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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Pinehurst Rehabilitation & Living Ce	205 Rattlesnake Trail Pinehurst, NC 28374

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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 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** Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 2 of 5 residents who were reviewed for unnecessary medication (Residents #93 and #13). The findings included: 1. Resident #93 was admitted to the facility on [DATE] with diagnoses that included dysfunction of the bladder, and retention of urine. A review of the Medication Administration Record (MAR) for Resident #93 from 12/24/25 to 12/30/25 revealed she did not receive an antibiotic medication. A quarterly MDS assessment dated [DATE] indicated Resident #93 had severely impaired cognition and was coded for an antibiotic during the seven-day assessment period. On 3/18/26 at 3:01 PM, an interview occurred with MDS Coordinator #2. She reviewed the 12/30/25 MDS and Resident #93's December 2025 MAR. MDS Coordinator #2 confirmed Resident #93 did not receive an antibiotic from 12/24/25 to 12/30/25 and that the antibiotic was coded in error on the MDS assessment. During an interview on 3/19/26 at 11:00 AM, the Director of Nursing indicated it was her expectation for the MDS assessment to be coded accurately. 2. Resident #13 was admitted to the facility on [DATE] with diagnoses of dementia with psychotic disturbance and postˆtraumatic stress disorder (PTSD). Physician orders dated 4/3/25 included an order for Hydroxyzine 25 milligrams (mg) tablets, to give 1/2 tablet (12.5 mg) twice daily for anxiety. A review of Resident #13's Medication Administration Record (MAR) for January 2026 revealed he received Hydroxyzine 12.5 mg twice daily throughout the month. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], completed by MDS Nurse #2, documented that Resident #13 was receiving medications from the antianxiety drug classification. The assessment also included documented indications for the use of antianxiety medications. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MDS Nurse #2 on 3/19/26 at 10:43 AM, she stated Resident #13 was not ordered any medications that belonged to the antianxiety drug classification. She reported she had coded the resident as receiving antianxiety medications based on the Hydroxyzine order. She further stated she was unsure of the drug classification for Hydroxyzine. After reviewing the medication information, MDS Nurse #2 confirmed Hydroxyzine is classified as an antihistamine. She acknowledged that coding Resident #13 as receiving an antianxiety medication on the MDS was an error. The Director of Nursing was interviewed on 3/19/26 at 11:05 AM. She stated she expected MDS assessments to be coded accurately.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) evaluation after the initial approval for nursing home placement expired for 1 of 1 resident reviewed for PASRR (Resident #3).The findings included: Resident #3 was admitted on [DATE] with diagnoses that included major depressive disorder, generalized anxiety disorder, and postˆtraumatic stress disorder.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had not been evaluated by a Level II PASRR and determined to have a serious mental illness, intellectual disability, or other related condition.Review of the admission record revealed Resident #3 was admitted with a Level II PASRR for shortˆterm admission that was issued on [DATE] and expired on [DATE]. There was no evidence within the medical record to indicate the facility had submitted a referral for another Level II PASRR evaluation to extend approval past the [DATE] expiration date.During an interview with the Social Worker on [DATE] at 1:30 PM, she confirmed Resident #3's Level II PASRR for shortˆterm admission had expired on [DATE] and she had not submitted a request for another Level II PASRR evaluation. She stated that Resident #3's expired Level II PASRR was an oversight that had fallen through the cracks, and a new Level II PASRR evaluation should have been requested before the temporary one expired.During an interview on [DATE] at 1:22 PM, the Administrator stated she expected PASRR evaluations to be monitored and up to date. She stated a review for Resident #3 should have been requested before the expiration date.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews with resident representatives, resident and staff, the facility failed to provide resident representatives and/or residents with the opportunity to participate in the care planning process for 2 of 3 residents reviewed for care plan participation (Residents #77 and #13). The findings included: 1.) Resident #77 was admitted to the facility on [DATE]. A review of Resident #77's 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated he was cognitively intact. Review of Resident #77's electronic health record indicated neither he nor his Resident Representative were included as attendees during care plan meetings conducted on 10/17/25, 1/13/26 and 3/2/26. An interview with Resident #77 on 3/16/26 at 12:14 PM revealed he had not been invited to a care plan meeting since residing at the facility. Resident #77 stated he was unaware the facility held care plan meetings until he heard others talking about them recently. Resident #77 indicated he would like to have attended care plan meetings with his daughter so he could have been actively involved in his care plan at the facility. The Social Worker (SW) was interviewed on 3/19/26 at 12:38 PM and stated she had not sent invitations to Resident #77 to attend care planning meetings. The SW indicated she was responsible for organizing and scheduling care plan meetings but had only been sending invitations for the 72-hour care plan meeting for new admissions or if families had expressed care concerns to her in person or via email. She stated she was unaware she should be inviting residents and/or resident representatives to care plan meetings on a regular basis. She stated that she was informed yesterday, 3/18/26, that she should be scheduling care plan meetings with residents and/or resident representatives based off the MDS calendar that was provided to her monthly by the MDS Coordinator. She indicated that she should be scheduling the care plan meeting, completing the care plan invitation, delivering to residents if applicable and providing the completed invitation to the receptionist to be mailed to the resident representative. The SW confirmed she had not been completing quarterly or annual care plan meetings with residents and/or resident representatives. An interview was conducted with the Administrator on 3/19/26 at 1:57 PM who stated she was unaware of residents and/or resident representatives not being invited to care plan meetings, and she would expect them to have the opportunity to be involved in person or by phone. 2. Resident #13 was admitted to the facility on [DATE] with diagnoses of dementia with psychotic disturbance, postˆtraumatic stress disorder (PTSD), abnormal weight loss, failure to thrive, and anemia. Minimum Data Set (MDS) assessments were completed for Resident #13 on the following dates: 2/11/25 – Quarterly 5/13/25 – Quarterly 8/11/25 – Comprehensive 11/11/25 – Quarterly 1/7/26 – Quarterly (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had severe cognitive impairment. Review of care plan conference invitation letters provided by the Social Worker (SW) showed Resident #13's Representative had been mailed one invitation letter. The letter was dated 11/7/25 and invited the Resident Representative to a quarterly care conference with the facility's Interdisciplinary Team (IDT) to review Resident #13's care plan. The meeting was scheduled to be held in person on 11/17/25 at 1:00 PM. Review of Resident #13's medical record revealed a care plan conference was held on 11/17/25 that included the Resident Representative. There were no other care plan conferences documented in the medical record. During an interview on 3/18/26 at 12:29 PM Resident #13's Representative stated they had only been notified of and invited to attend one care plan conference since Resident #13's admission. The Representative confirmed the meeting they attended occurred in November 2025 and stated they were unaware that routine care plan conferences should have occurred. During an interview on 3/18/26 at 1:30 PM the SW stated she had only been sending invitations and holding care meetings for the 72ˆhour postˆadmission residents or for residents or families who expressed concerns. She stated she was unaware she should have been inviting all residents and/or resident representatives to care plan meetings on a routine basis. The SW reported that she was informed today that she should have been scheduling care plan meetings based on the MDS calendar. The SW confirmed she had not completed quarterly or annual care plan meetings with all residents and/or resident representatives because she was not aware it was her responsibility. She stated the previous SW who trained her did not inform her of that. During an interview on 3/19/26 at 1:22 PM the Administrator stated that she had been made aware that annual and quarterly care plan meetings had not been completed for all residents, and residents and/or resident representatives were not invited to attend care planning meetings. The Administrator stated it was her expectation that the plan of care for all residents be reviewed quarterly and as needed with the resident and/or resident representative.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with the Medical Director and staff, the facility failed to administer scheduled medications as ordered by the physician for 1 of 6 residents reviewed for medication administration (Resident #12).The findings included:Resident #12 was admitted to the facility on [DATE] with diagnoses that included hypertension and constipation.A review of Resident #12's active physician orders for March 2026 revealed the following:An order dated 2/17/26 for Metoprolol Tartrate 25 mg. Give one tablet via G-tube two times a day for hypertension. Hold for heart rate less than 65 or systolic blood pressure less than 100.An order dated 2/17/26 for MiraLax 17 gm/scoop (grams per scoop) via G-tube two times a day for constipation.A review of the March 2026 Medication Administration Record (MAR) for Resident #12 revealed the following:Metoprolol Tartrate 25 mg was scheduled for 9:00 AM. Nurse #2 administered the medication at 12:07 PM on 3/16/26.MiraLax 17 gm/scoop was scheduled for 9:00 AM. Nurse #2 administered the medication at 12:07 PM on 3/16/26.An interview with Nurse #2 on 3/16/26 at 3:10 PM revealed he was an agency nurse who worked at the facility intermittently. Nurse #2 stated he fell behind on morning medication administration on 3/16/26 and did not administer Resident #12's scheduled morning medications until 12:00 PM. He reported he did not request assistance to ensure medications were given on time.The Director of Nursing was interviewed on 3/19/26 at 10:29 AM and stated Resident #12's medications were required to be administered on time. The DON reported Nurse #2 was an agency nurse and that agency staff had been instructed to request assistance if they fell behind with medication administration. The DON stated she did not know why Nurse #2 did not request assistance the morning of 3/16/26 as the medications should have been given one hour before or one hour after their scheduled time to remain in an acceptable timeframe. On 3/19/26 at 1:00 PM, the Medical Director was interviewed. He reviewed Resident #12's medical record and confirmed she experienced no ill effects related to the late administration of her medications on 3/16/26. He stated Resident #12's blood pressure and pulse remained within normal limits and she appeared clinically unaffected. The Medical Director acknowledged the facility's requirement that medications be administered within one hour before or after the scheduled time and stated he expected staff to follow this policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to provide nail care for 1 of 2 dependent residents reviewed for activities of daily living (ADL) (Resident #6). The findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses including contracture of unspecified joint (left hand) and reduced mobility.A care plan revised on 1/2/25 indicated Resident #6 had an ADL self-care performance deficit with a goal that read Resident #6 would maintain her current level of function. According to the care plan, the resident was dependent on the assistance of one staff with personal hygiene.The significant change Minimum Data Set (MDS) assessment completed 2/14/26 documented Resident #6 as cognitively intact, without rejection of care behavior, and dependent on others for personal hygiene.Review of the bath skin review sheets for Resident #6 for the dates of 3/10/26, 3/14/26, and 3/17/26 revealed only toenail condition was listed.Resident #6 was observed on 3/16/26 at 9:58 AM. The free edge of Resident #6's fingernails on both hands were either jagged or broken, extended past her fingertips by what appeared to be more than 1/4 inch, or about the width of a pencil eraser, and had a brown substance underneath the free edge of the nail. The fingers on the left hand were noted to be curled inward towards the palm. No wounds were observed in the palm of Resident #6's left hand when she uncurled the fingers with the use of her right hand. A subsequent observation of Resident #6's fingernails on 3/17/26 at 11:37 AM revealed them to be unchanged, and in the same condition as the observation from 3/16/26 at 9:58 AM.An interview conducted with Resident #6 on 3/16/26 at 9:58 AM indicated her preference was to keep her fingernails short, especially on the left hand since it was contracted. The resident stated long fingernails often stabbed into the palm of her left hand and caused her discomfort. Resident #6 stated Nurse Assistants (NA) would sometimes clean underneath her nails, but no one had offered to cut them.NA #4 could not be reached by phone for an interview after multiple attempts.A follow-up interview with Resident #6 on 3/17/26 at 11:37 AM revealed she had received a bath that morning, but the NA did not clean her fingernails.Nursing Assistant (NA) #1, who was assigned to Resident #6 on 3/17/26 for the 7:00 AM to 7:00 PM shift, was interviewed on 3/17/26 at 1:18 PM. NA #1 reported she would typically check the resident's nails every time she bathed someone. However, NA #1 stated she had given Resident #6 a bed bath earlier that morning, but she did not provide nail care or ask the resident if she wanted nail care completed. She did not explain why she failed to provide nail care, but NA #1 indicated she would go back and ask Resident #6 if she wanted nail care completed. An interview was conducted with Nurse #1 on 3/17/26 at 1:47 PM who stated it was ultimately the assigned nurse's responsibility to ensure nail care was provided to all residents on their assignment. Nurse #1 stated the nurses were supposed to complete a nail review during the resident's weekly skin assessment. Nurse #1 indicated she was unsure when Resident #6 was due for a weekly skin assessment.A review of the weekly skin assessments in Resident #6's electronic medical record did not contain documentation regarding the resident's fingernails for the last documented assessment dated [DATE].The Director of Nursing (DON) was interviewed on 3/19/26 at 11:45 AM, and stated she expected the NAs to provide nail care for the residents on the days they received their bath or shower. However, she explained she had also designated an NA to complete nail inspections weekly on all residents and made a list of those who needed nail care. According to the DON, the nurses would provide nail care for the residents or nail care would be completed as an activity for the residents by the Activities Director. The DON stated she was unsure how Resident #6's nail care was missed last week, but she would ensure the resident's fingernails were addressed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to clean and dry the syringe used to administer medications and water flushes through a gastrostomy tube/G-tube (a tube that delivers liquid nutrition and medications directly to the stomach) before storing it in a dry plastic bag for 1 of 2 residents reviewed for G-tube feeding management (Resident #12). This deficient practice had the potential to cause bacterial growth and contamination.Findings included:Resident #12 was admitted to the facility on [DATE] with diagnoses that included unspecified dysphagia (difficulty swallowing), gastrostomy status, and aphasia (communication impairment) following a cerebral infarction (stroke).An admission Minimum Data Set assessment dated [DATE] indicated Resident #12 was moderately cognitively impaired and received 51% of more of her total calories from enteral feedings. A review of the active orders revealed Resident #12 had an order for a tube feeding formula to be provided at 72/ml/hr. (milliliters/per hour) continuous over 20 hours with water flushes of 110 ml/hr. every 4 hours during feeds.A review of the electronic Medication Administration Record (MAR) dated March 2026 indicated Nurse #1 had administered medication to Resident #12 via the gastrostomy tube (G-tube) at 7:37 AM the morning of 3/17/26.On 3/17/26 at 10:23 AM, an observation revealed Resident #12's G-tube flush syringe stored in a plastic bag hanging from the feeding pump pole and was dated 3/17/26 and 0000, which indicated it had been changed at midnight. The syringe was separated from the plunger. However, the elongated syringe tip contained thick, crusted yellow material, and the lower third of the syringe barrel was coated with the same yellow substance. The plastic bag storing the syringe contained water droplets throughout with pooling at the bottom.An interview with Nurse #1 on 3/17/26 at 1:47 PM revealed she observed Resident #12's tubeˆfeeding syringe was discolored when she administered medications and water flushes earlier that morning. Nurse #1 stated some medications could stain the syringes, but she would need to verify which medications could cause discoloration. Nurse #1 reported rinsing the syringe with water after use but stated she had no supplies to scrub it. Nurse #1 indicated she separated the syringe and plunger and placed them in the storage bag after rinsing. Nurse #1 stated she knew the syringe should be stored with the plunger removed but was not aware the syringe and plunger should be allowed to air dry before being placed into a clean, dry bag.An interview was conducted with the Director of Nursing on 3/19/26 at 1:00 PM who revealed Resident #12's G-tube syringe should have been washed and the plunger removed from the syringe to allow it to dry before placing it back into a dry bag to prevent any bacterial growth. However, she explained the observed stained syringe should have been discarded and replaced with a new one. According to the DON, all G-tube syringes were routinely replaced every night shift.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and the Medical Director, the facility failed to prevent a significant medication error when Nurse #2 did not administer scheduled medication as ordered. Resident #12 was prescribed scheduled anti-seizure medications to be administered every morning at 8:00 AM and 9:00 AM and Nurse #2 administered the medications 3 and 4 hours late. This deficient practice had the potential to increase seizure activity and affected 1 of 1 resident reviewed for significant medication error (Resident #12).The findings included:Resident #12 was admitted to the facility on [DATE] with diagnoses that included intractable epilepsy (a seizure disorder that is difficult to manage or treatment-resistant), without status epilepticus (a seizure lasting 5 minutes or multiple seizures occurring close together without the person regaining consciousness in between). An admission Minimum Data Set assessment dated [DATE] indicated Resident #12 had moderately impaired cognition and was coded as receiving anti-seizure medication. Review of Resident #12's revised care plan dated 2/24/26 revealed a focus for anti-seizure medications related to epilepsy with an intervention to give the medication as ordered by the doctor. Review of the active Physician orders for March 2026 revealed the following orders:An order dated 2/17/26 for Lacosamide 150 milligrams (mg). Give one tablet via G-tube (gastrostomy tube) two times a day for seizures.An order dated 2/17/26 for Levetiracetam 1000 mg. Give one tablet via G-tube every morning and at bedtime for seizures.An order dated 2/20/26 for Phenytoin Sodium Extended 100 mg. Give one capsule via G-tube two times a day for seizures.Review of Resident #12's March 2026 Medication Administration Record (MAR) revealed Phenytoin Sodium Extended 200 mg was scheduled to be given at 8:00 AM, Lacosamide 150 mg was scheduled to be given at 9:00 AM and 5:00 PM, and Levetiracetam 1000 mg was scheduled to be given at 9:00 AM and 9:00 PM. The March 2026 MAR documented that Resident #12 did not receive these medications from Nurse #2, as scheduled at 8:00 AM and 9:00 AM until 12:07 PM on 3/16/26.An interview with Nurse #2 on 3/16/26 at 3:10 PM, revealed he was an agency nurse who worked at the facility intermittently. Nurse #2 stated he fell behind on morning medication administration on 3/16/26 and did not administer Resident #12's scheduled morning medications until 12:00 PM. He reported he did not request assistance to ensure medications were given on time.The Director of Nursing (DON) was interviewed on 3/19/26 at 10:29 AM and stated Resident #12's seizure medications were required to be administered on time. The DON reported Nurse #2 was an agency nurse and that agency staff had been instructed to request assistance if they fell behind with medication administration. According to the DON, she was unaware Resident #12 received her morning medications outside the acceptable timeframe. The DON stated she did not know why Nurse #2 did not request assistance the morning of 3/16/26 as the medications should have been given one hour before or one hour after to remain in an acceptable timeframe.On 3/19/26 at 1:00 PM, the Medical Director was interviewed. He reviewed Resident #12's medical record and confirmed the resident did not appear to have suffered any ill effects due to the late administration of her anti-seizure medications on 3/16/26, however it could have increased her risk for seizure activity due to her diagnosis of intractable seizures. The Medical Director stated the resident's blood pressure and pulse remained within normal limits, no seizure activity was documented, and Resident #12 appeared clinically unaffected. The Medical Director acknowledged the facility's requirement that medications should be administered within one hour before or after the scheduled time and stated he expected staff to follow this policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interviews with staff and the Nurse Practitioner, the facility failed to follow its infection control policies and procedures for hand hygiene when the Assistant Director of Nursing failed to change gloves and perform hand hygiene during wound care for Resident #12 and Resident #4. The deficient practice occurred for 1 of 4 staff observed for infection control practices (Assistant Director of Nursing). The findings included:The facility's undated policy titled Infection Control Guidelines for All Nursing Procedures states that alcohol^based hand rub (60-95% ethanol or isopropanol) is the preferred method of hand hygiene when hands are not visibly soiled. The policy requires hand hygiene before donning gloves, before handling clean or soiled dressings or gauze, after handling used dressings or contaminated equipment, and after removing gloves. The facility's enhanced barrier precautions protocol states staff are to wear gloves and a gown with high-contact resident activities such as wound care and to perform hand hygiene before and after leaving the resident's room.a.) On 3/18/26 at 1:24 PM, the Assistant Director of Nursing (ADON) was observed performing wound care for Resident #12, who was under enhanced barrier precautions for wounds and an indwelling urinary catheter. The ADON donned a gown and gloves before entering the room and placed a clean towel on the bedside table as a barrier. She placed clean dressing supplies on the towel.The ADON removed the soiled dressing from the resident's right foot and placed the soiled dressing on the clean barrier next to unused supplies. The ADON did not remove gloves or perform hand hygiene before cleaning the right foot wound. Without performing hand hygiene or changing gloves, she opened a collagen package, tore off collagen, applied it to the wound, and applied a bordered dressing to Resident #12's foot.Without removing gloves or performing hand hygiene, the ADON removed the soiled sacral dressing and placed it on the bedside table barrier, cleaned the sacral wound, opened collagen, tore off a piece, and applied collagen and a bordered dressing.After completing both wound treatments, the ADON removed her gown and gloves, washed hands, exited the room, and placed unused supplies taken into the resident's room onto a paper towel on the treatment cart.b.) On 3/18/26 at 1:54 PM, an observation of the Assistant Director of Nursing (ADON) performing wound care for Resident #4 was conducted. Resident #4 had orders for enhanced barrier precautions due to the presence of a wound.The ADON donned a clean gown and gloves without performing hand hygiene before entering Resident #4's room. She placed a clean towel on the bedside table as a barrier and placed clean wound care supplies on top of the towel. The ADON repositioned the resident onto her left side and removed the soiled sacral dressing, leaving the dressing on the bed. She cleaned the sacral wound and placed the used gauze on the towel next to the clean supplies.Without removing gloves or performing hand hygiene, the ADON opened a collagen with silver packet, tore a piece, and placed it into the wound bed. She then applied a silicone^bordered dressing. The ADON removed her gloves without performing hand hygiene, exited the resident's room while still wearing the gown, and retrieved tape from the top of the wound cart in the hallway. She reentered the room, did not perform hand hygiene, and don clean gloves.The ADON then removed the soiled dressing from Resident #4's right foot and left the dressing on the bed. She wrapped the resident's foot with a dry dressing without removing gloves or performing hand hygiene between handling soiled items and applying clean dressings.After completing the wound care, the ADON discarded the used dressings and towel, removed her gown and gloves, and washed her hands. She removed unused wound care supplies from the resident's room and placed them on a paper towel on top of the wound care cart.An interview was conducted with the ADON on 3/18/26 at 2:05 PM. She reported she had only worked for the facility for two days and had not previously performed wound care there. The ADON stated she should have performed hand hygiene prior to donning gloves, removed gloves and performed hand hygiene after removing soiled dressings, then donned clean gloves before applying clean dressings. She acknowledged she should not have worn the same gloves throughout the procedure or used the same gloves from one wound to another. The ADON further (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Pinehurst Rehabilitation & Living Ce	205 Rattlesnake Trail Pinehurst, NC 28374

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she should have discarded soiled dressings in the trash and should not have placed soiled dressings on the clean barrier next to clean supplies. The ADON also stated she should not have removed unopened supplies from residents' bedside tables or placed them on the wound care cart. She then discarded the unused supplies in the trash and cleaned the top of the wound care cart with disinfecting wipes.On 3/19/26 at 10:29 AM, the Director of Nursing (DON) was interviewed and stated she expected the ADON to follow the facility's infection control policies, including hand hygiene and enhanced barrier precautions. The DON reported the ADON should have performed hand hygiene before wound care, between glove changes, and after completing wound care when removing her gown and gloves. The DON stated the ADON should not have entered the hallway wearing a gown or gloves and indicated the ADON required additional infection control education.The Wound Care Nurse Practitioner (NP) was interviewed on 3/19/26 at 11:13 AM and stated he could not speak to events that occurred when he was not present. He reported he would expect the facility to follow evidenceˆbased practice for enhanced barrier precautions and adhere to infection control policies.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review, observations, and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff scheduled for licensed and unlicensed nursing staff for 7 out of 30 days reviewed (2/16/26, 2/22/26, 2/23/26, 2/25/26, 3/1/26, 3/8/26 and 3/15/26). The facility also failed to post the daily nurse staffing sheet for 1 out of 5 days observed (3/16/26). The findings included: 1. A review of the facility's daily posting for nursing staff for the past 30 days (2/16/26 to 3/16/26) as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 2/16/26 indicated that 9 Nurse Aides (NAs) worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/16/26 documented that 7 NAs worked from 7:00 AM to 3:00 PM. b. The nursing schedule for 2/22/26 indicated that 8 NAs worked from 7:00 AM to 3:00 PM and 7 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/22/26 documented that 7 NAs worked 7:00 AM to 3:00 PM and 8 NAs worked 11:00 PM to 7:00 AM. c. The nursing schedule for 2/23/26 indicated that 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/23/26 documented that 5 NAs worked from 11:00 PM to 7:00 AM. d. The nursing schedule for 2/25/26 indicated that 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/25/26 documented that 7 NAs worked from 11:00 PM to 7:00 AM. e. The nursing schedule for 3/1/26 indicated that 7 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/1/26 documented that 5 NAs worked from 11:00 PM to 7:00 AM. f. The nursing schedule for 3/8/26 indicated that 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 3/8/26 documented that 7 NAs worked from 11:00 PM to 7:00 AM. g. The nursing schedule for 3/15/26 indicated that 1 Registered Nurse (RN) and 3 Licensed Practical Nurses (LPNs) worked from 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 3/15/26 documented that no RN and 4 LPNs worked from 7:00 AM to 7:00 PM. On 3/19/26 at 8:20 AM, an interview occurred with the Staff Scheduler who stated she managed the staffing schedule and daily postings. She was able to review the staffing schedules and daily postings and verified the number of staff working on 2/16/26, 2/22/26, 2/23/26, 2/25/26, 3/1/26, 3/8/26 and 3/15/26 did not match. She stated she failed to update the daily posted nurse staffing sheet when a staff member either called out, was a no-show for work or when a staff member came in to cover a need. The staff scheduler explained that on 3/15/26 she forgot to count the RN that worked on the 7:00 AM to 7:00 PM shift and mistakenly counted her as an LPN. The Administrator was interviewed on 3/19/26 at 11:30 AM and stated that the daily posted nurse staffing sheet and the nursing schedule should match the number of staff worked on any given shift. 2.) During the initial tour of the facility on 3/16/26 at 8:45 AM and a subsequent observation on (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	3/16/26 at 1:13 PM, the posting of the daily staffing data, located inside a clear plastic stand in the foyer of the reception area, was dated 3/13/26. An interview was conducted with the Scheduler on 3/17/26 at 10:29 AM who stated during the weekdays it was either her responsibility, or the Director of Nursing (DON) would help at times, to post the daily staffing sheets. She indicated she thought the DON had posted the daily staffing sheet the morning of 3/16/26. The Director of Nursing was interviewed on 3/19/26 at 10:29 AM who stated the Scheduler was responsible for posting daily staffing sheets Monday through Friday, and the Receptionists were responsible for posting them on the weekends. However, the DON indicated she had posted the staffing sheet herself Monday morning, 3/16/26, shortly after entering the facility at 6:00 AM. The DON stated she was not sure why the daily staffing sheet was not present when the State entered the building except maybe someone had pulled the sheets for review. She explained the daily staffing sheet should have been posted for 3/16/26. The Administrator was interviewed on 3/19/26 at 1:49 PM who stated the DON told her she had posted the daily staffing sheet on 3/16/26. According to the Administrator, it was possible someone removed the staffing sheet from the folder to review and failed to put it back.