STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE RIDGE HEALTH AND REHABILITATION CENTER	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)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Nurse Practitioner, and physician interviews, the facility failed to notify the physician a resident's oxygen saturation remained low after oxygen was administered per physician's orders [REDACTED].#1). Findings Included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident's #1's admission Minimum Data Set ((MDS) dated [DATE] specified the resident's cognition was severely impaired and the resident was not coded for receiving oxygen therapy. Review of Resident #1's medication record revealed he received [MEDICATION NAME], 40 milligrams (mg), a diuretic, once a day, [MEDICATION NAME] 20 mg once a day and [MEDICATION NAME] 3.125mg, a medication for heart failure, twice a day. Review of Resident #1's medical record revealed. Nurse #1 completed a change in condition on 8/4/20 at 5:00 AM due to the resident having crackles to upper left lobe, moist cough, fever, and O2 levels on room air at 89%. Nurse #1 called the Nurse Practitioner (NP) who ordered O2 at 2 liters per minute (LPM) via nasal cannula, [MEDICATION NAME] 1 gm intramuscular (IM), a chest x-ray (and to report findings), and to push fluids. A review of the Resident #1's vital signs on the following dates revealed: 7/27/20 oxygen saturation levels to be at 94% on room air. 8/3/2020 oxygen saturation levels to be at 96% at 3:42 AM on room air, 96% at 9:40 AM on room air. 8/4/2020 oxygen saturation was at 94% at 5:54 AM, on 2 liters oxygen via nasal cannula, 80% at 8:15 AM on oxygen via nasal cannula, 80% at 11:24 AM on room air, 80% at 12:12 PM on oxygen via nasal cannula and 82% at 1:06 PM on oxygen via nasal cannula. A progress note written on 8/4/2020 at 12:03 PM by Nurse #1 indicated Resident #1 was noted with a loose non-productive cough, O2 saturation levels were between 80% and 85% at 3 LPM via nasal cannula. Resident was eating about 25% of his meals and the x-ray report was pending. A respiratory care evaluation was completed on 8/4/2020 at 1:06 PM which revealed Resident #1's O2 levels were at 82%. The evaluation revealed the resident had abnormal lung sounds in the upper left lobe but did not indicate on the form the type of abnormal sounds. The resident had a non-productive cough. The Physician respiratory care treatment orders were not completed. The X-ray report dated 8/4/2020 at 4:15 PM for Resident #1 revealed the following impressions: Mild [MEDICAL CONDITION], Bilateral infiltrates (Pneumonia), right greater than left, no [MEDICAL CONDITION] is noted. A second progress note written on 8/4/2020 at 6:21 PM by Nurse #1 revealed the chest x-ray was faxed to the NP and an order was received to transfer Resident #1 to the emergency room (ER) for evaluation was obtained. EMS picked up Resident #1 up around 4:50 PM. A review of the hospital records dated 8/4/2020 revealed Resident #1was admitted to the emergency roiagnom on [DATE] with a history of stroke, a previous [MEDICAL CONDITION] with reduced ejection fraction of 25-30%, meaning the heart muscle does not contract effectively and therefore less blood is pumped out to the body. Resident #1 was found to have COVID-19 infection with some component of heart failure exacerbation contributing to his [MEDICAL CONDITION]. During the hospital course from 8/4/20 through 8/11/20 Resident #1 worsened on 8/10/20 requiring a bi-level positive airway pressure ([MEDICAL CONDITION]). His progress was poor and after discussion with the family he was made comfort care measures only and passed on 8/11/20 at 6:35 AM. A telephone interview was conducted on 8/13/2020 at 6:15 PM with Nurse #1 who worked 7:00 AM to 7:00 PM on 8/4/2020. He stated he took Resident #1's vitals around 8:00 AM. He then raised the residents head to make sure he could breathe better and started him on 2 liters of O2 per facility standing order. Nurse #1 stated the resident was breathing normally and his O2 stats were at 86 %. The Nurse stated he was keeping track on a piece of paper so he could have a record of the residents O2 levels to report to the NP but stated he was to wait for the chest x-ray to come back before contacting her. Nurse #1 stated once he got the results, he contacted the NP because Resident #1 was not holding his O2 levels and he was sent to the emergency room (ER) at approximately 4:45 PM. Nurse #1 stated in hindsight he may have called the NP earlier, but the resident was alert, and talking, he was not gasping for air and was not in any distress. Although Nurse #1 stated the residents O2 levels had improved to 86%, there was no nursing documentation on 8/4/2020 in the record. A telephone interview was conducted on 8/13/2020 at 12:35 PM with the RN supervisor. She worked the 3-11 PM shift on 8/4/2020. She stated when she had arrived at 3:00 PM she reviewed the reports for every hall and read Resident #1 had an intramuscular medication given and had a chest X-ray. She stated she did not check the O2 stats for that resident as she had been told by Nurse #1 the resident's O2 levels were going up. The RN supervisor stated that you did not have to wait for the results of the X-ray to come back before calling the physician with other issues such as low O2 sats and she would have called the physician, even at 8:00 AM after the O2 sats didn't come up to let them know the O2 was not bringing up the O2 sat for the resident. A telephone interview was conducted on 8/13/2020 at 2:02 PM with the Medical Director. The Medical director stated on 8/4/2020 the facility would have called his Nurse Practitioner. Resident #1's O2 stats were reviewed for 8/4/2020 with the Medical Director who stated that given his O2 stats alone he should have been sent out sometime that morning, especially that his levels did not come up over the course of the day. He stated he would have thought staff would have notified them sooner and he would have been sent out before noon. A telephone interview was conducted on 8/13/2020 at 5:02 PM with the Nursing Assistant #1(NA) who worked on 8/4/2020 from 7:00 AM to 3:00 PM on the 300 halls. NA #1 stated that the NAs do not take the vitals only the temperatures for the residents and remembered the Resident #1's temperature was approximately 98 degrees. She stated Nurse #1 had told her to push fluids for the resident. NA #1 reported the resident was lying flat on his bed but had his head raised approximately 45 degrees and every time she went in the room; he did have his O2 on. An interview was conducted on 8/14/2020 at 1:47 PM with the NP. She stated that she had received two phone calls for the resident on 8/4/2020. The first call was at 5:20 AM that his O2 was desaturating and she ordered O2, [MEDICATION NAME] IM, push fluids and a chest X-ray. The NP had received a second phone call on 8/4/2020 at approximately 4:45 PM requesting an order to transfer resident #1 to the ER for an evaluation due to his O2 levels being in the 80's. An interview was conducted on 8/14/2020 at 2:10 PM with the Director of Nursing (DON) who stated she had gotten a report on Resident #1 around 10:00 to 10:30 AM on August 4, 2020 that he may have pneumonia, a chest x-ray was ordered, [MEDICATION NAME] 1 gr, he was on O2 and was dehydrated. She stated when she looked at the notes documented for the resident a change in condition was completed and the NP was called around 5:00AM and to follow up with the NP when the x-ray report was back. The DON stated that she would not have waited for the x-ray report to come back and would have called the NP to let them know the residents' O2 levels were still at 80% and would have obtained additional orders. A follow up call with the NP on 8/14/2020 at 2:54 pm who stated given all the residents underlying diagnosis, NP did not think the outcome would have been different for the resident. The NP did state that given Resident #1's O2 status being in the 80's, she would have thought staff would have called sooner to either send him out the emergency room or to decide with the family to provide comfort care.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and facility guidelines, the facility failed to use hand hygiene after touching their

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE RIDGE HEALTH AND REHABILITATION CENTER	**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)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) face mask and during meal tray delivery in 4 of 4 residents rooms observed for infection control during a COVID 19 pandemic (Resident Rooms 106, 104,108 112). Findings included: A review of the facility's guidelines titled Personal Protective Equipment dated March 18, 2020 read in part staff must take care not to touch their facemask. If they touch their facemask, they must immediately perform hand hygiene. Review of the facility's long term care infection control facility self-assessment tool read in part personnel perform hand hygiene before contact with a resident, after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces, after contact with objects and surfaces in the resident environment. An observation on August 11, 2020 at 12:45 PM of a nursing assistant #1 (NA) walking in the 100-unit hallway had touched the outside of her face mask, walked to the meal delivery cart and picked up a lunch tray and delivered the tray to room [ROOM NUMBER]. NA #1 set up the lunch tray touching the silverware, straw and cup. She did not perform hand hygiene after touching her mask, nor while entering or when she exited room [ROOM NUMBER]. NA #1 then picked up another lunch tray and delivered and set up the lunch tray to room [ROOM NUMBER] and did not perform hand hygiene before going into room [ROOM NUMBER]. The NA did perform hand hygiene after exiting room [ROOM NUMBER]. NA #1 touched the outside of her mask again, did not perform hand hygiene and picked up a meal tray and delivered to room [ROOM NUMBER]. NA #1 did not perform hand hygiene while entering or exiting room [ROOM NUMBER]. NA #1 picked up a meal tray and delivered the tray to room [ROOM NUMBER]. NA #1 did not perform hand hygiene before entering the room but did wash her hands at the sink in resident's room before exiting. On August 11.2020 at 2:50 PM an interview was conducted with the NA who stated, I possibly did forget to wash my hands, I consider the residents like family and sometimes get sidetracked, I am human, I apologize. On August 11, 2020 at 5:45 PM an interview was conducted with the Director of Nursing (DON) who stated that staff should be handwashing prior to and after resident care, this includes setting up trays. The DON stated we have had several in-services with staff regarding hand hygiene most recently on August 7, 2020 which covered hand hygiene and K-95 masks On August 11, 2020 at 5:50 PM an interview was conducted with the Administrator who voiced when staff enter a resident's room they should gel in and gel out. When you come out wash your hands again. Anytime you touch your mask you should be sanitizing and washing your hands.