

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/13/2024
NAME OF PROVIDER OR SUPPLIER  Pine Ridge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  706 Pineywood Road Thomasville, NC 27360	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</b></p> <p>Based on record review, resident, staff interviews and student interviews, the facility failed to treat a resident in a dignified manner for 1 of 23 residents reviewed for dignity (Resident #17). Nurse #2 told Resident #17, in a loud and demeaning tone, to get back in her room and stop stalking her. Resident #17 stated Nurse #2's statement made her feel embarrassed and humiliated to be spoken to as if she were a child.</p> <p>Findings included:</p> <p>Resident #17 was admitted to the facility on [DATE] with the most recent readmission on 11/18/22. Her diagnoses included, in part, stroke, hemiplegia, diabetes mellitus and arthritis.</p> <p>An annual Minimum Data Set assessment dated [DATE] revealed Resident #17 cognitively intact and she required substantial to maximal assistance with her activities of daily living. She was independent in her wheelchair for ambulation.</p> <p>On 04/11/24 at 10:20 AM, while preparing to enter room across from Resident #17, this surveyor and Nurse #3 overheard Nurse #2 speak to Resident #17 in a demeaning manner. Nurse #2 told Resident #17 to get back in her room and to stop stalking her. Nurse #2 further told Resident #17 she would not attend to her any faster because she was sitting and watching her. Nurse #2 told Resident #17 her priority was the diabetics. The nurse was positioned a few rooms away on the same side of the hall as Resident #17. There was approximately 40 feet of distance between Nurse #2 and the Resident. Resident #17 blushed and backed her wheelchair back into her room.</p> <p>An interview was conducted with Resident #17 on 04/11/24 at 10:50 AM and she stated when Nurse #2 yelled down the hall and told her to go to her room she felt embarrassed and humiliated. She said Nurse #2 spoke to her like a child and she was not a child. She said it was demeaning to be spoken to in that manner. She stated she was not stalking Nurse #17; she was just sitting in the hall waiting for her medications because she did not want to miss getting her as needed pain medication. She stated she had not asked the nurse for anything prior to the nurse telling her to get back in her room. Resident #17 stated she was just watching for Nurse #2 because she had chronic pain and had to stay ahead of her pain, or it was too hard to control.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/11/24 at 11:12 AM an interview was conducted with Nurse #3, and she stated she heard Nurse #2 tell Resident #17 loudly, from between room [ROOM NUMBER] and 208, to go back in her room, stop stalking me, I'm not coming to you yet. Nurse #3 stated Nurse #2 talked to Resident#17 in an unprofessional and harsh manner. Nurse #3 stated Nurse #2's tone was too loud and was demeaning. Nurse #3 stated Nurse #2 had been sent home immediately. Nurse #3 added it was not common practice for the facility staff to speak to the residents in that manner. She stated the facility did not tolerate bad customer service.</p> <p>An interview was conducted with Nurse #2 on 04/11/24 at 1:00 PM and she stated she and Resident #17 always spoke to each other in that manner. Nurse #2 stated Resident #17 liked her and knew that was how she talked. She stated Resident #17 was a smoker and wanted her medications before she went to smoke. Nurse #2 stated she told Resident #17 that she had to administer medications to the diabetics and administer blood pressure medications first. She further stated she had to provide for residents going to dialysis and appointments and administer important medications before she could attend to Resident #17. Nurse #2 said Resident #17 was rushing her and she did not want to make a medication error. Nurse #2 stated Resident #17 sat and watched her from her bedroom door. Nurse #2 stated it was not about pain for Resident #17, it was about getting her medications prior to her smoke break. She stated she could not prioritize a cigarette break over diabetics and dialysis residents and other important matters. She further stated That's just how I sound, I don't speak like a Southerner, and I think everyone thinks I am talking harshly and nasty. Nobody is culturally competent in the south about my accent. People don't understand Northerners and now I look like the bad guy.</p> <p>On 04/11/24 at 1:35 PM an interview was conducted with the Director of Nursing (DON) and she stated Nurse #2 received a final written warning due to her unprofessional language with Resident #17. The DON stated Nurse #2 had not had any disciplinary action prior, but the unprofessional behavior necessitated a final level of disciplinary action. She stated the facility did not tolerate staff speaking to residents in such a manner.</p> <p>An interview was conducted with the Administrator on 04/11/24 at 1:49 PM and she stated she wrote the incident between Nurse #2 and Resident #17 up as a grievance and followed up with the Resident. She stated she expected staff to provide good customer service and to treat residents with dignity and respect.</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</b></p> <p>Based on observations and staff interviews, the facility failed to maintain walls (Rooms 111 B, 114 B, and 115 A) and a door (room [ROOM NUMBER]B) in good repair for 3 of 15 rooms (rooms [ROOM NUMBER]) on the 100-hall reviewed for environment.</p> <p>Findings included:</p> <p>1a. Observations of room [ROOM NUMBER] B on 04/09/24 at 12:32 PM and on 04/10/24 at 12:34 PM revealed areas of gouged drywall to the left of the bathroom door. A 3-to-4-inch triangular section of the bottom corner of the bathroom door was broken completely off from the hinge side of the door.</p> <p>1b. Observations of room [ROOM NUMBER] B's bathroom on 04/09/24 at 11:30 AM, and on 04/10/24 at 12:30 PM revealed the vinyl baseboard molding had separated from the wall on the right side from the commode in the bathroom. The 12-inch section of baseboard molding was attached to the bottom of the wall but hung loose from the wall at the top.</p> <p>1c. Observations of room [ROOM NUMBER] A on 04/09/24 at 4:35 PM and on 04/12/24 at 5:20 PM revealed a section of gouged drywall behind the head of the bed. The section of gouged drywall was 3 feet wide and 3 feet long with multiple vertical gouges from top to bottom.</p> <p>During an interview and room observations with the Maintenance Director on 4/12/24 at 3:32 PM he stated he had been the Maintenance Director for a short time. He further stated facility staff notified him of repairs that were needed in residents' rooms. The Maintenance Director shared he was aware that there were many areas in the facility that needed repairs, and they were prioritizing the areas as they identified concerns. He explained he prioritized repairs by working on those which impacted resident safety first. He stated he used a web-based software to manage building tasks and work orders.</p> <p>On 04/13/24 at 3:25 PM an interview was conducted with the Administrator, and she stated she expected the Maintenance Director to complete repairs that impacted patient safety first and then attend to cosmetic repairs.</p>		