STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide evidence that an prescribed antipsychotic injection (Risperdal) was administered every 2 weeks as ordered for 1 of 7 residents (Resident #3) reviewed for medication administration. Findings included: Resident #3 was admitted 7/18/11 with cumulative diagnoses of schizophrenia, bipolar disorder and end stage renal disease. The quarterly Minimum Data Set dated 5/29/15 indicated Resident #3 was cognitively intact with verbal behaviors and required extensive assistance with her activities of daily living. Resident #3 was care planned for her diagnoses of schizophrenia with the intervention for facility to administer the medications as ordered. In an observation on 7/20/15 at 5:50 AM, Resident #3 was sleeping in her bed. Nurse #2 provided Resident #3's medical administration record (MAR) indicating the Risperdal injection was signed out as last given on 7/9/15 6:00 AM and was due again on 7/23/15 at 6:00 AM. Nurse #2 stated she had never administered Resident #3's Risperdal injection but stated she was complaint with her morning blood sugar checks. A review of Resident #3 ' s physician orders	F 332	Richmond Pines Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Healthcare and Rehabilitation Center¿s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Healthcare and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. What measures did the facility put in place for the resident affected: On 7/23/2015, the director of nursing (DON) assessed resident #3 and observed no negative outcome. On 7/23/2015, the DON reviewed the July	8/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2015

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F 332	Continued From page 1 indicated she was to receive Risperdal 12.5 milligrams intramuscular injection every two weeks. A review of Resident #3's nursing notes from 1/1/15 to present indicated no medication refusal except one refusal of her morning sliding scale insulin but multiple refusals of dialysis. A quality improvement note for antipsychotic medications dated 1/21/15 made no mention of medication refusals but did indicate Resident #3 was refusing dialysis, striking out at staff and experiencing hallucinations/delusions. There was no recommendations made at that time. A physician progress note dated 2/20/15 indicated Resident #3's medications were reviewed and there was no documentation indicating refusals of her Risperdal injections. A review of Resident #3's MAR from January 2015 to present indicated no Risperdal injections were administered in the month or March and only once in June. There was no documentation of Resident #3 refusals or medication unavailability. Resident #3 was in the hospital 3/9/15 through 3/11/15 but the March MAR indicated the Risperdal injections was not due until 3/14/15 and again on 3/28/15. A care plan note dated 3/26/15 indicated Resident #3's family was updated on her current status and made no mention of her refusals of her medications. The June MAR indicated Resident #3 received the Risperdal injection on 6/11/15 but did not receive it as scheduled on 6/25/15.	F 332	medication administration record for resident # 3 and confirmed that the resident had received both scheduled doses for the month. On 7/23/2015 the DON found no Risperdal doses stored in the medication refrigerator, medication storage area, or medications carts. On 7/28/2015 the DON obtained notarized statements from nurses assigned to administer medication to Resident # 3 at 6 AM on 3/14/2015, 3/28/2015, and 6/25/2015 regarding the fact that the nurses did administer Resident # 3¿s Risperdal, but had not signed the MAR that they had administered the Risperdal. On 7/22/15 the DON contacted Resident # 3¿s physician and no new orders were received because resident # 3¿s physician stated that if Resident # 3 had not received the Risperdal that it would have had no negative impact. What measures were put in place for residents having the potential to be affected: On 7/31/2015 a 100% audit of all residents, including resident #3, was completed by the DON, ADON, QI Nurse, wound nurse, and MDS Nurses. The audit consisted of reviewing all resident MAR¿s for weekly, bi-weekly, or monthly medications. On 7/31/2015, the audit was completed to ensure all residents that have weekly, bi-weekly, or monthly medications had received the medications as ordered by the physician, using the QI MAR Audit Tool. On 7/31/2015 any resident who did not receive their weekly, bi-weekly, or monthly medication was assessed and the physician contacted.	

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F 332	Continued From page 2 In an observation on 7/21/15 at 4:30 PM, Resident #3 was sitting in her wheelchair in the hallway. She was cooperative but appeared to have a flat affect. She stated she was "washed out" from dialysis. In an interview on 7/22/15 at 2:20 PM, nurse #1 stated if Resident #3 refused her Risperdal injection on third shift as scheduled, it would be reported to her in the morning report. Nurse #1 stated Resident #3 does not usually refuse her medications but routinely refuses dialysis. In an interview on 7/22/15 at 2:30 PM, the director of nursing (DON) stated she was not aware of any Risperdal injection omissions for Resident #3 and stated her expectation was for the nurses to administer the medication as ordered, sign off of all medications administered or documentation refusals and contact the physician. In an interview on 7/22/15 at 4:10 PM, Resident #3's physician stated he was unaware of the Risperdal omissions but stated if the medications were not administered as ordered, it would not have a negative impact on her or would it have contributed to her dialysis refusals. He stated Resident #3 had a long standing history of dialysis refusals and the facility, dialysis staff, family and hospital staff have a difficult time getting Resident #3 to comply with dialysis. The physician stated his expectation was the staff to administer her medications as ordered or notify him of refusals or unavailability. In a telephone interview on 7/23/15 at 9:00 AM, nurse #3 stated she was 100% sure she administered the Risperdal injections as ordered	F 332	Medications that were not signed out for were followed up as per facility protocol. The physicians gave no new orders. What systems were put in place to prevent the deficient practice from reoccurring: On 7/31/15 education was initiated by the staff facilitator for all RNs, LPNs, and medication aides regarding proper medication administration, MAR completion on front and back, and documentation of weekly, bi-weekly, and monthly medications. The education also included informing RNs and LPNs that it is their responsibility to notify the nurse on call if a weekly, bi-weekly, or monthly medication has not been properly administered and documented on the MAR. The education will also include reminding medication aides to report to their nurse and informing RNs and LPNs that a weekly, bi-weekly, or monthly medication has not been properly administered and documented on the MAR. The education will be completed by 8/14/2015. RNs, LPNs, and medication aides will not be allowed to complete a shift after 8/14/2015 without completing the education. Newly hired RNs, LPNs and medication aides will be educated on proper medication administration, MAR completion on front and back, and documentation of weekly, bi-weekly, and monthly medications. RN¿s, LPN¿s, and Med Aides will receive education regarding that it is their responsibility to notify the nurse on call if a weekly, bi-weekly, or monthly medication This education will be completed by the staff	

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F 332	Continued From page 3 in March and June but she forgot to sign that she gave it.	F 332	facilitator or QI nurse during the orientation process. How the facility will monitor systems put in place: Using the QI MAR Audit Tool, 100% of current medication administration records (MARs) will be audited by the DON, ADON, QI nurse, MDS nurses, wound nurse, and/or consultant to ensure all weekly, every other week, and/or monthly medications on the MARs have been administered as ordered. This monitoring will occur twice a week for 2 weeks, once a week for 2 weeks, then every other week for 8 weeks, then monthly for 3 months. The Administrator, or DON in the administrator¿s absence, will review and initial the completed audit tools weekly for 4 weeks, then every other week for 8 weeks, then monthly for 2 months. Results of the QI MAR Audit Tool will be reviewed by the QI Committee monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, recommendations for monitoring and continued compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		8/3/15

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F 428	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on physician and consultant pharmacist interviews and record review the facility failed to address gradual dose recommendations (GDRs) for 2 (Resident #67 and Resident #108) of 5 residents reviewed for monthly medication regime. Findings included: 1. Resident #67 was admitted on 12/17/10 with a diagnosis of anxiety. The quarterly Minimum Data Set dated 7/2/15 indicated she was cognitively intact with no behaviors and required extensive assistance with her activities of daily living. Resident #67 was care planned for the use of a psychotropic medication (Zoloft) for anxiety with an intervention to include an evaluation for a gradual dose reduction. A consultant pharmacy recommendation dated 3/20/15 noted Resident #67 was taking Zoloft 50 milligrams by mouth daily for anxiety. The consult read Resident #67 was due for an annual GDR assessment. A second consultant pharmacy recommendation dated 6/23/15 read the Zoloft recommendation to the physician on 3/20/15 was not addressed and not observed the Resident #67's electronic or hardcopy medical record. In an interview on 7/22/15 at 4:10 PM, the physician stated he must have missed the GDR recommendation. The physician stated the Zoloft should have been addressed in March for possible GDR.	F 428	What measures did the facility put in place for the residents affected: On 7/23/2015, Resident # 67¿s physician reviewed the 3/20/2015 pharmacy recommendation. The physician did not agree with the annual gradual dose reduction (GDR) assessment for Resident #67¿s Zoloft 50 milligrams daily for anxiety, as recommended by the pharmacist. On 7/23/2015 the physician placed a checkmark in the ¿disagree¿ box and signed the 3/20/2015 pharmacy recommendation on 7/23/2015. Resident # 108¿s physician reviewed the 4/21/2015 pharmacy recommendation. The physician did not agree with the GDR for Resident # 108¿s Ativan 1 milligram twice daily for anxiety, as recommended by the pharmacist. On 7/23/2015 the physician placed a checkmark in the ¿disagree¿ box and signed the 4/21/2015 pharmacy recommendation. The also wrote a note stating ¿Didn¿t agree on 4/23/15¿ on the 4/21/2015 pharmacy recommendation. On 7/19/2015, Resident # 108¿s physician reviewed the 7/10/2015 pharmacy recommendation. The physician did not agree with the annual gradual dose reduction (GDR) assessment for Resident #108¿s Alprazolam 1 milligram twice daily for anxiety, as recommended by the pharmacist.	

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F 428	Continued From page 5 In an interview on 7/23/15 at 9:30 AM the consultant pharmacist stated in March he recommended the annual GDR for Zoloft and noted on his June monthly medication review that the physician had not addressed the recommendation. The pharmacist recalled questioning the facility about the recommendation done in March but they were unable to locate it. 2. Resident #108 was admitted on 6/26/14 with a diagnosis of anxiety. The annual Minimum Data Set dated 6/2/15 indicated Resident #108 was cognitively intact and required supervision with his activities of daily living. The Care Area Assessment indicated that Resident #108 would be evaluated for the lowest dose of his psychotropic medications for positive effects. He was care planned for a monthly medication review by the pharmacist. A consultant pharmacy recommendation dated 4/21/15 noted Resident #108 was taking Ativan 1 milligrams by mouth twice daily for anxiety. The consult read the physician may consider a GDR or provide a rationale for current dose. A second consultant pharmacy recommendation dated 6/23/15 read the Ativan recommendation to the physician dated 4/21/15 was not addressed and not observed in Resident #108's electronic or hardcopy medical record. In an interview on 7/22/15 at 4:10 PM, the physician stated he must have missed the GDR recommendation in April. The physician stated the Ativan should have been addressed in April for possible GDR. In an interview on 7/23/15 at 9:30 AM the consultant pharmacist stated April was the annual	F 428	What measures were put in place for residents having the potential to be affected: On 8/3/2015 a 100% pharmacy recommendation audit was initiated by the DON, ADON, QI nurse, MDS nurses and/or wound nurse. 100% of all current pharmacy recommendations from June 2015, to include resident # 67 and resident #108, are being audited using the Pharmacy Recommendation Follow-Up Audit tool to ensure all pharmacy recommendations have been reviewed, signed, dated, and returned by the residents¿ physician and placed in the residents¿ electronic or hardcopy medical record. Any missing pharmacy recommendations were resubmitted to the doctor for a response. What systems were put in place to prevent the deficient practice from reoccurring: On 8/3/2015 the administrator, DON, and medical records director initiated the Pharmacy Recommendation Tracking process. On 8/3/2015 the administrator educated the medical records director regarding timely follow up with the physician for pharmacy recommendations. On 8/3/2015, the administrator educated the DON and the medical records director on the Pharmacy Recommendation Tracking process. An unsigned copy of the pharmacy recommendations will be kept by the Director of Nursing or the Assistant Director of Nursing. When the signed pharmacy recommendation is received back to the facility, a copy of the signed	

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F 428	Continued From page 6 GDR recommendation for Ativan and he noted on his June monthly medication review that the physician had not addressed the recommendation. The pharmacist recalled questioning the facility about the recommendation done in March but they were unable to locate it.	F 428	pharmacy recommendation will be given by the medical records director to the Director of nursing or assistant director of nursing to be matched to the unsigned copy. Any unsigned copies that do not have a matching signed copy will be listed on the Pharmacy Recommendation Audit so that the director of nursing or assistant director of nursing will follow up with the physician. The Director of Nursing will track the pharmacy recommendations utilizing the Pharmacy Recommendation Audit Follow-Up Audit Tool. How the facility will monitor systems put in place: Using the Pharmacy Recommendation Follow-Up Audit Tool, 100% of pharmacy recommendation will be audited by the DON and/or the ADON to ensure all residents¿ pharmacy recommendations have been reviewed by the physician, to include resident¿s # 67 and # 108. This monitoring will occur monthly for 2 months, then every other month for 4 months. The Administrator, or DON in the Administrator¿s absence will review and initial the audit tool monthly for 2 months then every other month for 4 months. Results of the Pharmacy Recommendation Audit Tool will be reviewed by the QI Committee monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, recommendations for monitoring and continued compliance.	
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		8/14/15

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F 514	Continued From page 7 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure the availability of current physician orders for 2 of 7 residents (Resident # 58 and Resident # 71) reviewed for medication administration. The facility also failed to ensure the availability of resident diagnostic information along with pharmacy recommendations for 2 of 5 residents (Resident # 67 and Resident # 108) reviewed for unnecessary medications. Findings included: After a medication pass was conducted 7/20/15 on third shift, Resident # 58 and Resident #71 July physician orders were not be on the medical record. A random review of medical records at the nursing station revealed the absence of July physician orders. In an interview on 7/20/15 at 8:30 AM, the medical record director stated she had not had an opportunity to file July physician orders due to her other duties which included coding, resident admissions and scanning items into the electronic	F 514	What measures did the facility put in place for the resident affected: On 7/23/2015 the medical records director and DON looked for Resident # 58s and resident # 71s current physician orders were found and placed them on the chart. On 7/23/2015 the medical records director produced the diagnostic information for resident # 108 for review by the surveyor. Resident # 67 did not require the requested diagnostic information for Vitamin B12. Review of the lab monitoring policy for Vitamin B12 revealed that a scheduled B12 level is not required. The diagnostic information for resident # 108 was scanned and uploaded as part of the resident¿s electronic medical record on 8/4/2015. On 7/23/2015 the medical records director placed pharmacy recommendations on Resident # 67s and Resident # 108s hard copy medical	

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F 514	Continued From page 8 record. In an interview on 7/20/15 at 11:30 AM, the administrator stated to his knowledge, the medical record director did not do resident admissions but her responsibilities would be re-evaluated. A record review conducted on 7/21/15 for unnecessary medications revealed no evidence of a Prothrombin time lab result in the hard copy medical record nor in the electronic medical record since May 2015. A review of the physician hand written orders indicated a Prothrombin time was drawn in June and again in July. The director of nursing (DON) and medical record director presented a faxed copy of the results at 2:22 PM. It was at this time the medical records director stated she had scanned the Prothrombin time results into the electronic medical record but she had not uploaded the data into the computer at present. A medical record review, both hardcopy and electronic done 7/21/15 included no copies of the pharmacy recommendations for Resident # 67 and Resident # 108. At 3:40 PM the DON stated it was possible the pharmacy recommendations had not been returned from the physician's office yet. The DON stated the medical records director was responsible for following up with the physician within a few days to get signed items back timely. The DON stated she was not aware the pharmacy recommendations were not returned and available in the resident's medical records. In an interview on 7/22/15 at 2:20 PM nurse # 1 stated she had experienced problems with resident information not in the medical records or in the computer. Nurse # 1 stated unless a nurse admits a resident and reviews the hospital history and physical the day of the admission, it will not	F 514	record. On 7/23/2015 the director of nursing verified the resident physician orders, diagnostic information, and physician responses to pharmacy recommendations were complete and did not require additional follow-up. What measures were put in place for residents having the potential to be affected: On 7/20/2015, the medical records director began filing and scanning residents¿ medical record information, to include Residents #58, #71, #67, and #108. On 7/20/2015, the medical records director, administrator, DON, and facility consultant filed current physician orders onto the residents¿ hard copy medical record, to include Resident # 58 and Resident # 71. On 7/20/2015, the medical records director met with the administrator to discuss medical records being complete, accurate, and accessible. On 8/5/2015 the Medical Records Director was educated by the Administrator and the DON on the importance of the timeliness of placing the monthly orders on the medical record. On 7/23/2015, the medical records director received from the physician Resident # 108¿s 4/21/2015 Ativan 1 mg twice daily GDR pharmacy recommendation response. On 7/23/2015 the medical records director filed in Resident # 108¿s hard copy medical record Resident # 108¿s 4/21/2015 Ativan 1 mg twice daily GDR pharmacy recommendation response from the physician. On 7/23/2015, the	

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F 514	Continued From page 9 be seen again because the paperwork goes to medical records and is never scanned into the electronic record or placed on the resident hard copy charts. In an interview on 7/22/15 at 3:00 PM the admissions coordinator stated it was her job to complete everything required in the admission packet except the nursing information. She verified her admission back up assistant was the medical records director in her absence. The admission coordinator went on the state if an admission came after hours, it was the responsibility if the receptionist or the floor nurse to complete the entire admission. The admission coordinator stated she ensured the nurses had the physician orders and the history and physical while all other items was given to medical records to be scanning into the computer. She stated she was able to scan and upload items into the medical record and had done it in the past. In an interview on 7/23/15 at 9:30 AM, the consultant pharmacist stated he had ongoing issues with the availability of items in the medical record and the facility being unable to locate items for filing. In an interview on 7/23/15 at 11:30 AM, the administrator stated it was his expectation that items belonging in the resident medical record, either hard copy or electronic be filed and uploaded timely.	F 514	medical records director received from the physician Resident # 67¿s 3/20/2015 Zoloft 50 mg daily GDR pharmacy recommendation response. On 7/23/2015 the medical records director filed in Resident # 67¿s hard copy medical record Resident # 67¿s 3/20/2015 Zoloft 50 mg daily GDR pharmacy recommendation response from the physician. On 8/4/2015 a 100% audit was initiated by the DON, ADON, QI nurse, MDS nurses, wound nurse and/or medical records director to ensure received May-2015, June-2015, and July-2015 lab results are filed in the hard copy medical record or in the electronic medical record. On 8/6/2015, the 100% audit was completed by the DON, ADON, QI nurse, MDS nurses, wound nurse, and/or medical records director and documented on the POC Lab audit tool. The audit was completed on 8/5/2015 and there were no labs noted to be missing from the electronic medical record. What systems were put in place to prevent the deficient practice from reoccurring: On 8/3/2015 the administrator educated the medical records director on resident medical records completeness, accuracy, and accessibility, including reporting the results of the monthly audits to the administrator. On 8/5/2015 education was initiated by the administrator to the DON, medical records director, and staff facilitator regarding resident medical records¿	

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	345293	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 10	F 514	completeness, accuracy, and accessibility. On 8/14/2015 the DON, medical records director, and staff facilitator completed the education to all active RN¿s, active LPN¿s, active staff scheduler, and active receptionists. All staff that are not currently active will not be allowed to complete a shift until the education regarding Medical Records¿ completeness, accuracy, and accessibility is completed. The staff facilitator or QI nurse will educate new RNs, LPNs, receptionists, and schedulers regarding resident medical records¿ completeness, accuracy, and accessibility during the orientation process. On 8/5/2015 the administrator educated the medical records director on the Medical Records Policy-Auditing Active Medical Records Monthly Audit Protocol. On 8/5/2015 the medical records director initiated the Monthly Audit Protocol to identify items that are not in the medical record and obtain the necessary items. How the facility will monitor systems put in place: Beginning on 8/7/2015 the Administrator, or DON in the administrator¿s absence, will review and initial the completed Medical Records Monthly Audit monthly for 6 months. Results of the Medical Records Monthly Audit will be reviewed by the QI Committee monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, recommendations for monitoring and continued compliance.	

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