was up to date.					
	medical record that th representative was pr	as no information in the ne Resident or his legal rovided education regarding ntial side effects of the					
	C. Resident #34 was 10/30/18.	admitted to the facility on					
	revealed that Resider and had not received	ly MDS dated 01/16/24 ht #34 was cognitively intact the Influenza immunization ered and declined, and her					

If continuation sheet Page 100 of 110

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDI	NG _			C
		345011	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
					279 BRIAN CENTER DRIVE		
PINEACK	ES CENTER FOR NORS	ING AND REHABILITATION		I	LEXINGTON, NC 27292		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
F 883	Continued From page		F	883	3		
	Pneumococcal Immu	nization was up to date.					
	A review of Resident	#34's medical record					
		as no information in the					
		ne Resident or her legal					
		rovided education regarding ntial side effects of the					
	Influenza or Pneumo						
		is admitted to the facility on					
	04/06/22.						
	Review of the annual	MDS dated 01/22/24					
		nt #35 was cognitively intact					
		enza immunization in the					
	-	nd her Pneumococcal					
	immunization was up	lo dale.					
	A review of Resident	#35's medical record					
		as no information in the					
	medical record that th						
		rovided education regarding ntial side effects of the					
	Influenza or Pneumo						
	E. Resident #41 wa 10/19/23.	is admitted to the facility on					
	10/19/23.						
	Review of the quarter	rly MDS dated 01/25/24					
		nt #41 was moderately					
		and received the Influenza					
		acility on 10/22/23 and her nization was up to date.					
		יוובמוטרו שמש עף וט עמוב.					
	A review of Resident	#41's medical record					
		as no information in the					
		ne Resident or her legal					
		rovided education regarding ntial side effects of the					

Facility ID: 923005

If continuation sheet Page 101 of 110

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						С
		345011	B. WING			8/28/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
PINE ACRI	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(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) COMPLETIOI DATE
F 883	Continued From page	e 101	F 883	3		
	Influenza or Pneumoo	coccal immunization.				
		ng (DON) was interviewed .M. She explained the facility e Influenza and				
	Pneumococcal immun quality improvement of	nization initiative with the organization. They had immunization protocol and				
	made some adjustme explained that when r	ents to it. The DON new admission came to the				
	and pulled what inform state database. Once	tained their immunization history at information they could from the . Once they had the information,				
	they got consent form immunization was new immunization would b					
	pharmacy and admini documented in the me	istered to the resident then edical record. The DON				
	program they realized	ew of the immunization I that the consent forms that ot have the risk and benefits				
	on them, so we conta obtained new consen	icted the pharmacy and t that had all the required				
	December 2023 start	Those were implemented in ing with new admissions. nts were signed, they were				
		ident's medical record.				
	4:45 PM. The Adminis	s interviewed on 03/21/24 at strator explained that the				
	facility had recently m Influenza and Pneum program. She stated t	ococcal immunization				
	consent form that the the risks and benefit e	y were using did not include education that was required.				
		ted that they pulled a new				

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IUMAN SERVICES DICAID SERVICES				FORM	APPROVED 0. 0938-0391
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
345011	B. WING				C 28/2024
		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AND REHABILITATION					
IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)					(X5) COMPLETION DATE
2 ed into the system. following corrective on consent form was ion of the benefits and affuenza and dministration on rator. ouse medical records ntation of resident and potential side and Pneumococcal ecord Manager and c, or Assistant Director of sident who consented to ad is able to make the Responsibility Party efits and potential side which they consented to ad sign were in serviced by at before offering the scal immunizations each sentative must receive benefits and potential ization, and it must be ent's medical record. ill audit all new of resident or x 12 weeks to ensure	F	883			
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011 AND REHABILITATION ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  2 ed into the system. following corrective on consent form was on of the benefits and fluenza and dministration on ator. ouse medical records nation of resident and potential side ad Pneumococcal ecord Manager and , or Assistant Director of sident who consented to d is able to make e Responsibility Party fits and potential side ///ich they consented to ator, Unit Manager, and ing were in serviced by at before offering the al immunizations each sentative must receive enefits and potential zation, and it must be nt's medical record.	DICAID SERVICES         PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         345011       B. WING         AND REHABILITATION       B. WING         AND REHABILITATION       PREF         ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)       ID PREF         2       F         ed into the system.       following corrective         on consent form was on of the benefits and fluenza and dministration on ator.       fluenza and dministration on ator.         ouse medical records ntation of resident and potential side d Pneumococcal ecord Manager and       , or Assistant Director of sident who consented to d is able to make e Responsibility Party fits and potential side /hich they consented to         ator, Unit Manager, and ing were in serviced by it before offering the al immunizations each sentative must receive enefits and potential zation, and it must be nt's medical record.         III audit all new of resident or x 12 weeks to ensure       III audit all new	DICAID SERVICES         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345011         B. WING	DICAID SERVICES         PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         345011       B. WING         AND REHABILITATION       STREET ADDRESS, CITY, STATE, ZIP CODE         273 BRIAN CENTER DRIVE EXINGTON, NC 27292       STREET ADDRESS, CITY, STATE, ZIP CODE         ENT OF DEFICIENCIES       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD B CROSS-REFERENCED TO THE APPROPRIN DEFICIENCY)         2       F 883         ed into the system.       F 883         following corrective       DEFICIENCY         on consent form was on of the benefits and fluenza and diministration on ator.       F 883         ouse medical records tation of resident and potential side did Pneumococcal ecord Manager and ecord Manager and of is able to make e Responsibility Party fits and potential side thich they consented to ator, Unit Manager, and ing were in serviced by the bore offering the al immunizations each sentative must receive enefits and potential zation, and it must be nt's medical record.         II audit all new of resident or x12 weeks to ensure       II audit all new	DICAID SERVICES     ONE NO       PROVIDER/SUPPLIENCIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING     (X3) DATE COMP       345011     B. WING     03/ 03/ 278 BRIAN CENTER DRIVE LEXINGTON, NC 27292       AND REHABILITATION     STREET ADDRESS, CITY, STATE, ZIP CODE 278 BRIAN CENTER DRIVE LEXINGTON, NC 27292       ENT OF DEFICIENCIES STBE PRECEDED BY FULL DEFICIENCY     ID PROVIDER'S PLAN OF CORRECTION TAG       2     F 883       ed into the system.     F 883       following corrective     F 883       on on of the benefits and fluenza and dministration on ator.     F 883       ouse medical records tation of resident and potential side dropotential side doerod Manager and     A Assistant Director of sident who consented to d is able to make e Responsibility Party fits and potential zation, and it must be nt's medical record.     III audit all new of resident or x 12 weeks to ensure

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	-	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345011	B. WING			C 03/28/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	279 BRIAN CENTER DRIVE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		L	LEXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 883	Continued From page	e 103	F	883			
	effects of the Influenz	a and Pneumococcal					
		I and is documented in the					
	resident's medical rec						
	*The DON will be res	ponsible for brining					
		on audit to the Quality					
	-	ce Improvement Committee					
		ing starting on 12/19/23.					
		e Committee will determine					
	the need for further e	ducation and monitoring.					
	Date of Compliance:	12/20/23.					
	The facility's correctiv	e action plan was validated					
	•	al audit of all in house					
		on records was reviewed.					
		as provided to the resident					
		sentative was also reviewed					
		The education included the					
		efits of each immunization.					
	•	Imission Coordinator and					
		I new admissions were					
	-						
	discussed in morning						
	· · ·	was reviewed. Any needed					
		ons were reviewed with the					
		epresentative that explained					
	the potential risk and						
		ed. The consent form was					
	-	e resident's medical record.					
	-	ere reviewed with each audit					
		nission residents. All new					
		or resident representatives					
		cation of potential risk and					
		ination requested and that					
	education was provid	ed in the medical record.					
	The completion date	of 12/20/23 was validated.					
F 887	COVID-19 Immunizat	ion	F	887	,		
SS=D	CFR(s): 483.80(d)(3)	(i)-(vii)					
			I				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/19/2024 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		345011	B. WING			0	C 3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREETA	DDRESS, CITY, STATE, ZIP CODE	•	
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION			N CENTER DRIVE TON, NC 27292		
(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) COMPLETION DATE
F 887	Continued From page	e 104	F 8	87			
	LTC facility must deve and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID- immunization is medi resident or staff mem immunized; (ii) Before offering CO members are provide regarding the benefits effects associated witi (iii) Before offering CO resident or the reside receives education re- risks and potential sid the COVID-19 vaccin (iv) In situations wher requires multiple dos- resident representation provided with current additional doses, incl benefits or risks and p associated with the C requesting consent for additional doses; (v) The resident, reside member has the oppor COVID-19 vaccine, a (vi) The resident's me documentation that in the following: (A) That the resident was provided educati	-19 vaccine unless the cally contraindicated or the ber has already been DVID-19 vaccine, all staff ed with education is and risks and potential side th the vaccine; DVID-19 vaccine, each int representative egarding the benefits and de effects associated with e; re COVID-19 vaccination es, the resident, ve, or staff member is information regarding those uding any changes in the potential side effects COVID-19 vaccine, before or administration of any dent representative, or staff ortunity to accept or refuse a ind change their decision; edical record includes indicates, at a minimum, or resident representative on regarding the I risks associated with					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/202 FORM APPROVEI OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345011	B. WING		C 03/28/2024
	ROVIDER OR SUPPLIER	ING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
(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)	OULD BE COMPLETION
F 887	to the resident; or (C) If the resident did vaccine due to medic contraindications or r (vii) The facility maint to staff COVID-19 var includes at a minimur (A) That staff were pr the benefits and pote associated with COV (B) Staff were offered information on obtain (C) The COVID-19 var related information as Disease Control and Healthcare Safety Net This REQUIREMENT by: Based on record rev facility failed to includ medical record of edu benefits and potentia COVID-19 immunizat Resident #35, and Re reviewed for infection The findings included a. Resident #10 wa 02/07/23. Review of the quarter dated 01/19/24 indica cognitively intact. Review of Resident # revealed no informati	VID-19 vaccine administered not receive the COVID-19 eal efusal; and tains documentation related ccination that m, the following: ovided education regarding ntial risks ID-19 vaccine; the COVID-19 vaccine or ing COVID-19 vaccine; and accine status of staff and is indicated by the Centers for Prevention's National etwork (NHSN). T is not met as evidenced iew and staff interviews the le documentation in the ucation regarding the I side effects of the tion for 3 of 5 (Resident #10, esident #41) residents in control. I: as admitted to the facility on	F 88	7 Past noncompliance: no plan of correction required.	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/19/2024 DRM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345011	B. WING _				C 03/28/2024	
	ROVIDER OR SUPPLIER	ING AND REHABILITATION		279 B	ET ADDRESS, CITY, STATE, ZIP CODE RIAN CENTER DRIVE NGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<u> </u>	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 887	COVID-19 immunization b. Resident #35 wat 04/06/22. Review of the annual indicated that Reside Review of Resident # revealed no information representative was porthe benefits and pote COVID-19 immunization C. Resident #41 was 10/19/23. Review of the quarter indicated that Reside cognitively impaired. Review of Resident # revealed no information representative was porthe benefits and pote COVID-19 immunization COVID-19 immunization The Director of Nursion 03/21/24 at 9:34 A had participated in the the quality improvement recently looked at the made some adjustment explained that when the facility, they obtained and pulled what information state database. Once	ntial side effects of the tion. Is admitted to the facility on MDS dated 01/22/24 nt #35 was cognitively intact. 35's medical record on that the Resident or legal rovided information about ntial side effects of the tion. admitted to the facility on rly MDS dated 01/25/24 nt #41 was moderately 41's medical record on that the Resident or legal rovided information about ntial side effects of the tion. 441's medical record on that the Resident or legal rovided information about ntial side effects of the tion. ng (DON) was interviewed M. She explained the facility e immunization initiative with ent organization. They had a immunization protocol and	F 8	87				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/19/2024 APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345011	B. WING		_	03/2	C 28/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURSI	ING AND REHABILITATION		279 BRIAN CENTER DRIVI LEXINGTON, NC 27292			
(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 B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 887	documented in the me added during the revie program they realized they were using did m on them, so we conta obtained new consen- information on them. December 2023 starti Once the new consen- uploaded into the resi The Administrator was 4:45 PM. The Adminis facility had recently m immunization program that the consent form include the risks and l required. The Adminis pulled a new consent began getting them fill with new admissions. forms were signed, th system. The facility submitted action plan: *The resident immuni- updated to reflect edu potential side effects of administration on 12/ <sup>*</sup> All current residents were audited for docu	eded. Then the be ordered from the istered to the resident then edical record. The DON ew of the immunization I that the consent forms that ot have the risk and benefits cted the pharmacy and t that had all the required Those were implemented in ing with new admissions. Its were signed, they were ident's medical record. Is interviewed on 03/21/24 at strator explained that the hade changes to their n. She stated they realized that they were using did not benefit education that was strator stated that they from the pharmacy and lled out and signed starting Once all the new consent ey were uploaded into the the following corrective zation consent form was ucation of the benefits and of the Covid-19 vaccine 19/23 by the Administrator. in house medical records umentation of resident	F 88	7			

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DEPART CENTER		FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2024		
		345011	B. WING					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
PINE ACRES CENTER FOR NURSING AND REHABILITATION				279 BRIAN CENTER DRIVE LEXINGTON, NC 27292				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 887	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 108 Record Manager and DON on 12/19/23. *The DON, Unit Manager, or Assistant Director of Nursing provided each resident who consented to vaccine administration and is able to make his/her own decision or the Responsibility Party the education of the benefits and potential side affects of the vaccine in which they consented to receive on 12/19/23. *The Admissions Coordinator, Unit Manager, and Assistant Director of Nursing were in serviced by the DON on 12/19/23, that before offering the Covid-19 immunization each resident or resident representative must receive education regarding the benefits and potential side effects of the immunization, and it must be documented in the resident's medical record. *The DON or designee will audit all new admission and interview of resident or responsible party weekly x 12 weeks to ensure education of the benefits and potential side effects of the Covid-19 vaccine was provided and is documented in the resident's medical record. *The DON will be responsible for bringing immunization education audit to the Quality Assurance performance Improvement Committee x 3 consecutive meeting. The Quality Assurance Committee will determine the need for further education and monitoring starting on 12/19/23. Date of Compliance: 12/20/23. The facility's corrective action plan was validated on 03/22/24. The initial audit of all in house residents' immunization records was reviewed. The education that was provided to the resident		F	887				

Event ID:9BNO11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/19/2024 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345011	B. WING			C 03/28/2024	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PINE ACR	ES CENTER FOR NURS	ING AND REHABILITATION		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 887	with no issues noted. potential risk and ben Interviews with the Ac DON revealed that all discussed in morning immunization history or wanted immunizati resident or resident re the potential risk and immunization request then uploaded into the 13 weeks of audits we containing 5 new adm admission residents of had received the educ benefits of each vacc education was provid	sentative was also reviewed The education included the efits of each immunization. Imission Coordinator and I new admissions were meeting and their was reviewed. Any needed ons were reviewed with the epresentative that explained	F 88	7			

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