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	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

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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 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 [DATE] with diagnoses that included vascular dementia. 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 [DATE] 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 [DATE] 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 cognition and was coded with one fall with minor injury since the last assessment. (continued on next page)

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 9:50 AM, an interview was completed with the MDS Coordinator, who reviewed the MDS assessment dated [DATE] 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. 46095 3. Resident #3 was admitted to the facility on [DATE] 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). An interview was conducted with the MDS Coordinator on 12/5/24 at 9:55 AM. The MDS Coordinator reviewed the MDS assessment dated [DATE] 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 [DATE] 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46095 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. 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 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48916 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 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 [NAME] #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. 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.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46095 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. 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.