STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertificatin and complaint investigation survey was conducted on 122/2/24 through 12/5/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MPJY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey ws conducted from 12/2/24 through 12/5/24. Event ID# MPJY11. The following intakes were investigated NC00223440, NC00224044, NC00217695, NC00216310, NC00209931, NC00224070, NC00216425, NC00221495, NC00213275 and NC00224239. 0 of the 33 complaint allegations resulted in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of accidents (Residents #63, #64 and #17). This was for 3 of 22 residents whose MDS assessments were reviewed. The findings included: 1. Resident #63 was admitted to the facility on 11/30/22 with diagnoses that included vascular dementia.	F 641	F- 641 Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: RN MDS nurse corrected and resubmitted the identified assessments on 12.05.2024 for residents 63, 64 and 17. Address how the facility will identify other	12/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/17/2024

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F 641	Continued From page 1 A review of Resident #63's medical record revealed he had a fall on 9/20/24 with a minor injury since the quarterly MDS assessment on 8/9/24. The annual MDS assessment, dated 11/9/24, indicated Resident #63 had severe cognitive impairment and was not coded for any falls since the last assessment. On 12/5/24 at 9:50 AM, an interview occurred with the MDS Coordinator, who reviewed the MDS assessment dated 11/9/24 as well as Resident #63's medical record. The MDS Coordinator confirmed Resident #63 had a fall since the last assessment on 8/9/24 and should have been coded for a fall with minor injury. She stated it was an oversight. An interview was conducted with the Administrator on 12/5/24 at 10:12 AM and stated it was his expectation for the MDS assessments to be coded accurately in the area of falls. 2. Resident #64 was admitted to the facility on 6/5/23 with diagnoses that included history of a stroke with left sided weakness and repeated falls. A review of Resident #64's medical record revealed he had falls on 7/5/24 with no injury, 7/25/24 with no injury, 8/3/24 with no injury, 8/7/24 with no injury and another fall on 8/7/24 with minor injury since the annual MDS assessment on 6/15/24. The quarterly MDS assessment, dated 9/15/24, indicated Resident #64 had moderately impaired	F 641	residents having the potential to be affected by the same deficient practice: A thirty-day lookback was conducted on fall coding for assessments completed in that timeframe with all identified assessments corrected and resubmitted on 12.05.2024 by RN MDS nurse. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a. The MDS team were educated on 12.05.2024 by the Director of Nursing on assessment coding accuracy. This education was also added to new hire orientation by the Director of Nursing on 12.05.2024. Anyone that does not receive this training will not be scheduled until completion. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or RN MDS Coordinator will audit five assessments weekly for four weeks, then three assessments weekly for four weeks, then randomly thereafter for fall coding accuracy. The Facility Administrator will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The Facility Administrator and/or designee	

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F 641	Continued From page 2 cognition and was coded with one fall with minor injury since the last assessment. On 12/5/24 at 9:50 AM, an interview was completed with the MDS Coordinator, who reviewed the MDS assessment dated 9/15/24 as well as Resident #64's medical record. The MDS Coordinator confirmed Resident #64 had four falls without injury since the last assessment on 6/15/24 and should have coded the MDS assessment as 2 or more falls with no injury. She stated it was an oversight. An interview was conducted with the Administrator on 12/5/24 at 10:12 AM and stated it was his expectation for the MDS assessments to be coded accurately in the area of falls. 3. Resident #3 was admitted to the facility on 05/19/22 with diagnoses that included Dementia. a. A review of Resident #3's medical record revealed she had a fall on 07/24/24 with no injuries. A quarterly Minimum Data Set (MDS) assessment, dated 07/31/24, indicated Resident #63 had moderate cognitive impairment and was not coded for any falls since the last assessment (quarterly dated 6/15/24). b. A review of Resident #3's medical record revealed she had a fall on 08/05/24 with no injuries. A quarterly MDS assessment, dated 09/15/24, indicated Resident #3 had moderate cognitive impairment and was not coded for any falls since the last assessment (quarterly dated 7/31/24).	F 641	will review the plan during the QAPI meeting to ensure that the audit results are completed and present them to the facility monthly QAPI meeting to ensure continued compliance. Indicate dates when corrective action will be completed: 12.16.2024. The Director of Nursing will be responsible for this plan of correction.	

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F 641	Continued From page 3 An interview was conducted with the MDS Coordinator on 12/5/24 at 9:55 AM. The MDS Coordinator reviewed the MDS assessment dated 07/31/24 as well as Resident #3's medical record. The MDS Coordinator confirmed Resident #3 had a fall since the last assessment on 07/24/24 and should have been coded for a fall with no injury. She then reviewed the MDS assessment dated 09/15/24 as well as Resident #3 ' s medical record. The MDS Coordinator confirmed Resident #3 had a fall since the last assessment on 08/05/24 and should have been coded for a fall with no injury. She stated it was an oversight. An interview was conducted with the Administrator on 12/5/24 at 10:12 AM and stated it was his expectation for the MDS assessments to be coded accurately in the area of falls.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		12/16/24

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F 761	Continued From page 4 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on manufacturer's recommendations, observations, record review and staff, and Consultant Pharmacist interviews, the facility failed to discard expired medications in 1 of 2 medication carts (Masters Hall Medication Cart) reviewed for medication storage and labeling. Findings included: An observation was conducted on 12/04/24 at 1:50 PM of the Masters Hall medication cart in the presence of Nurse #1. The observation revealed the following expired medications: a. One opened bottle of Latanoprost eye drops used to treat glaucoma (a condition in which increased pressure in the eye can lead to gradual loss of vision) with an opened date of 09/10/24. The manufacturer's recommendation was to discard 6 weeks after opening. b. One opened bottle of Latanoprost eye drops used to treat glaucoma (a condition in which increased pressure in the eye can lead to gradual loss of vision) with an opened date of 10/16/24. The manufacturer's recommendation was to discard 6 weeks after opening.	F 761	F- 761 Medication Storage—Label drugs and biologicals 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Unit Manager and/or Director of Nursing immediately removed and disposed of the identified expired items on 12/4/24. The expired eye drops were replaced without any interruption of care. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All nursing carts and medication rooms were audited by Unit Managers on 12.05.2024 to ensure no other medications were stored improperly. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 761	Continued From page 5 c. One opened bottle of Latanoprost eye drops used to treat glaucoma (a condition in which increased pressure in the eye can lead to gradual loss of vision) with an opened date of 10/18/24. The manufacturer's recommendation was to discard 6 weeks after opening. An interview was conducted with Nurse #1 on12/04/24 at 1:52 PM. She verified the medications were expired and she removed them from the medication cart and discarded them. She indicated nurses were to check dates on all multi-use medications prior to administration to make sure they were not expired. She then stated she did not realize the medications were expired. She indicated she had not checked the medication cart for expired medications on 12/04/24. An interview was conducted with the Director of Nursing (DON) on 12/05/24 at 10:01 AM. She stated all nurses were responsible for checking dates on multi-use medications prior to administration to verify that they were not expired. She explained that the unit managers could also check the medication carts for expired medications however there was no set days or schedule for them to follow. She then stated the pharmacist should be performing medication cart audits when they were in the building. She expected the nurses to always check dates prior to administration and to remove medications that were expired. A phone interview was conducted with the facility Pharmacist on 12/05/24 at 11:15 AM. She stated she came to the facility every other month and checked the medication carts for dated and expired medications. She explained that she tried	F 761	The licensed nurses and certified medication aides were educated on 12.05.2024 by the Director of Nursing and Unit Managers on medication storage requirements, policy and standards. This education was also added to new hire and agency orientation by the Director of Nursing on 12.05.2024. Anyone that does not receive this training prior to 12.16.2024 will not be scheduled until completion. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: a. The Director of Nursing and unit managers will audit medication storage five times weekly for four weeks, then three times weekly for four weeks, then randomly thereafter to ensure medications are stored per policy and regulation. The Facility Administrator/designee will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The Facility Administrator and/or designee will review the plan during the monthly QAPI meeting to ensure continued compliance and the audits will continue at the discretion of the QAPI committee. 5. Indicate dates when corrective action will be completed 12.16.2024. 6. The Director of Nursing will be responsible for this plan of correction.	

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F 761	Continued From page 6 to look at all four medication carts while in the facility but that was not always possible, however, she did review at least two of them. She indicated the last time she was at the facility was in October and she checked two medication carts at that time. She did not recall which medication carts that she reviewed in October. The Pharmacist verified the manufacturer's recommendation was to discard Latanoprost eye drops 6 weeks after opening.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date leftover food items stored for use in the dry goods storage area and in 1 of 1 walk-in coolers. This practice had the potential to	F 812	F- 812 Food Procurement, Storage/Prepare/Serve-Sanitary 1.Address how corrective action will be	12/16/24

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F 812	Continued From page 7 affect food served to residents. The findings included: a. An observation on 12/2/24 at 9:35 AM of the dry goods revealed the following concerns: - an open and undated bag of corn flakes placed in transparent wrapping. - an undated bag of leftover brown sugar stored in a plastic bag that was not sealed. b. An observation of the walk-in cooler on 12/2/24 at 9:45 AM revealed the following concerns: - an undated leftover package of sliced cheese stored in transparent wrapping - an undated leftover package of sliced ham stored in transparent wrapping - a stainless-steel container with cooked mixed vegetables that had not been dated An interview with the Dietary Manager on 12/2/24 at 10:00 AM indicated that she was new in the position. She stated she was responsible for making sure food items were dated and stored properly. An interview with Cook #2 on 12/3/24 at 11:10 AM revealed that she knew that refrigerated leftover food had to be used within 3 days. She further indicated that all dry goods should be sealed and labeled with an open date and used within 7 days. If not used in 7 days, the dry foods should be thrown out. An interview with Dietary Aide #1 on 12/3/24 at 11:13 AM indicated that food items should be sealed, dated and the expiration or use by date should be checked daily, and thrown out when indicated.	F 812	accomplished for those residents found to have been affected by the deficient practice: Dietary Manager and Administrator in Training immediately disposed of the identified expired items on 12.02.2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All dietary storage areas were audited by Dietary Manager and Administrator in training to ensure no other food items were stored improperly. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a. The dietary cooks and dietary aides were educated on12.02.2024 by the Dietary Director on food storage requirements, policy and standards. This education was also added to new hire orientation by the Administrator on 12.05.2024. Anyone who has not received this education/training prior to 12.16.2024 will not be scheduled until completion. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary Manager will audit food storage five times weekly for four weeks, then three times weekly for four weeks,	

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F 812	Continued From page 8 An interview with the Administrator on 12/4/24 at 9:30 AM revealed the Dietary Manager was new on the job. He then said that sanitary and safe food was very important, and he would make sure the Dietary manager would have a system in place to monitor food items for proper wrapping and dating of leftover foods.	F 812	then randomly thereafter to ensure food products are stored per policy and regulation. The Facility Administrator will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The Facility Administrator and/or designee will review the plan during the monthly QAPI meeting to ensure continued compliance and the audits will continue at the discretion of the QAPI committee. The Facility Administrator will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee to continue compliance. Indicate dates when corrective action will be completed by 12.16.2024 The Administrator will be responsible for this plan of correction.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		12/16/24

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F 947	Continued From page 9 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NAs) received annual Dementia training. This was for 4 (NA #1, NA #2, NA #3 and NA #4) of 5 NAs reviewed for staffing. The findings included: a.NA #1's date of hire was 06/22/10. Review of NA #1's Education/In-services records indicated no record of Dementia training since 06/07/23. b.NA #2's date of hire was 02/02/16. Review of NA #2's Education/In-services records indicated no record of Dementia training since 06/07/23. c.NA #3's date of hire was 12/20/99. Review of NA #3's Education/In-services records indicated no record of Dementia training since 06/06/23. d.NA #4's date of hire was 12/19/22. Review of NA #4's Education/In-services records indicated no record of Dementia training since 06/07/23.	F 947	F- 947-- Required In-Service Training for Nurse Aides Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Dementia Training was scheduled by the Human Resources Manager on 12.10.2024 and 12.12.2024 for the staff training. Anyone that does not receive the training prior to 12.16.2024 will not be scheduled until completion. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 947	Continued From page 10 An interview was conducted with the Director of Nursing (DON) on12/05/24 at 10:01 AM. She explained the current Staff Development Coordinator (SDC) had been out on medical leave since October 2024 however she had requested to step down from her current position of SDC upon returning. The DON stated Dementia training should be completed yearly, and it was an oversight it wasn't completed within the last year. The DON verified with the previous SDC nurse that it was an oversite that the Dementia training was not completed. An interview was conducted with the Administrator on 12/05/24 at 10:35 AM. He confirmed Dementia training had not been completed since 06/07/23. He stated it was an oversight that the training had not been done. The Administrator stated it was his expectation that the NAs received annual Dementia training.	F 947	The Administrator, Human Resources Director and Director of Nursing were educated on 12.05.2024 by the Regional Director of Operations on ensuring that the center staff receive the required education for nursing assistants. This education was also added to new hire orientation for these positions by the Regional Director of Operations on 12.05.2024. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator/designee will audit the in-service monthly calendar and attendance sheets monthly for 3 months, then quarterly for one quarter then randomly thereafter to ensure required trainings are being held, documented and attended. The Facility Administrator/designee will review the audit to identify patterns/trends and will adjust the plan to maintain compliance. The Facility Administrator/designee will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee to ensure continued compliance. Indicate dates when corrective action will be completed: 12.16.2024 The Administrator will be responsible for this plan of correction.	

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