PRINTED: 08/17/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 07/16/2020
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 07710/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
E 000	Initial Comments		E 00	00	
F 000	conducted on 7/12/20 facility was found in c requirement CFR 483 Preparedness. Even	3.73, Emergency t ID# HCOC11.	F 00	00	
F 641 SS=E	survey was conducte 7/16/20. Event ID# F complaint allegations in a deficiency. Accuracy of Assessm	was substantiated resulting	F 64	11	8/11/20
	resident's status. This REQUIREMENT by: Based on record rev facility failed to code (MDS) assessments diagnoses (Residents (Resident # 11), Nutr hospice (Resident #7 (Resident #59) for 7 or reviewed. Findings included: 1a. Resident # 59 wa 3/21/19 with multiple	is not met as evidenced iew and staff interview, the the Minimum Data Set accurately in the areas of s # 59, # 42 & # 66), falls ition (Resident # 20 & #19), 6) and PASRR level II of 25 sampled residents		Based on record review and staff interview, the facility failed to code th Minimum Data Set assessments accurately in the areas of diagnoses (Residents #59, #42 & #56),Falls (Resident #11),Nutrition (Residents #19), Hospice (Resident #76), and PASRR Level II (Resident #59) for 7 sampled residents review. 1. Resident #59 & #42 with diagnose Chronic Viral Hepatitis active was corrected to in-active on 7/15/2020. Resident #66 with diagnoses of an addiagnosis of a Urinary Tract infection	es of
	The doctor's progress	s note dated 3/25/19		corrected on 7/15/2020 to in-active. Resident #11 that Minimum Data Set	
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/31/2020

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.

Electronically Signed

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	C	X3) DATE SURVEY COMPLETED
		345293	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343233	1 2: *******	CTREET ADDRESS OFF STATE 710 COD	<u> </u>	07/16/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E	
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
		-		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From p	age 1	F 6	41		
	of Chronic Viral He	S assessment dated 6/27/20		(MDS) was coded as a fall wit was coded to a fall with injury 7/15/2020. Resident #20 the parenteral/IV feeding that was	on s coded	
		ident #59's cognition was intact, ctive diagnosis of Viral Hepatitis.		in-correctly on the Minimum D Set(MDS) was corrected on 7 Resident #19 was in-correctly	/15/2020	
	interviewed. She see Chronic Viral Hepa getting treatment of been coded under 6/27/20 MDS asseed on 7/16/20 at 11:0 (DON) was interviewed by MDS Nurse had be MDS Nurse for 1 at the MDS Nurse was considered.	2 PM, the MDS Nurse was stated that Resident #59 had atitis and was not currently for it and it should not have active diagnoses on the essment. 25 AM, the Director of Nursing ewed. The DON stated that the een working at the facility as and ½ years. She indicated that as still learning MDS, but she cassessments to be coded		the Minimum Date Set(MDS) toss of 5% or more in the last loss of 10% or more in the last loss of 10% or more in the last This was corrected on the Min Set (MDS) on 7/27/2020. Res who was not on the Minimum (MDS) for receiving hospice of coded correctly for receiving hon 7/27/2020. Resident #59 ND Data Set (MDS) was corrected resident Preadmission Screen Review (PASRR) level II is duillness 7/15/2020. These corrected to the Minimum Date (MDS) Registered Nurse (RN)	for weight month or a set 6 months nimum Data sident #76 Data Set care is now nospice car Minimum d that the n & Resider to menta ections wer ate Set	nt
		vas admitted to the facility on ole diagnoses including d Psychosis.		2. All residents have the pote being coded on the MDS inco3. On 7/15/2020 the facility has	rrectly. as correcte	
	Preadmission Scre	evaluated on 2/5/18 for eening and Resident Review nd was reevaluated on 2/11/19 ess.		the deficiency as it relates to t Data Set Registered Nurse by provided by the MDS Consulta regarding criteria needed for ourinary trach infection on read	/ education ant Nurse coding	
	indicated that Res and was not relate	assessment dated 3/27/20 ident #59 was a PASRR level II ed to mental illness.		hospital, coding active diagno per Resident Assessment Inst Manual, for coding accurate representation of falls on the N	trument	S
	interviewed. She	5 PM, the Social Worker was stated that Resident #59 was a e to mental illness.		RAI Manual. MDS Consultant re-educated on Hospice codin 7/29/2020. Dietary Manager w	ng on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D MANAGE				C
		345293	B. WING _			07/	16/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		Н	IIGHWAY 177 S BOX 1489		
TATO TIME OF T	DI INCO HEACHIOANE	AND REMADIEMATION SERVE		Н	IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page		F 6	641	re-educated by the MDS Consultant or		
		M, the MDS Nurse was			7/15/2020 on calculating weight varian	ce	
		ified that Resident #59 was			for section K and coding Nutrition		
		to mental illness. The MDS			approaches accurately per RAI Manua		
		e coded the 3/27/20 annual			7/15/2020 MDS Consultant & MDS nui	se	
	MDS inaccurately.				audited 100% of last 90 days of falls,		
					PASSAR Level II's and hospice. Any		
		AM, the Director of Nursing			identified concerns were corrected at t	nat	
		ed. The DON stated that the			time. We had no other falls coded with		
		n working at the facility as			injury to correct, we had to correct 19 PASSAR Level II's to corrected coding		
		l ½ years. She indicated that still learning MDS, but she			and 1 hospice coding had to be correct	tod	
		ssessments to be coded			MDS Consultant & MDS nurse are also		
	accurately.	ssessments to be coded			auditing 100% of current residents on		
	accuratory.				most recent MDS for accuracy section		
					coding for nutrition and weight variance		
	2 Resident #11 was	admitted to the facility on			To be completed by 8/7/2020 and to be		
	1/23/20 with multiple	diagnoses including			given to the Director of Nursing.		
	Alzheimer's Disease.	•					
	assessment dated 4/				4. Director of Nursing/Designee will au		
		vere cognitive impairment			5 MDSs per month for accuracy in area		
		lls with no injury since			of concern PASSAR Level II, diagnose		
	admission /reentry or	prior assessment.			falls, weight loss variance and nutrition		
		and an impact and a date of 2/6/20			approaches accurately. These audits	WIII	
		nd nurse's note dated 3/6/20			be turned into the Nursing Home		
		that Resident #11 had told ne had a fall in the bathroom.			Administrator monthly for 3 months.		
		ve a small hematoma to her			Identified Concerns will be corrected as	,	
		oose egg" above left eye.			identified. Minimum Data Set (MDS)	•	
	, ,	esponsible party (RP) were			Registered Nurse (RN) will continued to be educated as concerns are identified		
		x-ray of face was obtained.			MDS Consultant. Nursing Home	Бу	
	Houned. All bluef lot	A-ray or lace was obtained.			Administrator will share findings at the		
	│ │	M, the MDS Nurse was			QAPI Committee monthly meeting for	3	
		ified that the fall on 3/6/20,			months to review for any trends, trainir		
		ed hematoma on her left eye			needs, additional recommendations ar		
		1/15/20 should have been			to determine the need for continued	· ·	
	coded as fall with inju				monitoring to ensure compliance. QAF	OI.	
	Ocaca as ian wini liju	ary bat it was not.			Committee will make a determination a		
	On 7/16/20 at 11:05 A	AM, the Director of Nursing			the end of 3 months for continued		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			1	C	
NAME OF PI	ROVIDER OR SUPPLIER	0.0200	1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 077	16/2020	
					GHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	÷3	F 6	641				
	MDS Nurse had beer MDS Nurse for 1 and the MDS Nurse was s	ed. The DON stated that the a working at the facility as ½ years. She indicated that still learning MDS, but she seessments to be coded			monitoring as needed. 5. 08/11/2020 All corrections completed on 8/04/2020 Nursing Home Administrator.) by		
	6/24/20 with multiple Tract Infection (UTI). Data Set (MDS) asse indicated that Reside impairment and had r for 5 days during the	nt #66 had severe cognitive eceived an antibiotic drug assessment period. The dicated that Resident #66						
	revealed that Resider diagnosis of UTI, and facility on 6/24/20 on	e summary dated 6/23/20 Int #66 had an active In she was discharged to the Indicate Amoxicillin (an antibiotic Ings.) twice a day for 5						
	June 2020 revealed t	375 mgs daily for 5 days						
	interviewed. She ver admitted from the hos resident was admitted Amoxicillin 875 mgs t MDS Nurse indicated MDS for UTI since the	M, the MDS Nurse was ified that Resident #66 was spital on 6/24/20. The d with an order for wice a day for UTI. The that she did not code the e resident did not meet the iteria used by the long-term						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 07/16/2020
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COI HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0771672020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 641	(DON) was interview. MDS Nurse had been MDS Nurse for 1 and the MDS Nurse was expected the MDS as accurately. The DON Resident #66 had red during the assessme	AM, the Director of Nursing ed. The DON stated that the n working at the facility as ½ years. She indicated that still learning MDS, but she essessments to be coded I further indicated that since beived an antibiotic for UTI ant period, the MDS dated een coded for UTI under	F6	41		
	11/14/10 with multiple dysphagia and traum quarterly Minimum D dated 4/28/20 indicat moderate cognitive ir parenteral/intravenou 7 days while a reside. The Medication Admi for 4/2020 were reviet that Resident #20 ha not parenteral/IV feed On 7/15/20 at 1:13 P interviewed. She ver receiving tube feedin that the 4/28/20 quar nutritional status, the	nistration Records (MARs) wed. The MARs revealed d received tube feeding but				
	assessment period.	teral/IV feeding during the AM, the Director of Nursing				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING _			C 07/16/2020
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, Z HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ZIP CODE	07/10/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE
F 641	MDS Nurse had bee MDS Nurse for 1 and the MDS Nurse was	e 5 red. The DON stated that the n working at the facility as d ½ years. She indicated that still learning MDS, but she ssessments to be coded	Fe	641		
	9/25/18 with multiple Viral Hepatitis. The hospital discharg	s admitted to the facility on diagnoses including Chronic ge summary dated 9/18/18 ent #42 had diagnosis of Viral				
	indicated that Reside	ent # 42 had moderate and had active diagnosis of				
	interviewed. She state Chronic Viral Hepatit getting treatment for	PM, the MDS Nurse was ted that Resident #42 had is and was not currently it and it should not have ctive diagnoses on the 6/3/20				
	(DON) was interview MDS Nurse had bee MDS Nurse for 1 and the MDS Nurse was expected the MDS accurately. 6) Resident #76 was facility on 2/21/17 and	AM, the Director of Nursing ed. The DON stated that the n working at the facility as d ½ years. She indicated that still learning MDS but she ssessments to be coded originally admitted to the d was discharged from the His diagnoses included				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345293	B. WING _			C 07/16/2020
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		01110/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag		F 6	41		
	Alzheimer's disease					
	A physician's order of admission to Hospid	dated 1/27/2020 indicated an e care.				
	(MDS) assessment resident was marked Alzheimer's disease	e in Status Minimum Data Set dated 2/4/2020 revealed the d with an active diagnosis of and a prognosis of less than oded with receiving Hospice				
	7/16/2020 at 9:50 A aware the resident h and Hospice was no	with the MDS Nurse on M, she confirmed she was nad received Hospice care of marked on the MDS 1/4/2020. She stated it was an				
	Nursing on 7/16/202	nducted with the Director of 20 at 11:30 AM, and stated it for the MDS to be coded				
	facility 10/12/18 with	as originally admitted to the diagnoses that included a stroke), dysphagia (difficulty betes.				
		n Data Set (MDS) /23/20 revealed Resident #19 nt loss of 5% or more in the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		345293	B. WING			C 07/16/2020
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	'	317 TG/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From page	ge 7	F 64	41		
	last month or a loss months.	of 10% or more in the last 6				
	weights during the period of November showed a 3.52% we 0.52% weight loss if 4/16/2020 192 lbs. 3/10/2020 199 lbs. 11/4/19 193 lbs. On 7/16/2020 at 9:5 conducted with the	ght data revealed the following MDS assessment look back 2019 to April 2020, which eight loss in a month and an 6 months: 50 AM, an interview was MDS Nurse who stated the ded the nutrition section of the				
	on 7/16/2020 at 10: nutrition area on the data, indicated it wa	ed with the Dietary Manager 15 AM. She reviewed the e 4/23/20 MDS and weight as coded incorrectly and en coded as a weight loss.				
	on 7/16/2020 at 11:	with the Director of Nursing 30 AM, she indicated it was the MDS to be coded				
	facility 10/12/18 with	as originally admitted to the n diagnoses that included a stroke), dysphagia (difficulty betes.				
	4/22/2020 revealed nutrition and fluids of dysphagia and noth	#19's active care plan dated a care plan in place for via the PEG tube due to ing by mouth (NPO) status. nd interventions were present.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETI	
		345293	B. WING _		O7/16/2	2020
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 011101	2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) DMPLETION DATE
F 641	had severe cognitive total assistance from the PEG tube (Percuit Gastrostomy- a way of fluids) She was code (ml) or less of fluid intube. A review of the April 2 indicated Resident #1 every 4 hours, 50 ml medication administrate each medication give On 7/16/2020 at 9:50 conducted with the M Dietary Manager code MDS. An interview occurred on 7/16/2020 at 10:15 nutrition area on the 4 500 ml or less of fluid	Data Set (MDS) 23/20 revealed Resident #19 impairment and required staff for fluid intake through	F 6	41		
F 656 SS=D	on 7/16/2020 at 11:30 her expectation for the accurately. Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe	Comprehensive Care Plan	F 6	56	8/1	1/20

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		345293	B. WING			C 7/16/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	care plan for each re resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identificated assessment. The coldescribe the followin (i) The services that or maintain the resid physical, mental, and required under §483 (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclustreatment under §48 (iii) Any specialized sere abilitative service provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wire resident's represental (A) The resident's profuture discharge. Fact whether the resident community was asset local contact agencial entities, for this purpor (C) Discharge plans plan, as appropriate,	hensive person-centered sident, consistent with the rith at §483.10(c)(2) and icludes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive imprehensive care plan must grare to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will for PASARR a facility disagrees with the RR, it must indicate its ent's medical record. It the resident and the attive(s)-mals for admission and reference and potential for collities must document as desire to return to the resident and reference and any referrals to resident appropriate	F 6	56		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
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		345293	B. WING _			7/16/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD)E	
DICHMON	ID DINES HEAT THEA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
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(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From p	age 10	F 6	56		
		ENT is not met as evidenced				
	by:	in is not mot as evidenced				
	•	review and staff interview, the		Based on record review and	staff	
		velop a comprehensive care		interviews, the facility failed to	o develop a	
	plan in area of hos	spice for 1 of 4 residents		comprehensive care plan in t	•	
	(Resident #15) rev	viewed for hospice care.		hospice for 1 of 4 residents (I #15) reviewed for hospice ca		
	The findings include	ded:		,, 10, 101101101 101 1105p100 00		
	J			A comprehensive care pla	n for	
	Resident #15 was	most recently admitted to the		Hospice has been developed		
facility on 2/21/19 with diagnoses				#15. This was completed on	7/16/2020 by	
		pertension, and hyperlipidemia.		Minimum Data Set Registere		
				Hospice Residents were aud	ited to	
	A physician 's ord	er dated 4/14/20 for Resident		ensure that they had a Hospi	ce	
	#15 indicated a ho	spice consultation was to be		Comprehensive Care Plan.	Γhe other	
	conducted.			four Hospice residents did ha Comprehensive Care Plan fo		
	An admission form	n for hospice care indicated		· ·	'	
		admitted on 4/16/20.		2. All residents that are admi	itted to	
				hospice have the potential to	be affected	
	The significant cha	ange Minimum Data Set (MDS)		by this practice. All residents	admitted to	
	assessment dated	l 4/21/20 indicated Resident		hospice will have a comprehe	ensive care	
		as severely impaired. He was		plan developed for hospice c	are.	
		nosis of less then 6 months and				
	was on hospice.			3. On 7/29/2020 Minimum D		
				Registered Nurse Consultant		
		ctive care plan was reviewed		the MDS Nurse that residents		
		AM. There was no care plan in		admitted to hospice need to h		
	place related to ho	ospice care.		comprehensive care plan dev	reiopea.	
	An interview was	conducted with the Assistant		Nursing Home Administration	tor/Director	
	Director of Nursing	g (ADON) on 7/16/20 at 10:13		of Nursing will monitor for 3 n		
	AM. The ADON	confirmed Resident #15 was on		every resident of the facility tl		
	· •	e 4/16/20. The active care plan		receiving hospice will be prot	-	
		vas reviewed with the ADON.		having a comprehensive care		
		ed a newly initiated care plan		developed at admission to ho		
		dated 7/16/20, with the focus		Any residents transferred to h	•	
		are due to a terminal illness.		is identified that they do not h		
	She verified there	was no care plan in place		Comprehensive Care Plan th	e Minimum	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (X4) PLAN OF CORRECTION (X5) DATE (X6) MULTIPLE CONSTRUCTION (X6) DATE (X6) DATE (X6) DATE (X7) MULTIPLE CONSTRUCTION (X7) DATE (X7) DATE (X7) DATE (X8) DATE (X8) DATE (X8) MULTIPLE CONSTRUCTION (X8) DATE		SURVEY PLETED				
		345293	B. WING			C / 16/2020
NAME OF PI	ROVIDER OR SUPPLIER	0.10200		STREET ADDRESS, CITY, STATE, ZIP CODE	07	110/2020
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	related to hospice car 7/16/20. She reported to be developed by he Nursing (DON), the Mursing expected for Resident # since 4/16/20 at 11:20 A confirmed Resident # since 4/16/20. She winterview that indicate place related to hospi prior to 7/16/20. She initiated a hospice call the significant change to the hospice admissionable to explain why hospice care plan for 4/21/20 significant change to the hospice admissionable to explain why hospice care plan for 4/21/20 significant change to the hospice admissionable to explain why hospice care plan for 4/21/20 significant change to the hospice care plan for 4/21/20 significant change to the hospice admissionable to explain why hospice care plan for 4/21/20 significant change to the hospice care plan for 4/21/20 significant change to be developed within 3/20 AM she indicate expected to be developed was on hospice care. Care Plan Timing and CFR(s): 483.21(b)(2)(2)(2)(4)(4)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	the for Resident #15 prior to dethat care plans were able berself, the Director of IDS Nurse, as well as the ADON was unable to explain the dethat the ADON was unable to explain the according to the ADON was on hospice care the according to the ADON was on hospice care the according to the ADON was on the ADON was on the ADON was on the ADON was on the ADON was explain the ADON was explain the ADON was assessment related which was according to the ADON on 7/16/20 at the ADON on 7/16/20 at the ADON on 7/16/20 at the ADON on The A	F 65	Data Set Registered Nurse will be provided further education as need Negative outcomes will be reported QAPI Committee monthly for 3 more the NHA/DON to review for trends, additional recommendations and to determine the need for continued monitoring to ensure continued compliance for 3 months and then directed by the QAPI Committee. 5. 8/11/2020	I to the nths by	8/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 07/16/2020	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07/16/2020	
				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 657	Continued From page	e 12	F 65	57		
	(B) A registered nurse resident.	e with responsibility for the				
	(C) A nurse aide with resident.	responsibility for the				
	(D) A member of food	and nutrition services staff.				
	(E) To the extent prac	ticable, the participation of				
	the resident and the r	esident's representative(s).				
	An explanation must	be included in a resident's				
		participation of the resident				
		resentative is determined				
	not practicable for the	e development of the				
	resident's care plan.					
		staff or professionals in				
		ined by the resident's needs				
	or as requested by th					
		ised by the interdisciplinary				
		ssment, including both the				
	comprehensive and q	uarterly review				
	assessments.					
	This REQUIREMENT	is not met as evidenced				
	by:					
		ew, observation and staff		Based on record review, observation		
		ailed to revise the care plan		staff interview, the facility failed to rev	ise	
	_	f motion for 1 (Resident #		the care plan in the area of range of		
		dents reviewed for limitation		motion for 1 (Resident #42) of 3 samp		
	in range of motion (R	OM).		residents reviewed for limitation in ran	ige	
				of motion (ROM).		
	Findings included:					
	D			1. Resident #42 care plan was revise	d on	
		mitted to the facility on		7/16/2020 by Minimum Data Set		
	9/25/18 with multiple			Registered Nurse.		
		nd, left shoulder and left				
		Minimum Data Set (MDS		2. All residents have the potential to b		
	assessment dated 6/3			affected by this practice that are recei		
	Residents #42 had m	•		restorative nursing that are referred ba	аск	
		imitation in range of motion		to therapy.		
	on both sides of uppe	er and lower extremities.		0 71 6 77		
	On 5/28/20, Resident	#42 had a doctor's order for		The facility corrected the deficiency it relates to the individual Minimum Date.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			l	C 16/2020
NAME OF PI	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2020
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 13	F 6	657			
	Occupational Therapy as indicated. The OT note dated 5/2 Resident #42 was ref and high risk of worse decreased shoulder felbow extension and increased tone in his benefit from change of for greater wrist exterpositioning. Review of Resident # was conducted. One was resident at risk formotion in lower extreinave no further limital extremities by the next included splint to left resident tolerates by the observed lying in bed splint on his left elbow	(28/20 revealed that erred due to decline in ROM ening contractures, exhibits lexion, shoulder abduction, hand extension. He had bilateral wrist and may of splints or splint adjustment asion and improved 42's care plan dated 6/3/20 of the care plan problems or limitation in range of mities. The goal was to tion in ROM in lower at review. The approaches elbow and bilateral hands as restorative aide/nursing aide.			Set (MDS) Registered Nurse (RN) she was re-educated by the MDS Consultar on 7/30/2020. Restorative care plans waudited to make sure that they were accurate on 7/30/2020. There were no identified concerns from this audit. The MDS Nurse will meet weekly with the restorative aide for 12 weeks to audit or load and ensure care plan is updated wany resident discontinued from restoral and/or referred back to therapy. These audits will be turned in to the Director or Nursing weekly for 12 weeks. The syst to ensure that the problem does not resis to identify concerns by our audits regarding not revising care plans timely and to provide further education with o MDS Nurse as appropriate or more 1 of training by the MDS Consultant. 4. Director of Nursing will report any negative findings to the QAPI Committer of 3 months to review for any trends, additional recommendations and to determine the need for continued monitoring at the end of 3 months.	nt vere ase vith tive e of em cur vir	
	Aide (RNA) was inter Resident #42 was no splinting. She stated up by the Occupation in May 2020 and rest	viewed. The RNA stated that			5. 8/11/2020		
	interviewed. She ver Resident #42 in May	M, the MDS Nurse was ified that OT had picked up 2020 and when the OT was dent, restorative nursing was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 7/16/2020	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		7710/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658 SS=D	MDS Nurse stated the the splint application On 7/16/20 at 11:05 of (DON) was interview. Resident #42 was pide and the MDS assess 6/3/20, she expected reviewed and revised application by restoration by restoration the care plan Services Provided M. CFR(s): 483.21(b)(3) §483.21(b)(3) Compite Services provide as outlined by the compustion of the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compustion of the services provided as outlined by the compusion of the services provided as outlined by the compustion of the services provided as outlined by the compusion of the services provided as outlined by the compusion of the services provided as outlined by the compusion of the services provided as outlined by the compusion of the services provided as outlined by the compusion of the services provided as outlined by the services	at she should have removed from the care plan. AM, the Director of Nursing ed. The DON stated that cked up by OT in May 2020 ment was completed on the care plan to have been by removing the splint ative aide/nursing aide from eet Professional Standards (i) The chensive Care Plans d or arranged by the facility, mprehensive care plan,	F 6		off and	8/11/20	
	interviews, the facility admission orders for for 1 of 2 residents re (Resident #22). The findings included Resident #22 was or on 10/5/18 with the n of 7/7/2020. His diag neuromuscular dysfu chronic kidney disease. The quarterly Minimus	r failed to transcribe a urinary catheter change eviewed for urinary catheters d: iginally admitted to the facility nost recent readmission date noses included nction of the bladder and se.		physician interviews, the facil transcribe admission orders for catheter change orders for 1 residents reviewed for urinary (Resident #22) 1. Resident #22 urinary cathe order was transcribed to the National Administration Record by the Nurse (RN) Unit Manager on 2. Any resident that has a uricatheter at admission has the be affected by this practice.	lity ailed to for a urinary of 2 y catheters eter change Medication Registered 7/14/2020.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245202	B. WING		С	
	20//255 05 0//25//55	345293		OTREET ARRESTS OF A STATE TO CORE	07/16/2020	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 658	Continued From page	e 15	F 658	8		
	#22 had severe cogni	itive impairment and		3. All residents that have a urinary		
		nce from staff for toileting.		catheter were audited to assure that the	neir	
	An indwelling cathete			catheter change order was transcribed		
	J	·		the Medication Administration Record		
	The hospital discharg	e summary dated 7/7/2020		7/14/2020. The audit did not show any	,	
	was reviewed and inc	licated in the Details of		other concerns. The Assistant Directo	r of	
	Inpatient Stay section	to change the suprapubic		Nursing was re-educated on transcrib	ing	
	urinary catheter in on	e month.		to the MAR accurately on 7/22/2020 b		
				the Director of Nursing. All residents v		
		dated 7/7/20 for Resident		urinary catheter orders will be transcri		
		nd no order to change the		to the MAR on admission. Transcribin	·	
	suprapubic catheter v	vas noted.		the MAR is completed by the admitting		
	Decident #2015 summer	at MAD and Tractice and		nurse at time of admission. The facility		
		nt MAR and Treatment		ensure that all orders are transcribe to		
		ds (TAR) dated 7/7/20 to ed and no entry was noted to		MAR on all new admissions by review all new admission orders at morning	iiig	
		ic catheter in one month.		nurses meeting 5x a week to assure		
	change the suprapub	ic catheter in one month.		accuracy. All Licensed Nursing Staff v	vill	
	On 7/16/2020 at 9·10	AM, an interview occurred		be re-educated on transcribing to the	''''	
		ector of Nursing (ADON)		MAR on new admissions and any new	,	
		ssion orders under the		orders by the Staff Development		
	"medications reviewe	d by" section. She reviewed		Coordinator (SDC). New hires and ag	ency	
	the Hospital Discharg	e Summary dated 7/7/2020		staff will be educated during orientation	n by	
	and visualized the ins	truction to change the		the Staff Development Coordinator.		
		n one month. The ADON		8/4/2020		
		eviewed the discharge				
		the diagnoses, discharge		4. The Director of Nursing/Designee	will	
		utpatient follow-ups, and		audit new admits 5x a week times 4		
	_	he whole summary for any		weeks then monthly times 8 weeks.	.44	
		e verbalized it was an		Anything not transcribed will be correct		
	•	have been transcribed to AR. The ADON further		at that time and education provided to admitting nurse as needed. Director o		
		or the Staff Development		Nursing will share negative findings to		
	•	the transcribed admission		QAPI Committee monthly for 3 month		
	orders.	are dansonbed dumission		review any trends, needs to more		
	5. 3010.			education to licensed staff, additional		
	Nurse #1 was intervie	ewed on 7/16/2020 at 10:25		recommendations. QAPI Committee	will	
		e was on the admission		determine at the end of 3 months the		
		nplete entries checked"		need for continued monitoring.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 07/16/202 0	0
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	, , , , , , , , , , , , , , , , , , ,		-
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5 COMPLI DAT	ETION
F 658	as well as the hosp 7/7/2020 and verific the suprapubic cath present. Nurse #1 f as it was in the deta and she should have summary for other in been present. On 7/16/2020 at 11 was interviewed an new admissions or entire hospital dischoften find other inst summary. The Med expect the nursing hospital discharges orders/instructions. The Director of Nur 7/16/2020 at 11:30 expected the admis correctly and accurate Bedrails CFR(s): 483.25(n)(\$483.25(n) Bed Ra The facility must attallaternatives prior to a bed or side rail is correct installation, rails, including but relements.	red the current MAR and TAR ital discharge summary dated at the instruction to change neter in one month was not surther stated she overlooked it ails of the hospital stay section are reviewed the entire instructions that may have 100 AM, the Medical Director distated when he assessed readmissions, he reviewed the narge summary as he would ructions throughout the sical Director added he would staff to review the entire summary for sing was interviewed on AM and reported she sion orders to be transcribed ately.	F 6	5. 8/11/2020		8/11/20	0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 07/16/2020	
NAME OF P	ROVIDER OR SUPPLIER	I .	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		0171072020	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	Continued From pag		F 70	00			
	bed rails with the res	w the risks and benefits of sident or resident btain informed consent prior					
		e that the bed's dimensions ne resident's size and weight.					
	and maintaining bed This REQUIREMEN	nd specifications for installing					
	resident and staff int assess the resident rails and then quarte	view, observation and erview, the facility failed to prior to the use of the side orly for 1 of 2 sampled or side rail use (Resident		Based on record review, obseresident and staff interview, the failed to assess the resident process of the side rails and then of 1 of 2 sampled residents review rail use (Resident #11)	e facility rior to the quarterly for		
	1/23/20 with multiple Alzheimer's Disease assessment dated 4 Resident #11 had se and had 2 or more fa admission /reentry or Review of the nurse revealed that Reside and 3/19/20.	evere cognitive impairment alls with no injury since r prior assessment. s notes and incident reports ent #11 had a fall on 3/6/20		 Resident #11 physical device evaluation was completed on 7 by the Staff Development Cool Side rails were removed on 7/2 the Maintenance Director. All residents could be affect practice. All residents will have device use evaluation prior to a bedrails. Maintenance Director educated by the Nursing Home Administrator to not add bed rabed with out first talking to the Nursing on 7/31/2020. 	7/15/2020 rdinator. 15/2020 by ted by this e a physical adding r was e ails to any		
	care plan initiated or side rails. The probl increasing or mainta	eviewed. Resident #11 had a n 3/20/20 for the use of the em was "use of bed rails for ining current bed mobility or y in transfers-bilateral quarter		3. Measures taken by the faci ensure that the problem of usin without a physical device use of All residents are to have a phy	ng bedrails evaluation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						;	
		345293	B. WING _	-	07/1	6/2020	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE		
DIGUMON	D DIVIEO LIEAL TUO	DE AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 700	Continued From p	page 18	F 7	00			
	rails". The approa	ches included to assess		use evaluation completed by	8/7/2020 and		
		f entrapment from bed rails		then quarterly. 100% bed rai			
		s necessary and to evaluate use		completed on 7/15/2020 by S			
		odically for continued		Development Coordinator, R	N Unit		
	effectiveness and	appropriateness.		Manager, Treatment Nurse a			
				Director of Nursing. No other	r side rails		
	On 7/13/20 at 2:0	3 PM, Resident #11 was		were identified as needing to	be removed		
		bed with bilateral quarter rails in		or that did not have a physica			
		he resident stated that she		evaluation. Licensed Nursing	·		
	used it for turning	from side to side.		re-educated that a physical d			
				evaluation must be complete			
		3 PM, the MDS Nurse was		rails can be added to a reside	-		
		MDS Nurse stated that she		8/7/2020. Education to nursin	_		
	Resident #11 on 3	why the side rails were used for		provided by Staff Developme Coordinator. Maintenance w			
	Resident #11 on c	3/20/20.		Director of Nursing before a	-		
	On 7/16/20 at 8:5	0 AM, the Administrator was		added to a resident's bed. Ed			
		stated that Resident #11 had a		the Maintenance Director wa			
		d the care plan for the side rails		the Nursing Home Administra			
		/20/20. She reported that the		7/31/2020. A copy of the phy			
		e evaluated/assessed the		use evaluation once complete			
	resident prior to th	ne use of the side rails.		be given to the director of nu			
	·			was unable to identify how th			
	On 7/16/20 at 8:5	2 AM, the Director of Nursing		received rails and due to this	all side rails		
	(DON) was intervi	iewed. She stated that Resident		were removed off of all unoco	cupied beds		
		d for the need of the side rails		by Maintenance Department	on		
		he did not need them, so they		8/03/2020.			
		m her bed. The DON further					
		rse on 3/20/20 should have		4. The Director of Nursing/D	•		
	-	rail assessment for the resident		audit 20 beds weekly on walk	-		
	prior to use.			for 3 months to ensure side r			
	0-7/40/00 105	F ANA Nisses #44		been added to a resident's be			
		5 AM, Nurse # 1, assigned to		the use of the physical device			
		3/20/20, was interviewed. She		evaluation. A copy of the phy			
		sical Device assessment should		use evaluation once complete			
		or to the use of side rails. Nurse she didn't know why the		be given to the Director of Nu for 3 months. Audits will be t	•		
		issessment was not completed		the Nursing Home Administra			
		prior to the use of the side rails.		for 3 months. The Director of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			l	C 16/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2020
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	the DON was conductions she expected the nur	e 19 AM, a follow interview with ted. The DON stated that ses to complete the side r to use and then quarterly.	F 7	700	Nursing/Designee will share negative findings with the QAPI Committee to review for trends, additional recommendations & education needs. QAPI Committee will determine at the of 3 months the need for continued monitoring. 5. 8/11/2020	end	
F 756 SS=E	S483.45(c) Drug Reg §483.45(c)(1) The drumust be reviewed at I licensed pharmacist. §483.45(c)(2) This re of the resident's medical facility's medical direct and these reports mu (i) Irregularities to the at facility's medical direct and these reports mu (i) Irregularities including that meets the c (d) of this section for (ii) Any irregularities in during this review mu separate, written report attending physician a director and director and director and the irregularity th (iii) The attending phy resident's medical recirregularity has been	imen Review. ug regimen of each resident east once a month by a view must include a review ical chart. armacist must report any tending physician and the ctor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a	F 7	756			8/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			07/:	C 16/2020
NAME OF PR	ROVIDER OR SUPPLIER		1	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	011	10/2020
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 756	Continued From page	e 20	F	756			
	be no change in the r	nedication, the attending					
	physician should doc	ument his or her rationale in					
	the resident's medica	I record.					
	\$483.45(c)(5) The fac	cility must develop and					
		procedures for the monthly					
	-	that include, but are not					
	limited to, time frame	s for the different steps in					
		s the pharmacist must take					
		fies an irregularity that					
	This REQUIREMENT	n to protect the resident. is not met as evidenced					
	by:	f, hospice staff, Consultant			Based on facility staff, hospice staff,		
	_	Director (MD) and Hospice			Consultant Pharmacist, Medical Director	nr	
		views and record review, the			and Hospice Medical Director interview		
		st failed to identify and			and record review the Consultant		
		PRN) Ativan orders that			Pharmacist failed to identify and addres	ss	
		in duration (Residents #40,			as needed (PRN) Ativan orders that we		
	#32, #60, #15) for 4 c	of 4 residents reviewed for			not time limited in duration (Resident #	40.	
		also failed to act upon			#32, #60 & #15) for 4 of 4 residents		
	_	t recommendations to			reviewed for hospice. The facility also		
		al Involuntary Movement			failed to act upon Pharmacy Consultan	t	
	, ,	(Resident #59) 5 residents			recommendations to complete an		
		sary medications. The			Abnormal Involuntary Movement Scale		
	findings included:				(AIMS) for 1 of (#Resident #59) 5 residents reviewed for unnecessary		
	1 Resident #40 was	admitted on 9/25/17 with			medications.		
		of Cerebral Vascular			modicalions.		
		onic Obstructive Pulmonary			1. Residents #40, #32, #60 & #15 Ativa	an	
	Disease (COPD) and				are currently time limited in duration.		
	, ,	•			Hospice Nurse corrected this deficiency	y	
	Resident #40's revise	ed care plan dated 2/20/20			by obtaining clarification orders from th		
	read he was on hospi	ice care due to a terminal			Hospice Medical Director on 7/22/2020	to	
	illness.				include identifying and addressing as		
					needed psychotropic medication orders	s	
		2020 Physician orders			with time limited in duration. The		
	included an order dat				Abnormal Involuntary Movement Scale		
	(antianxiety) one milli	gram (mg) by mouth three			(AIMS) was completed on Resident #59	9	

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _				C / 16/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	10/2020	
				н	IIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	E AND REHABILITATION CENTE			IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From pag	ge 21	F 7	756				
	times a day as need	ed (hold for sedation).			by Staff Development Coordinator on 7/15/2020.			
	Resident #40's Medi	ication Administration						
	Records (MAR) from	n March 2020 to July 16, 2020			2. All residents that could be ordered			
	reveal he last receive	ed an Ativan dose on 3/10/20.			psychotropic medications as needed			
					(PRN) could be affected by the practic	e of		
		st Consultant Progress Note			not having a time limited duration. All			
		a medication regimen review			residents that are on psychotropic			
	was completed with	no recommendations.			medications could be affected by the			
	A monthly Dharmasi	at Canaultant Bragrass Note			practice of not completing a pharmacy			
		st Consultant Progress Note medication regimen review			recommendation of completing an Abnormal Involuntary Movement Scale	2		
		no recommendations.			(AIMS) quarterly, medication change	•		
	was completed with	no recommendations.			added or discontinued.			
	A monthly Pharmaci	st Consultant Progress Note						
	_	a medication regimen review			3. Licensed Nursing Staff & DON were	Э		
		no recommendations.			educated on following pharmacy			
					recommendations and completing			
		st Consultant Progress Note			Abnormal Involuntary Movement Scale			
		a medication regimen review			(AIMS) quarterly by the Staff Developn			
	•	a recommendation to			Coordinator 8/7/2020. 7/21/2020 phor			
	nursing.				conference was held with Administrativ	re		
	Th - O				Nursing Staff, Nurses, Nursing Home	4		
		rmacist's Medications			Administrator and Pharmacy Consultar to review the Executive Summary.	าเร		
	_	te for nursing dated 6/20/20 onsider discontinuation PRN			Recommendations were put in place a	nd		
		natic stop order policy. This			taken to QAPI Committee on 7/23/202			
	•	luded Ativan. It further read			In-service on Pharmacy Executive	J.		
		RNs that have not been used			Summary to Director of Nursing by the	;		
		tions from going out of date,			Wound Consultant on 7/22/2020.			
	free up medication c	art storage and save the			Licensed Nurses were in-serviced on			
		ollow through response read			automatic stop order policy and MAR			
	that the Ativan was a	a hospice order for comfort			checks on 7/16/2020 by the Staff			
	care.				Development Coordinator. Staff			
	.				Development Coordinator will educate			
		nducted with the Assistant			Hospice nurses that provide services to			
		ADON) on 7/16/20 at 8:27			our on facility on psychotropic medicat			
		Consultant Pharmacist			having time limited duration by 8/7/202			
	∣ ⊢nysician Recomme	endations were given to the			An audit will be completed for the last	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			07/	16/2020
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DIGUMON	D DINES HEALTHOAD	- 4 N.D. DELLA DIL ITATION OF NITE		HI	GHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	E AND REHABILITATION CENTE		H	AMLET, NC 28345		
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F 756	to make sure they we she reviewed the Me notes and addressed identified. She stated response on the Con Medications Regime The ADON stated R was prescribed by he aware that PRN Ative duration and reassed. A telephone interview Consultant Pharmace She stated she was she had discussed a medications time lim Consultant Pharmace complete a Physicia 3/24/20, 4/18/20 and noted Resident #40' Medication Regimer addressed by nursin policy to streamline abother the prescribin The facility's automation 4/15/11 did not in medications.	d she followed up with the MD ere addressed. She stated edication Regimen Review d any nursing concerns d she wrote the follow through insultant Pharmacist's en Review note dated 6/20/20. esident #40's PRN Ativan ospice and she was not an had to be time limited in ssed by the Physician. W was conducted with sist #1 on 7/16/20 at 8:54 AM. new to the facility and that at length the PRN antianxiety exist #1 confirmed she did not in Recommendation on d 5/18/20. She stated she is PRN Ativan orders in her in Review notes to be g by using the automatic stop the process in an effort not to ing Physician.	F 7	756	months regarding the Executive summand the last 30 days regarding the pharmacy recommendations by the DON/Designee 8/09/2020. An audit will completed on all residents that are ordered PRN as needed psychotropics the last 30 days to ensure for automatic stop orders or the need to discontinue. This audit will be reviewed with the Medical Director 8/09/2020 4. Facility will review all new or discontinued psychotropic medications that are PRN to ensure that problem do not recur. This will be reviewed in Nurs morning meeting daily 5 times a week of 12 weeks for duration time limit. The Director of Nursing/Designee will identified address PRN psychotropic medications for 12 weeks. Director of Nursing to review pharmacy's executive summary with the Medical Director monthly for 3 months to ensure pharmare recommendations are completed. The Director of Nursing/Designee will report on progress to the Quality Assurance & Performance Improvement Committee monthly for 3 months and then at the direction of the QAPI Committee. Director of Nursing/Designee will present negating to the QAPI Committee monthly to review for trends, the need for provice monthly for trends, the need for provice in the progress of the part of the province of the quality Assurance of the QAPI Committee monthly to review for trends, the need for provice in the part of the province of the quality and the part of the quality and the part of the quality Assurance o	for conserved to conserve to c	
	He stated he was ave time limited in durati continued use. He s Physician Recomme #40's PRN Ativan. H Physician Recomme	vare that Ativan had to be on then re-evaluated for the tated he not received any endations regarding Resident le stated he received endations from his other in this facility. He stated the			re-education, additional recommendation and to determine the need for continue monitoring. 5. 08/11/2020	ons	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 07/16/2020
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 07710/2020
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 756	the Consultant Phamedication review a any medication irre Consultant Pharma Another interview won 7/16/20 at 9:20 contact the prescribthe Medication Regwas her understand Recommendation worder Consultant Pharmato address. The AD Regimen Review no prescribing Physicianursing. An interview was consultant Pharmato address. The AD Regimen Review no prescribing Physicianursing. An interview was consultant Pharmato address. The AD Regimen Review no prescribing Physicianursing. An interview was consultant physicianursing.	endations were triggered by rmacist during a monthly and it was his expectation that gularities be address by the cist. Vas conducted with the ADON AM. She stated she did not bing Physician when reviewing imen Review notes because it	F 756	,	
	Medical Director re- Physician Recomm about PRN medical seeing any from thi An interview was co 7/16/20 at 10:55 AN Consultant Pharma Recommendation for he had not received Recommendation r Ativan. The MD sta the Consultant Pharma	ceived faxed pharmacy endations from other facilities tions but she did not recall s facility. onducted with the MD on M. He stated normally the cist generated a Physician or him to address. He stated			

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345293	B. WING			C 7/16/2020
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	EAND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 756	Another telephone in Consultant Pharmaco AM. She stated she recommendations all in the Executive Sum Pharmacist's Medica given to the facility she doesn't always a stated she was awar for PRN psychotropi why she did not com Recommendations. An interview was con Nursing (DON) on 7/stated it was her exp Consultant Pharmaco Recommendation re Ativan. 2. Resident #15 was the facility on 2/21/19 included heart disea hyperlipidemia. The significant changassessment dated 4/#15's cognition was noted with a prognos was on hospice. A physician's order 6/1/20 indicated Ativ	n review regarding any ties. Interview was conducted with ist #1 on 7/16/20 at 11:09 documented her cout the PRN psychotropics mary of the Consultant ation Regimen Review report nonthly. She stated she only one day a month and that access to the MAR's. She are of the time limited duration cs but was unable to explain aplete Physician	F 75	56		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		345293	B. WING _			07/1	; 16/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		0.2020
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
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F 756	Continued From page	e 25	F7	756			
	medication regimen recompleted on 6/12/20 #2. There were no recompleted to Resident # on 6/1/20 that was parent of the 6/1/20 that was parent of the 6/1/20 the facility resident #15 indicate administered. The July 2020 active Resident #15 were recompleted the 6/1/20 Forder continued to be an interview was condificated by the facility resident was regulation applied to the facility residents that orders for PRN psychrequired to be time lin Nurse #1 revealed the facility revealed	ducted with the Assistant ADON) on 7/16/20 at 8:27 d Resident #15 's PRN d by the hospice physician. It is aware of the regulation ician 's orders for PRN ician to be time limited in a not aware that the hospice residents. I ducted Hospice Nurse #1 on She stated PRN Ativan was offert package and it was stop date. She indicated she regulation applicable to all indicated physician 's notropic medications were mited in duration. Hospice at all of their hospice y had a physician 's order					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 07/16/2020
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	CODE	07/16/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	Hospice Medical Dire He confirmed that the normally included a partial Ativan with no stop of aware of the regulation residents that indicate PRN Ativan were requiration. He reported Ativan with no stop of resident, he was aler recommendation from Consultant and/or by stop date was impler received no notification physician 's order dawith no stop date. A phone interview was Consultant #2 on 7/1 stated that she was a medications were reduration. The PRN Adated 6/1/20 that con Resident #15 was reconsultant #2. She notes in her June 20 Resident #15 had a pativan with no stop dithere were times who out of the hard copy	wwas conducted with the ector on 7/16/20 at 9:05 AM. e hospice comfort package physician 's order for PRN late. He stated he was on applicable to all facility ed physician 's orders for puired to be time limited in that normally, if PRN late was ordered for a facility	F	756		
	psychotropic medica had been on an ongo back as far as Febru that every month she Consultant #1 compl	tion orders with no stop date bing issue at the facility going ary 2020. She explained				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
345293 B. WING		C 07/16/2020	
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	07/16/2020	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			
Review" that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. Pharmacy Consultant #2 requested that the "Executive Summary of Consultant Pharmacist's Medication Regimen Review" for June 2020 be reviewed for additional information. As requested by Pharmacy Consultant #2 during her phone interview, the "Executive Summary of Consultant Pharmacist's Medication Regimen Review" dated 6/20/20 for the time period of 6/1/20 through 6/20/20, read, in part: "All PRNs [psychoactive medications] require stop dates per [Centers for Medicare and Medicaid Services]. May wish to make all prescribers and nursing staff aware of this regulation." An interview was conducted with the Medical Director on 7/16/20 at 10:55 AM. The Medical Director stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration. He additionally stated that he was aware this regulation applied to hospice residents. He indicated that it was an error if a stop date was not included in the physician's order for a PRN psychotropic medication. The Medical Director reported that he depended on the Pharmacy Consultant to identify and address PRN psychotropic medication orders that had no stop date during the monthly medication regimen review. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN psychotropic medications to be	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 7/ 16/2020	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		7716/2020	
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F 756	that she was aware hospice residents. The explain why Resider PRN Ativan (initiated date. She indicated hospice staff audited their facility resident physician 's orders date and that this had and corrected. She on the Pharmacy Coladdress PRN psychological properties of the propert	on. She additionally stated this regulation applied to The DON was unable to at #15 had an active order for the one of 1/20) that had no stop that it was possible that the the comfort packages for so one 6/1/20 and reinitiated for PRN Ativan with no stop and not yet been not identified a reported that she depended onsultant to identify and otropic medication orders that ring the monthly medication	F 75	56			
	the facility on 9/20/1 included heart disear A physician 's order 6/1/20 indicated Ativ milligram (mg) every This PRN Ativan phydate. The quarterly Minimassessment dated 6 #60 's cognition was was noted with a proand was on hospice The most recent momedication regimen completed on 6/12/2 #2. There were no related to Resident #	for Resident #60 dated an (antianxiety medication) 1 a 8 hours as needed (PRN). a sician 's order had no stop um Data Set (MDS) a resident b moderately impaired. He b ognosis of less than 6 months					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED		
		345293	B. WING _			C 07/16/2020	
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		<u>'</u>	07710/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 756	Continued From pa	ge 29	F 7	56			
	Medication Adminis Resident #60 indica administered. The July 2020 activ Resident #60 were revealed the 6/1/20 order continued to b An interview was co Director of Nursing AM. The ADON sta Ativan was prescrib She revealed she w that required all phy psychotropic medic duration, but she was	20 through 7/15/20 hard copy tration Records (MARs) for ated no PRN Ativan had been be physician 's orders for reviewed on 7/15/20 and PRN Ativan physician 's period active. Inducted with the Assistant (ADON) on 7/16/20 at 8:27 ted Resident #60 's PRN led by the hospice physician. It is aware of the regulation visician 's orders for PRN ations to be time limited in as not aware that the pohospice residents.					
	7/16/20 at 9:50 AM part of the hospice prescribed without a was not aware of the facility residents that orders for PRN psyrequired to be time Nurse #1 revealed residents at the facility at the facility PRN Ativan with A telephone intervied Hospice Medical Diese He confirmed that the normally included a Ativan with no stop	onducted Hospice Nurse #1 on She stated PRN Ativan was comfort package and it was a stop date. She indicated she regulation applicable to all at indicated physician 's chotropic medications were limited in duration. Hospice that all of their hospice lity had a physician 's order no stop date. The was conducted with the rector on 7/16/20 at 9:05 AM. The hospice comfort package physician 's order for PRN date. He stated he was tion applicable to all facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			01710/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 756	PRN Ativan were reduration. He report Ativan with no stop resident, he was all recommendation for Consultant and/or it stop date was imple received no notifical physician 's order of with no stop date. A phone interview were reduration. The PRN dated 6/1/20 that consultant #2 on 70 stated that she was medications were reduration. The PRN dated 6/1/20 that consultant #2. She notes in her June 2 Resident #60 had a Ativan with no stop there were times whout of the hard copy Pharmacy Consultant psychotropic medic had been on an one back as far as Febrithat every month she Consultant Pharm Review" that provide the medication regimenth. She further was not part of the	ated physician 's orders for equired to be time limited in the dethat normally, if PRN date was ordered for a facility erted by a pharmacy on the facility 's Pharmacy or facility nursing staff and a temented. He revealed he tion related to Resident #60 's dated 6/1/20 for PRN Ativan was conducted with Pharmacy (16/20 at 12:00 PM. She aware that PRN psychotropic equired to be time limited in Ativan physician 's order ontinued to be active for eviewed with Pharmacy ereported that she had no 020 review that indicated a physician 's order for PRN date. She explained that then telephone orders slipped or charts and/or were missed. In the properties with no stop date going issue at the facility going uary 2020. She explained the and/or Pharmacy oleted an "Executive Summary of men review results for that explained that this summary medical record for each of Consultant #2 requested that	F 7	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD SUDDI IED	343233	B. WING _	STREET ADDRESS CITY STATE 7ID CODE		07/16/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
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F 756		e 31 ation Regimen Review" for	F 7	756			
	June 2020 be reviewe	ed for additional information. macy Consultant #2 during					
	her phone interview, to Consultant Pharmacis	he "Executive Summary of st 's Medication Regimen					
	6/1/20 through 6/20/2	ive medications] require					
	Medicaid Services]. I prescribers and nursi regulation."	May wish to make all					
	Director on 7/16/20 at Director stated he wa	ducted with the Medical t 10:55 AM. The Medical s aware of the regulation					
	be time limited in dura that he was aware thi	psychotropic medications to ation. He additionally stated s regulation applied to a indicated that it was an					
		a PRN psychotropic lical Director reported that					
	identify and address I	t had no stop date during					
		ducted with the Director of 6/20 at 11:30 AM. The					
	DON stated she was required all PRN psyc	aware of the regulation that chotropic medications to be					
	that she was aware th	n. She additionally stated his regulation applied to he DON was unable to					
	PRN Ativan (initiated	#60 had an active order for on 6/1/20) that had no stop hat it was possible that the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 756	their facility residen physician 's orders date and that this h and corrected. Shoon the Pharmacy C address PRN psychhad no stop date do regimen review. 4. Resident #32 was the facility on 5/23/included heart diseapulmonary disease. The quarterly Minimassessment dated 's cognition was senoted with a prognowas on hospice. A physician 's orde 6/1/20 indicated Atimilligram (mg) ever This PRN Ativan physication regimer completed on 6/20/recommendations resident prescribed with no second A review of the 6/1/Medication Administration regimer completed with no second physician is prescribed with no second physician is physician in the physician is prescribed with no second physician is physician in the physician in the physician is prescribed with no second physician in the physician is physician in the	d the comfort packages for ts on 6/1/20 and reinitiated for PRN Ativan with no stop ad not yet been not identified e reported that she depended onsultant to identify and notropic medication orders that uring the monthly medication s most recently admitted to 19 with diagnoses that ase and chronic obstructive for mum Data Set (MDS) 15/7/20 indicated Resident #32 everely impaired. She was posis of less than 6 months and for for Resident #32 dated wan (antianxiety medication) 1 by 8 hours as needed (PRN). The system of the system o	F 75	6	

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	TE SURVEY MPLETED	
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F 756	Resident #32 were revealed the 6/1/20 order continued to be an interview was concentrated by the An interview was prescribed. The ADON staff Ativan was prescribed she was regulation applied to the An interview was concentrated at the facility residents the orders for PRN psychotropic medical to the hospice of the hospice of the facility residents the orders for PRN psychotropic medical to the hospice of the hospice of the facility residents the orders for PRN psychotropic medical to the tresidents at the facility residents at the fa	e physician 's orders for reviewed on 7/15/20 and PRN Ativan physician 's be active. Inducted with the Assistant ((ADON) on 7/16/20 at 8:27 ted Resident #32 's PRN ed by the hospice physician. It is as aware of the regulation resician 's orders for PRN ations to be time limited in as not aware that the phospice residents. Inducted Hospice Nurse #1 on She stated PRN Ativan was comfort package and it was a stop date. She indicated she e regulation applicable to all at indicated physician 's chotropic medications were limited in duration. Hospice that all of their hospice lity had a physician 's order no stop date. In was conducted with the rector on 7/16/20 at 9:05 AM. The hospice comfort package physician 's order for PRN date. He stated he was tion applicable to all facility ated physician 's orders for quired to be time limited in	F 75	6			
	Ativan with no stop	ed that normally, if PRN date was ordered for a facility erted by a pharmacy					

1 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED	
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F 756	Continued From pa	ge 34 om the facility ' s Pharmacy	F 75	56			
	Consultant and/or be stop date was imple received no notifical	by facility nursing staff and a semented. He revealed he tion related to Resident #32 's dated 6/1/20 for PRN Ativan					
	A phone interview was conducted with Pharmacy Consultant #1 on 7/16/20 at 8:54 AM. She indicated that she was new to the facility and she worked with Pharmacy Consultant #2. She stated that she was aware that PRN psychotropic						
	duration. The PRN dated 6/1/20 that co Resident #32 was r	equired to be time limited in Ativan physician 's order ontinued to be active for eviewed with Pharmacy e confirmed she had not					
	addressed the 6/1/2 order with no stop of medication regimen	acy recommendation that 20 PRN Ativan physician 's late during the June monthly review for Resident #32. ant #1 revealed that PRN					
	psychotropic medic had been an ongoir explained that inste	ation orders with no stop date ng issue at the facility. She ad of writing a pharmacy secific to Resident #32, the					
	orders with no stop summary of monthly provided to the facil Pharmacy Consulta	N psychotropic medication date was addressed in the y regimen reviews that was ity. She indicated that int #2 would be able to explain					
	Consultant #2 on 7/ Pharmacy Consulta Consultant #1 ' s sta psychotropic medic	vas conducted with Pharmacy 16/20 at 12:00 PM. int #2 reiterated Pharmacy					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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F 756	back as far as Februa that every month she Consultant #1 comple of Consultant Pharma Review" that provided the medication regime month. She further ewas not part of the mresident. Pharmacy the "Executive Summe Pharmacist's Medica June 2020 be review." As requested by Phather phone interview, Consultant Pharmacist Review" dated 6/20/2 6/1/20 through 6/20/2 [psychotropic medicate [Centers for Medicare May wish to make all staff aware of this regulation of the state of the wastaff aware and the wastaff aware this hospice residents. Herror if a stop date was physician's order for medication. The Medication orders that the monthly medication.	ary 2020. She explained and/or Pharmacy eted an "Executive Summary acist's Medication Regimen of the facility a summary of en review results for that explained that this summary edical record for each Consultant #2 requested that eation Regimen Review" for ead for additional information. The "Executive Summary of est's Medication Regimen Period of entry of the time period of entry of the time period of entry of the time period of entry ent	F 7	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345293	B. WING		07/16/2020
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	01/10/2020
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F 756	DON stated she warequired all PRN ps time limited in durat that she was aware hospice residents. explain why Reside PRN Ativan (initiate date. She indicated hospice staff audite their facility residen physician's orders date and that this hand corrected. Shoon the Pharmacy Caddress PRN psych	ge 36 7/16/20 at 11:30 AM. The s aware of the regulation that ychotropic medications to be ion. She additionally stated this regulation applied to The DON was unable to nt #32 had an active order for d on 6/1/20) that had no stop is that it was possible that the d the comfort packages for ts on 6/1/20 and reinitiated for PRN Ativan with no stop ad not yet been not identified a reported that she depended onsultant to identify and notropic medication orders that uring the monthly medication	F 75	56	
	3/21/19 with multipl Schizophrenia and MDS assessment of Resident #59's cog exhibited other beh Resident # 59 was psychiatric services management. Duri psychiatric service discontinue the Ris for Resident #59. On 3/23/20, the Co conducted the drug Resident #59 and h for "need Dyskinesi	as admitted to the facility on the diagnoses including Psychosis. The quarterly atted 6/27/20 indicated that the inition was intact, and she had avioral symptoms. The ing followed by the monthly for medication and the 3/12/20 visit, the mad recommended to perdal (an antipsychotic drug) The insultant Pharmacist had regimen review (DRR) for ad recommended to nursing a Identification System cale (DISCUS) due to			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
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F 756	discontinuation of Ris The electronic record reviewed. The last D 2/27/20. There was r 3/23/20. On 7/15/20 at 1:45 Pl (DON) was interviewed. Assistant Director of responsible for makin recommendations frowere acted upon. On 7/15/20 at 5:05 Pl interviewed. She star for responding to the recommendations. S received the recomm	s for Resident #59 were ISCUS completed was on no DISCUS completed after M, the Director of Nursing ed. The DON stated that the Nursing (ADON) was g sure the m the Pharmacy Consultant M, the ADON was ted that she was responsible	F	756		
F 758 SS=E	resident, but she did On 7/16/20 at 11:05 A was conducted with t that she expected the recommendation to b reported that the reco DISCUS for Resident the part of the ADON Free from Unnec Psy CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(c)(3) A psyciaffects brain activities processes and behave	AM, a follow up interview the DON. The DON stated to Pharmacist the acted upon timely. She to part of the need of the state of the stat	F7	758		8/11/20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 758	resident, the facility of \$483.45(e)(1) Reside psychotropic drugs a unless the medicatio specific condition as in the clinical record; \$483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in a drugs; \$483.45(e)(3) Reside psychotropic drugs punless that medicate diagnosed specific or in the clinical record; \$483.45(e)(4) PRN or are limited to 14 day; \$483.45(e)(5), if the prescribing practition appropriate for the Pbeyond 14 days, he rationale in the residindicate the duration \$483.45(e)(5) PRN or \$483.45(e)(6)(6) PRN	ensive assessment of a must ensure that ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive entraunt to a PRN order on is necessary to treat a condition that is documented and enter for psychotropic drugs is. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and	F 758			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		` ′				(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CUIDDUED	343233	B: Wiite _		TREET ADDRESS CITY STATE ZID CODE	07/	16/2020	
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489			
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F 758	Continued From page renewed unless the a	ttending physician or	F 7	758				
	the appropriateness of	er evaluates the resident for of that medication. is not met as evidenced						
	Based on facility staf Pharmacist, Medical Medical Director inter facility failed to ensur needed (PRN) Ativan duration (Residents # residents reviewed for included:	f, hospice staff, Consultant Director (MD) and Hospice views and record review, the re physician's orders for as were time limited in 40, #32, #60, #15) for 4 of 4 r hospice. The findings			Based on facility staff, hospice staff, Consultant Pharmacist, Medical Director and Hospice Medical Director interview and record review, the facility failed to ensure physician's orders for as neede (PRN) Ativan were limited in duration (Residents #40, #32, #60 & #15) 4 of 4 residents reviewed for hospice.	d		
	Accident (CVA), Chro Disease (COPD) and Resident #40's quarte	s of Cerebral Vascular nic Obstructive Pulmonary anxiety. erly Minimum Data Set indicated severe cognitive			orders were changed on 7/16/2020 to be limited in duration. All now have a stop order. Hospice RN corrected deficience by obtaining clarification order from Hospice Medical Director on 7/22/2020	y		
	impairment and he was behaviors. The MDS received any antianxi also coded for hospic	as coded for physical indicated he had not ety medications. He was e.			2. All residents that are on psychotropic medications PRN have the potential to affected by this practice. All residents that are put on hospice with orders for a comfort package will have stop orders in	be hat		
	read he was on hospillness.	d care plan dated 2/20/20 ce care due to a terminal			the regulation regarding Psychotropic medications PRN's must have a time liduration. 3. The Director of Nursing/Designee w			
	included an order dat (antianxiety) one milli times a day as neede Resident #40's Medic Records (MAR) from 2020 revealed, the Pl	gram (mg) by mouth three d (hold for sedation).			audit all Hospice residents that are on Psychotropic medications that are PRN will be audited for stop orders by 8/03/2020. All Hospice residents had thave stop orders for PRN psychotropic which was corrected by the Hospice RI on 7/22/2020. Any that do not have sto orders will be brought to the Medical Director's attention to determine if he	o s N		

DI AN OF CORRECTION INTERCATION NUMBER:			B) DATE SURVEY COMPLETED		
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inued From pa	ge 40	F 75	8		
esident last rec 20. Executive Sum macist's Medica 20 read the fact the Centers of lices (CMS) reg I) time limited of Executive Sum macist's Medica 20 read all PRI date per CMS I date date per CMS I date date per CMS I date date date date date date date date	mary of Consultant's ation Regimen Review dated sility was still having issues Medicare and Medicaid ulation regarding as needed duration of psychotropics. mary of Consultant's ation Regimen Review dated N psychotropics must have a regulation. mary of Consultant's ation Regimen Review dated N psychotropics must have a regulation. mary of Consultant's ation Regimen Review dated N psychotropics must have a regulation. must be a few of the Assistant (ADON) on 7/16/20 at 8:27 reviewed the Executive tant's Pharmacist's an Review summary monthly. The sident #40's PRN Ativan pospice and she was not a read to be time limited in seed by the Physician. W was conducted with cist #1 on 7/16/20 at 8:54 AM. new to the facility and that	F 75	wants to discontinue the milimit the durationstop order Director of Nursing/Design hospice nurses & facility lic regarding time limit duration. Psychotropic medications. be completed by 8/7/2020. review all residents admitted ensure for stop orders on predications to ensure that limited in duration so problemeter 5 times a week for 12 morning meeting. Also at a meeting 5x a week all order reviewed for psychotropic I stop orders. This will be on of Nurses morning meeting. 4. The Director of Nursing share negative findings more Quality Assurance & Perfolimprovement Committee for any trends, recommendation.	er by 8/4/2020 ee will educate censed staff in son PRN Education to Facility will ed to Hospice to esychotropic they are time em does not 2 weeks at morning nurses ers will be PRN's with no in-going as part 3. //Designee will onthly to the rmance or 3 months for ons, training	
E E E E E E E E E E E E E E E E E E E	EXECUTIVE Summariastics (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited of the Centers of lices (CMS) reg N) time limited o	IDENTIFICATION NUMBER: 345293 R OR SUPPLIER ES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) cinued From page 40 esident last received a dose of Ativan on	R OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Finued From page 40 esident last received a dose of Ativan on 1/20. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read the facility was still having issues the Centers of Medicare and Medicaid ices (CMS) regulation regarding as needed 1/20 read all PRN psychotropics. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated 1/20 at 8:27 She stated she reviewed the Executive mary of Consultant's Pharmacist's iciation Regimen Review summary monthly. ADON stated Resident #40's PRN Ativan prescribed by hospice and she was not re that PRN Ativan had to be time limited in tion and reassessed by the Physician. ephone interview was conducted with sultant Pharmacist #1 on 7/16/20 at 8:54 AM. stated she was new to the facility and that had discussed at length the PRN antianxiety iciations time limited duration with the facility documented her recommendations in the	R OR SUPPLIER SHEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILD'S TO EXPECTED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Insued From page 40 Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. 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Executive Summary of Consultant's macist's Medication Regimen Review dated (20 read all PRN psychotropics must have a date per CMS regulation. Executive Summary of Consultant's macist's Medication Regimen Review

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
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F 758	•	ew was conducted with the	F 75	58			
	He stated he was a time limited in dura continued use. He recommendations of Ativan and it was homedication irregular. An interview was compact and the state of	irector on 7/16/20 at 9:05 AM. It was that Ativan had to be to the stated he not received any regarding Resident #40's PRN is expectation that any rities be address by the facility. I conducted the Hospice Nurse 50 AM. She stated since the lart of the hospice comfort at re-evaluated. She stated she he time limited use of PRN spice resident's Physician ect.					
	7/16/20 at 10:55 Al received any recon Resident #40's PR his expectation that pharmacy recommendication irregular An interview was conversing (DON) on stated it was her expectation on any Expectation of the pharmacy of the properties of the prope	onducted with the MD on M. He stated he had not homendations regarding N Ativan. The MD stated it was at the facility follow-up on any endations regarding any rities. Onducted with the Director of 7/16/20 at 11:25 AM. She expectation the that the facility executive Summary of hacist's Medication Regimen ecommendations regarding a of PRN psychotropics.					
	the facility on 2/21/	as most recently admitted to 19 with diagnoses that ase, hypertension, and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 758	Continued From pa	ge 42	F 75	58			
	assessment dated #15 's cognition wanoted with a prognowas on hospice. A physician 's order 6/1/20 indicated Atimilligram (mg) ever This PRN Ativan physician PRN Ativan physician Administered. A review of the 6/1/Medication Administered. The July 2020 active Resident #15 indicated administered. The July 2020 active Resident #15 were revealed the 6/1/20 order continued to be a fixed by the physician was prescribed by the physician applied to the physician applied	onducted with the Assistant (ADON) on 7/16/20 at 8:27 ted Resident #15 's PRN bed by the hospice physician. vas aware of the regulation visician 's orders for PRN ations to be time limited in as not aware that the to hospice residents. onducted Hospice Nurse #1 on She stated PRN Ativan was comfort package and it was					
	date. A review of the 6/1/ Medication Adminis Resident #15 indica administered. The July 2020 activ Resident #15 were revealed the 6/1/20 order continued to I An interview was co Director of Nursing AM. The ADON sta Ativan was prescrib She revealed she w that required all phy psychotropic medic duration, but she w regulation applied to An interview was co 7/16/20 at 9:50 AM part of the hospice prescribed without a was not aware of the	20 through 7/15/20 hard copy stration Records (MARs) for lated no PRN Ativan had been be physician 's orders for reviewed on 7/15/20 and PRN Ativan physician 's per active. Inducted with the Assistant (ADON) on 7/16/20 at 8:27 ted Resident #15 's PRN led by the hospice physician. It is orders for PRN ations to be time limited in lass not aware that the lon hospice residents.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 7/16/2020		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		7/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 758	required to be time I Nurse #1 revealed to residents at the facil for PRN Ativan with A telephone intervie Hospice Medical Dir He confirmed that the normally included a Ativan with no stope aware of the regulatoresidents that indicate PRN Ativan were reduration. He reported Ativan with no stope are sident, he was alto recommendation from Consultant and/or both stope date was implead to receive the no notificate physician is ordered with no stope date. A phone interview were with the facility of the faci	chotropic medications were imited in duration. Hospice that all of their hospice ity had a physician 's order no stop date. W was conducted with the fector on 7/16/20 at 9:05 AM. It has be hospice comfort package physician 's order for PRN date. He stated he was ion applicable to all facility ted physician 's orders for quired to be time limited in the data normally, if PRN date was ordered for a facility red by a pharmacy method that normally is Pharmacy y facility nursing staff and a mented. He revealed he ion related to Resident #15 's ated 6/1/20 for PRN Ativan	F 75					
	indicated she was n worked with Pharma stated she was awa for PRN psychotropic to be time limited in PRN psychotropic m date had been an or A phone interview w Consultant #2 on 7/stated she was awa psychotropic medical	16/20 at 8:54 AM. She ew to the facility and she acy Consultant #2. She re that all physician 's orders ic medications were required duration. She revealed that nedication orders with no stop agoing issue at the facility. as conducted with Pharmacy 16/20 at 12:00 PM. She re that all orders for PRN ations were required to be on. Pharmacy Consultant #2						

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		2.45000		_			
		345293	B. WING			07/	16/2020
	ROVIDER OR SUPPLIER ID PINES HEALTHCARE	EAND REHABILITATION CENTE		н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	that PRN psychotrons stop date had been of facility going back as explained that every Consultant #1 complion of Consultant Pharma Review" that provide the medication regime month. She further of was not part of the medication. Pharmacy the "Executive Summer Pharmacist" is Medically June 2020 be review. As requested by Phase Pharmacist in Shedically Services and Prescribers and nursure gulation." An interview was conditionally prescribers and nursure gulation. The prescribers in the was aware the spice residents. Herror if a stop date with the was aware the spice residents. Herror if a stop date with physician is order for medication.	Consultant #1 's interview of medication orders with no on an ongoing issue at the safar as February 2020. She month she and/or Pharmacy leted an "Executive Summary facist 's Medication Regimen and the facility a summary of the review results for that explained that this summary medical record for each Consultant #2 requested that mary of Consultant teation Regimen Review" for yed for additional information. Tarmacy Consultant #2 during the "Executive Summary of the "Executive Summary of the "Executive Summary of the "Executive Regimen 20 for the time period of	F	758			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 07/16/2020		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 758	DON stated she wa required all PRN ps time limited in durat that she was aware hospice residents. explain why Reside PRN Ativan (initiate date. She indicated hospice staff audited their facility resident physician 's orders date and that this had and corrected. 3. Resident #60 was the facility on 9/20/1 included heart disease. A physician 's order 6/1/20 indicated Atimilligram (mg) even This PRN Ativan physician 'massessment dated 6/1/20 indicated Atimilligram (mg) even This PRN Ativan physician dated. The quarterly Minimassessment dated 6/1/20 indicated Ativan physician was noted with a physician was noted with a physician dated for the following physician was noted with a physician w	/16/20 at 11:30 AM. The s aware of the regulation that ychotropic medications to be ion. She additionally stated this regulation applied to The DON was unable to nt #15 had an active order for d on 6/1/20) that had no stop that it was possible that the d the comfort packages for s on 6/1/20 and reinitiated for PRN Ativan with no stop ad not yet been not identified as most recently admitted to 9 with diagnoses that	F 758				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 07/16/2020	
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	revealed the 6/1/20 order continued to be a continued and a continued to be a continued and a continued to be a continue	reviewed on 7/15/20 and PRN Ativan physician 's be active. Inducted with the Assistant (ADON) on 7/16/20 at 8:27 ted Resident #60 's PRN ed by the hospice physician. It is a saware of the regulation visician 's orders for PRN eations to be time limited in eas not aware that the polyphysician hospice residents. Inducted Hospice Nurse #1 on She stated PRN Ativan was comfort package and it was a stop date. She indicated she had regulation applicable to all at indicated physician 's chotropic medications were limited in duration. Hospice that all of their hospice lity had a physician 's order	F 75	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			07/·	C 16/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	, <u>, , , , , , , , , , , , , , , , , , </u>	10/2020	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 758	Continued From page	e 47	F 7	758				
	stop date was implen	nented. He revealed he on related to Resident #60 ' s ted 6/1/20 for PRN Ativan						
	Consultant #1 on 7/10 indicated she was ne worked with Pharmac stated she was award for PRN psychotropic to be time limited in dPRN psychotropic medate had been an one	s conducted with Pharmacy 6/20 at 8:54 AM. She w to the facility and she by Consultant #2. She et that all physician 's orders a medications were required duration. She revealed that edication orders with no stop going issue at the facility.						
	Consultant #2 on 7/10 stated she was aware psychotropic medicat time limited in duration reiterated Pharmacy that PRN psychotropic stop date had been of facility going back as explained that every consultant #1 completed of Consultant Pharmackeriew" that provided the medication regimmenth. She further ewas not part of the more sident. Pharmacy the "Executive Summer Pharmacist's Medical June 2020 be review."	ation Regimen Review" for ed for additional information.						
	her phone interview,	rmacy Consultant #2 during the "Executive Summary of st's Medication Regimen						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 07/16/2020	
	ROVIDER OR SUPPLIER D PINES HEALTHCAF	RE AND REHABILITATION CENTE	•	STREET ADDRESS, CITY, STATE, ZIP O HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 758	6/1/20 through 6/20 "All PRNs [psychological prescribers and nuregulation." An interview was confirmed in that required all Properties and interview was aware hospice residents. An interview was confirmed in designed in the second in the	0/20 for the time period of	F	758			
		as most recently admitted to 19 with diagnoses that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 07/16/2020	
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, Z HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ZIP CODE	07710/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 758	included heart diseas pulmonary disease. The quarterly Minimu assessment dated 5/3 's cognition was sevenoted with a prognosi was on hospice. Reseantianxiety medication back period. A physician 's order food food food food food food food foo	m Data Set (MDS) 7/20 indicated Resident #32 erely impaired. She was s of less than 6 months and ident #32 received no n during the 7-day MDS look for Resident #32 dated n (antianxiety medication) 1 8 hours as needed (PRN). sician 's order had no stop of through 7/15/20 hard copy ation Records (MARs) for ed no PRN Ativan had been physician 's orders for viewed on 7/15/20 and RN Ativan physician 's active. ducted with the Assistant DON) on 7/16/20 at 8:27 d Resident #32 's PRN d by the hospice physician. s aware of the regulation cian 's orders for PRN ions to be time limited in not aware that the	F	758			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 07/16/2020
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	'	01710/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	7/16/20 at 9:50 AM. part of the hospice of prescribed without a was not aware of the facility residents that orders for PRN psycrequired to be time. Nurse #1 revealed to residents at the facility for PRN Ativan with. A telephone intervied Hospice Medical Did He confirmed that the normally included a Ativan with no stope aware of the regular residents that indicated PRN Ativan were reduration. He reported Ativan with no stope resident, he was also recommendation from Consultant and/or be stope date was impleaded and the stope date. A phone interview we consultant #1 on 7/ indicated she was award or PRN psychotrop to be time limited in PRN psychotropic in PRN psychotropic in the stope of the stope date.	She stated PRN Ativan was comfort package and it was a stop date. She indicated she regulation applicable to all tindicated physician 's chotropic medications were imited in duration. Hospice hat all of their hospice lity had a physician 's order no stop date. We was conducted with the rector on 7/16/20 at 9:05 AM. The hospice comfort package physician 's order for PRN date. He stated he was ion applicable to all facility sted physician 's orders for quired to be time limited in ed that normally, if PRN date was ordered for a facility	F7	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING) DATE SURVEY COMPLETED
		345293	B. WING			C 07/16/2020
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	<u> </u>	07/16/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	Continued From page	e 51	F 75	58		
	Consultant #2 on 7/1 stated she was award psychotropic medical time limited in duratic reiterated Pharmacy that PRN psychotrop stop date had been of facility going back as explained that every Consultant #1 complo of Consultant Pharmac Review" that provide the medication regim month. She further ewas not part of the more resident. Pharmacy the "Executive Summ Pharmacist's Medic June 2020 be review. As requested by Phaher phone interview, Consultant Pharmacist Review" dated 6/20/26/1/20 through 6/20/2"All PRNs [psychoac stop dates per [Center Medicaid Services]. prescribers and nursi regulation." An interview was con Director on 7/16/20 and Director stated he was that required all PRN be time limited in dur	ation Regimen Review" for ed for additional information. rmacy Consultant #2 during the "Executive Summary of st's Medication Regimen 20 for the time period of 20, read, in part: tive medications] require ers for Medicare and				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING _		C 07/16/2020
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	07/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 758	hospice residents. Herror if a stop date with physician 's order formedication. An interview was corn Nursing (DON) on 7/DON stated she was required all PRN psytime limited in duration that she was aware thospice residents. Texplain why Residen PRN Ativan (initiated date. She indicated their facility residents physician 's orders for date and that this had and corrected. Label/Store Drugs ard CFR(s): 483.45(g) Labeling Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h) (1) In accessional principle appropriate accessor instructions, and the applicable.	le indicated that it was an as not included in the ra PRN psychotropic anducted with the Director of 16/20 at 11:30 AM. The aware of the regulation that chotropic medications to be on. She additionally stated his regulation applied to the DON was unable to the Had an active order for on 6/1/20) that had no stop that it was possible that the the comfort packages for son 6/1/20 and reinitiated or PRN Ativan with no stop d not yet been not identified and Biologicals so used in the facility must be ewith currently accepted es, and include the	F 7		8/11/20
	biologicals in locked	compartments under proper , and permit only authorized			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED
		345293	B. WING _			C 07/16/2020
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COL		01710/2020
DIG: 11401				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCAI	RE AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 761	Continued From pa	age 53	F 7	61		
	locked, permanent storage of controlle the Comprehensive Control Act of 1976 abuse, except whe package drug distr quantity stored is robe readily detected. This REQUIREME by: Based on record rinterview, the facility Purified Protein Desort of tuberculosis) and supplement) when rooms (main) and 400 hall) observed. Findings included: 1. On 7/13/20 at 12 room was observed used bottle of Put (PPD) with an open instruction on the Fafter opening. On 7/13/20 at 12:4 interviewed. The Normal Supplement Normal Supplem	eview, observation and staff ty failed to discard expired erivatives (used in the diagnosis d to date the Prostat (a protein opened in 1 of 2 medication 1 of 3 medication carts (upper		Based on record review, obs staff interview, the facility aile expired Purified Protein Derivin the diagnosis of tuberculos date the Prostat (a protein su when opened in 1 of 2 medic (main) and 1 of 3 medication 400 hall) observed. 1. The expired Purified Prote with an open date of 6/02/202 Prostat (a protein supplemen not dated when opened were discarded on 7/13/2020 2. All residents would have to be affected by this practices. 3. All licensed Nurses will be by the Director of Nursing/Deregarding daily checking of materials for expired medications prostat when opened and unwhen opening Purfied Proteir it expires once opened in 30 8/2/2020 New hires and ager be educated at orientation.	ed to discard vatives (used sis) and to applement) action rooms carts (upper in Derivatives 20 and the et) that was a both the potential estanciary and the enedication of dating derstanding in Derivatives days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			С	
		345293	B. WING _			07/16/2020	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 761	and she was obse bottle. On 7/15/20 at 2:05 (DON) was intervie she expected the find discard dates and to be followed. She policy and the mark date the PPD whe days after opening expected the nurse and the medication undated medication undated medication undated for prosent date of opening of the Prostat read opening. On 7/13/20 at 3:01 Aide) assigned on interviewed. She I Prostat and verific opened. She stated date the bottle of Find DON) was interviewed she expected the find discard dates and to be followed. She policy and the mark date the Prostat was discarded to the prostat was disc	the PPD was already expired rived to discard the used PPD 5 PM, The Director of Nursing ewed. The DON stated that facility policy on medications the manufacturer's instruction he reported that the facility hufacturer's instruction was to no pened and to discard 30 g. She also indicated that she es to check the medication cart in room daily for expired and	F 7	4. The Director of Nursing/D perform observation audits of medications and open dates weeks and then monthly or 2. The Director of Nursing/Designessure all medications carts medication rooms are audited 4 weeks then monthly for 2 results of the audits will be recommendation of trends, training recommendations additional actions and the need for commonitoring at the end of 3 mms. 5. 08/11/2020	or expired weekly for 4 months. ignee will and ded weekly for months. The eported to r 3 months for ng needs and corrective titinued		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 07/16/2020	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	·	01110/L020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	Continued From page medication cart and to expired and undated	he medication room daily for	F 7	761			