STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinehurst Healthcare & Rehabilitation Center	300 Blake Boulevard 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, Nurse Practitioner (NP), and staff interviews, the facility failed to speak to a resident in a dignified manner causing the resident to feel shocked, angry, hurt and embarrassed for 1 of 1 resident reviewed for dignity (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE]. A review of the nursing progress notes dated 2/3/26 at 1:52 PM revealed a note written by Nurse #9 that read: When the resident was asked about taking his morning medications Nurse #9 bumped his bed several times to wake him up and offer his morning medication along with getting his blood sugar reading. The Resident had covers pulled over his head and refused to respond. He was asked several times before breakfast. When the reporting nurse came in again at lunch time, looked behind the privacy curtain and resident was in the same spot. He did allow his blood sugar reading to be done by another staff member. Resident requested his medication that was pulled and when approached resident in his room at bedside he stated, oh so you brought me my medications huh? Reporting nurse I came in several times and called your name and bumped your bed to wake up and you haven't/wouldn't respond. Resident stated, You are a lying bit*h, you haven't brought me sh*t Again, reporting nurse was holding the cup of medications to offer them to him but stated to the resident, If I try to wake you up and you decide not to respond then I can't do anything but go on. Resident stated, naw bit*h that's your job to wake me up. Reporting nurse, Considering you have to choose to be noncompliant and continue to refuse your medications all I can do is try and wait, but I will not leave medications in your room at bedside. Resident then stated (something to this effect), bit*h get out my room and take them da*n meds with you, you lying bit*h, you did try to wake me up. Reporting nurse was already at door and walked out and showed unit manager cup of medications and explained to her what happened. Review of the quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #1 as cognitively intact. Resident #1 was coded as displaying verbal behavioral symptoms towards others between 1 to 3 days during the look back period.An interview was conducted with Resident #1 on 4/27/26 at 9:58 AM who stated back in February 2026 Nurse #9 argued with him about whether she had given him his morning medications before ultimately calling him a crippled motherf****r before walking out of his room and slamming the door. In a follow-up interview with Resident #1 on 4/29/26 at 10:42 AM, the resident stated he was shocked at first then became angry and hurt when Nurse #9 called him that. Resident #1 stated it hurt his feelings because he is completely dependent on others for his care, and it embarrassed the resident to be called crippled because other people were in the room and heard her say those words. Resident #1 stated Nurse #9 told him she was going to feed him the same energy he fed her you crippled motherf****r.On 4/28/26 at 5:20 PM a phone interview was conducted with Nurse #9 who stated she recalled the exchange she had with Resident #1 although she was unsure of the date. According to Nurse #9 she had never been cussed out so bad by a resident before, and it caused her to become so enraged that she could neither confirm nor deny that she called him a derogatory term.A phone interview was conducted with Nurse Aide (NA) #1 on 4/28/26 at 5:28 PM who stated she remembered the incident between Resident #1 and Nurse #9 well. NA #1 affirmed she was assisting Resident #1 to get ready (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for an appointment when Nurse #9 walked into the resident's room. According to NA #1, Resident #1 was upset because he had not received his morning medications and was calling Nurse #9 every name in the book. NA #1 stated Nurse #9 was trying to be professional and asked the resident to stop cursing at her when Resident #1 called her a really derogatory name. NA #1 stated Nurse #9 informed Resident #1 she was about to give him the same energy he was giving her and then called the resident a crippled motherf****r and walked out. NA #1 stated she was in shock about what had happened and went to the Director of Nursing to report the exchange as soon as she helped Resident #1 get dressed.On 4/29/26 at 10:55 AM the Nurse Practitioner (NP) was interviewed and stated he spoke with Resident #1 the day of the incident with Nurse #9, and the resident told him the phrase she used (he could not recall the exact words) against him. The NP indicated he thought Resident #1 might have been saying things out of anger or frustration, but he reported what Resident #1 told him to the Director of Nursing after the conversation was complete. According to the NP, the Director of Nursing later told him she had investigated the incident and what Resident #1 reported was true.The Director of Nursing (DON) was interviewed on 4/30/26 at 10:34 AM and stated back in February 2026 NA #1 reported she felt Nurse #9 spoke badly to Resident #1. According to the DON, NA #1 informed her Nurse #9 was calm and polite to Resident #1 when she told him she had tried to give his morning medications earlier that day but Resident #1 accused Nurse #9 of lying to him. The DON stated NA #1 further stated Nurse #9 told Resident #1 that he would not like it if she was giving him the same energy he was giving her and proceeded to call him a crippled motherf****r. The DON explained she was unable to speak with Resident #1 immediately because he had already left for an appointment. However, when Resident #1 returned from his appointment the DON interviewed him. According to the DON, Resident #1 informed her Nurse #9 could call him a motherf****r, but she could not call him crippled, and that he was mad. The DON stated she then called Nurse #9 to the office and the nurse informed her she had her back to Resident #1 and did not think he could hear her, but Nurse #9 admitted to calling Resident #1 a crippled motherf****r. The DON indicated she then walked Nurse #9 out of the building. The facility submitted a plan of correction that was reviewed but did not meet the standard for past non-compliance due to not focusing on dignity or including monitoring of the residents in section 4 of the plan of correction.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to maintain a safe environment as evidenced by a housekeeping staff member mopping the entire width of the lower 300 hallway (Rooms 304 through 312) which would have required residents, staff, and visitors to walk on a wet floor. This deficient practice occurred on 1 out of 5 resident hallways.Findings included:A continuous observation was conducted on 4/29/26 from 2:47 PM to 2:51 PM of Housekeeper #1 mopping the entire length and width of the floor at the lower end of the 300 hallway. The total area mopped was approximately 4-foot x 10-foot, and the floor was completely wet across the hall. There was a wet floor sign located at the end of the hallway near room [ROOM NUMBER].An interview was conducted with Housekeeper #1 on 4/29/26 at 2:51 PM who stated she usually mopped across the entire floor then followed up with a dry mop to go back over the area. She explained she understood about safety and had placed a wet floor sign at the end of the hallway to warn residents, staff, and guests to be careful when they walked across the floor. Housekeeper #1 remarked she should have left a dry area for others to walk on for safety. On 4/29/26 at 3:01 PM the Director of Housekeeping was interviewed and stated Housekeeper #1 should have only mopped one side of the floor on the 300 hallway to leave a dry area for residents, staff, and visitors to walk on. He stated a wet floor cautionary sign should have been placed at the end of the wet floor area to warn others to use the other side of the hallway. The Director of Housekeeping further stated mopping was not normally the responsibility of the housekeepers unless there was a spill that needed attention. According to the Director of Housekeeping, the facility has floor technicians who clean the floors every day, and if Housekeeper #1 saw the entire floor needed to be cleaned, she should have reached out to the floor technician.On 4/30/26 at 9:39 AM Floor Technician #1 was interviewed and stated he used a floor cleaning machine to clean all the hallways every morning. He explained the machine was equipped with scrubbers that clean the floor as well as a vacuum and squeegee to dry the floor immediately after. Floor Technician #1 indicated he cleaned one half of the floor at a time and left half of the floor dry for others to walk on. Then he repeated the process on the other half of the hall once the first half was dry. Floor Technician #1 stated the only time housekeeping would need to mop the hall was if there was a minor spill or stickiness on the floor. He stated the floor technician team would clean up any major spill.The Director of Nursing was interviewed on 4/30/26 at 10:50 AM and specified Housekeeper #1 should have left a dry clear path for residents, staff, and visitors to walk on, and she should have only mopped one half of the hallway floor at a time.