**F 431**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 431</td>
<td>Richmond Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</td>
<td></td>
</tr>
</tbody>
</table>

Richmond Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.

**This REQUIREMENT is not met as evidenced by:**
- Based on observations, interviews and record

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

*Brandt A. Conklin*

**TITLE**

*Administrator*

**DATE**

*8/2/2013*
<table>
<thead>
<tr>
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<tr>
<td>F 431</td>
<td>Continued from page 1 review, the facility failed to return discontinued medications for active residents in 2 of 4 medication carts, and the facility failed to label 2 inhalers with the resident's name and directions for use in 1 of 4 medication carts reviewed for medication storage. Findings included: 1. On 7/9/13 at 5:20 PM, the medication cart for 100 hall-lower end was inspected for medication storage. A tube of Neo/Poly/Dex, an antibiotic ophthalmic ointment was observed with resident #17’s name on it with the fill date of 9/22/11. Nurse #1 stated that resident #17 was no longer receiving the medication. She indicated that it should have been returned to the pharmacy once it was discontinued. A review of the July 2013 medication administration record (MAR) for resident #17, indicated she was no longer prescribed Neo/Poly/Dex ophthalmic ointment. In an interview on 7/11/13 at 10:47 AM, the administrator indicated her expectation that discontinued medications be returned to the pharmacy and not left on the medication cart. 2. On 7/9/13 at 6:00 PM, the medication cart for the 400/100 hall-upper end cart was inspected for medication storage. There was 1 bottle of Durezol 0.5% eye drops for resident #5 in the cart. Durezol eye drops are sterile drops used to treat pain after eye surgery. The bottle label read, &quot;Durezol 0.5% to the right eye for 1 week then discontinue.&quot; It was dated as filled on 7/12/12. In an interview nurse #2, indicated that the bottle of Durezol had been discontinued for resident #5 and should have been returned to the pharmacy. A review of the July 2013 MAR for resident #5 indicated she was not receiving</td>
<td>F 431</td>
<td>F-431</td>
<td>8-26-13</td>
</tr>
</tbody>
</table>

Resident #17 is not identified on the resident roster from the state agency. On 7-9-13, the discharged medication for resident #5 and resident #45 was removed from the medication cart by the QI nurse and returned to the pharmacy. On 7-9-13 a 100% audit of all medication carts was completed by the DON, ADON, QI nurse, MDS nurses, and Medication Aides to ensure that all discharged and/or unused resident medications were removed from the medication carts and returned to pharmacy per facility procedure. On 7-9-13 a 100% audit of all medication room refrigerators and the medication room was completed by the DON, ADON, QI nurse, and MDS nurses to ensure that all discharged and/or unused resident medications were removed and returned to pharmacy per facility procedure.
Continued From page 2

Neo/PolyDex eye drops to her right eye.

Also observed on 7/9/13 at 6:00 PM, the medication cart for the 400/100 hall-upper and contained a bottle of Neo/PolyHC 1% ear drops for resident #45. This medication was used to treat bacterial infections of the ear. It was dated as filled 11/30/12. The label indicated it was to be administered 3 times a day for 5 days then discontinued. Nurse #2 indicated that when this medication was discontinued, it should have been returned to the pharmacy. A review of the July 2013 MAR for resident #45 indicated she was not receiving Neo/PolyHC ear drops.

In an interview on 7/11/13 at 10:47 AM, the administrator indicated her expectation that discontinued medications be returned to the pharmacy and not left on the medication cart.

3. On 7/9/13 at 5:20 PM, the medication cart for 100 hall-lower end contained a Spiriva Handi-Inhaler and a Symbicort Inhaler, both used to treat chronic obstructive pulmonary disease and/or asthma, were found with no resident name or instructions for use. Nurse #1 indicated she was unsure which resident was using the inhalers. She stated they should have been labeled with the resident's name or they should have been kept inside the package they came in from the pharmacy.

In an interview on 7/11/13 at 10:47 AM, the administrator indicated her expectation that all medications be labeled with the resident's name and how the medication was to be administered to a resident to include inhalers.

On 7-9-13 the facility nurse consultant initiated an in-service with all nursing staff, to include, RN's and LPN's, on Facility Procedure for Disposal of Unused Medications from the medication carts, medication room refrigerators, and medication room to ensure that all discharged and/or unused resident medications are removed and returned to pharmacy per facility procedure.

On 7-9-13 the administrator initiated the Quality Improvement Audit Tool to monitor disposal of discharged and/or unused resident medication and correct labeling of residents' medications. The Quality Improvement Audit Tool will be completed weekly for four weeks, then one time every other week for three months. The Quality Improvement Audit Tool will be completed by the DON, ADON, QI Nurse, and/or MOS nurse to ensure all discharged and/or unused resident medication is disposed of per facility procedure.

On 7-29-13, the facility nurse consultant initiated an in-service with RNs, LPNs and medication aides on medication labels. Medication labels must contain the medication name (generic and/or brand), strength, expiration date when applicable, resident's name, route of administration, appropriate instructions and precautions.
F 505
Continued From page 3
F 505
483.75(i)(2)(ii) PROMPTLY NOTIFY PHYSICIAN
OF LAB RESULTS

The facility must promptly notify the attending
physician of the findings.

This REQUIREMENT is not met as evidenced
by:
Based on record review and staff interview, the
facility failed to notify the attending physician
of the positive wound culture results dated
5/31/2013 for 1 of 2 sampled residents (Resident
# 126.)

Findings included:
Resident #126 was admitted to the facility on
1/30/13. A review of an incident report dated
3/20/13 revealed resident sustained a bruised
blisters to right lower leg. During an interview
on 7/11/2013 the Treatment Nurse indicated the area
continued to decrease in size with increased
drainage and she renamed the wound a vascular
wound on 4/18/2013. The attending physician
gave a telephone order dated 5/28/2013 to obtain
a culture and sensitivity of the wounds of the legs.

On 7/12/2013 at 2:47 pm the Director of Nursing
(DON) stated, "I cannot find where the doctor
was notified of these results." She further
indicated, "My expectation is that lab results are
received and abnormal labs are reported to the
physician immediately." The DON obtained a
copy of the wound culture results from the
hospital printed 7/12/2013 at 12:54 pm. Review
of the wound culture results dated 5/31/2013
indicated positive growth of the bacteria
Citrobacter Koseri.

F 505
The Quality Improvement Executive
Committee (consisting of the Medical
Director, Administrator, Director of
Nursing, Assistant Director of Nursing,
Quality Improvement Nurse, Minimum
Data Set Nurse, Social Workers,
Bookkeeper, Activity Director, Dietary
Director, Medical Records Director, and
Maintenance Director) will review the
Quality Improvement Medication Audit
Tool monthly make recommendations
and take actions as appropriate to
maintain compliance in this area.

F 505
Resident #126 no longer resides in the
facility and was sent to hospital on
7-6-13.

On 7-19-13 the QI nurse initiated a 100
% audit to ensure all wound culture
results were completed from 6-1-13 to
7-19-13 to include culture obtained,
results obtained, MD/RP notification,
and MD orders received were followed
through on as applicable.

On 7-30-13 a facility nurse consultant
completed a 100% lab audit of all
residents' charts to ensure all labs were
completed from 6-1-13 to 7-29-13. Any
identified concerns were addressed with
the medical doctor and followed-up on
by the QI nurse.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345293

(x2) MULTIPLE CONSTRUCTION
A. BUILDING

(x3) DATE SURVEY COMPLETED

07/12/2013

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

(x4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(x5) COMPLETION DATE

On 7-12-13, the facility nurse consultant initiated an in-service for the administrator on the Quality Improvement Wound Care Audit Tool.

On 7-12-13, the facility nurse consultant initiated an in-service for the DON, ADON, QI nurse, and MDS nurses. The in-service covered the need for review of all labs five times a week, to ensure completion of labs, follow-up on labs, MD/RP notification, and review of any new orders.

On 8-1-13, the facility nurse consultant initiated an in-service for the DON, ADON, QI nurse, and MDS nurses the in-service covered the need for review of the wound culture results once per week to ensure completion of wound cultures, follow-up on wound cultures, MD/RP notification, and review of any new orders.

On 7-12-13, the facility nurse consultant initiated an in-service on for all RNs, LPN's, ward clerks, medication aides, and the medical records director regarding the placement of a lab results tray, labeled "Lab Results", at the nurses' station. All received lab results will be placed in the Lab Results tray.

See attachment (1) for remainder of ESOS Plan of Correction.
F.505

The QI nurse will complete a lab audit five times a week for four weeks and then twice a week for three months to ensure completion of labs, follow-up on lab results, MD/RP notification, and review of any new orders utilizing the Lab QI Audit Tool.

The QI nurse will complete a wound culture audit weekly for four months to ensure completion of wound cultures, follow-up on wound culture results, MD/RP notification, and review of any new orders utilizing the Wound Culture QI Audit Tool.

The Administrator will review the Quality Improvement Wound Care Audit Tool and the Quality Improvement Lab QI audit tools once weekly for four months to ensure all areas are reviewed with appropriate interventions and notification to MD and RP.

The Quality Improvement Executive Committee (consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director) will review the quality improvement audit tools, to include the Lab Audit Tool, Wound Care Audit Tool, and the Quality Improvement Action Team for Wound Care and Skin Assessment. The Quality Improvement Executive Committee monthly reviews will be for the purpose of making recommendations and taking actions as appropriate to maintain compliance in these areas.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERs FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

345293

**AUGUST 7, 2013**

**B. WING**

**DATE SURVEY COMPLETED:**

08/07/2013

**NAME OF PROVIDER OR SUPPLIER:**

RICHMOND PINES HEALTHCARE AND REHABILITATION CENTRE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

HIGHWAY 177 S BOX 1489

HAMLET, NC 28345

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<td>Richmond Pines Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care to residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceedings.</td>
</tr>
<tr>
<td>K 012</td>
<td>The ceiling in the riser room was repaired with a fire sealant by the Maintenance Director on 8-7-2013.</td>
</tr>
<tr>
<td>K 029</td>
<td>The Maintenance staff will check any areas of the facility where outside contractors have worked monthly for 3 months to assure that ceilings still meet the appropriate fire resistance rating and do not have penetrations utilizing a Fire Penetration QI Audit Tool. The Administrator will review the Fire Penetration QI Audit Tool monthly to assure continued compliance in this area.</td>
</tr>
</tbody>
</table>

**Llaboratory Director's or Provider/Supplier Representative's Signature**

Brenda C. Cooling

**Title**

Administrator

**Date**

8/23/13

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 discoverable 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 discoverable 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.
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<tr>
<td>K029</td>
<td>Continued From page 1 48 inches from the bottom of the door are permitted. 19.3.2.1</td>
<td>K029</td>
<td>The Executive Quality Improvement Committee will review monthly the Fire Penetration QI Audit tool for additional recommendations and monitoring of continued compliance in this area.</td>
</tr>
<tr>
<td>K046</td>
<td>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following hazardous area was non-compliant, specific findings include the door to the clean linen side of the laundry to assure proper close, latch, and seal on 8-9-2013.</td>
<td>K046</td>
<td>K029 The Maintenance Director repaired the door to the clean linen side of the laundry to assure proper close, latch, and seal on 8-9-2013.</td>
</tr>
<tr>
<td></td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</td>
<td></td>
<td>An audit of facility doors was conducted by the Maintenance Director and Assistant Maintenance on 8-9-2013 to assure doors close, latch, and seal properly. Any doors identified were adjusted as appropriate.</td>
</tr>
<tr>
<td>K062</td>
<td>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following emergency lighting was non-compliant, specific findings include the existing emergency light located near the generator did not function properly upon testing.</td>
<td>K062</td>
<td>The Administrator Inspected on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that doors properly close, latch, and seal.</td>
</tr>
<tr>
<td></td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5.</td>
<td></td>
<td>The Maintenance Staff will check all facility doors to assure that doors close, latch, and seal properly monthly for three months then quarterly thereafter utilizing a Door Closure QI Audit Tool. The Administrator will review the Door Closure QI Audit Tool monthly for three months then quarterly thereafter to assure continued compliance in this area.</td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by:</td>
<td></td>
<td>The Executive Quality Improvement Committee will review monthly for three months then quarterly thereafter, the Door Closure QI Audit Tool for additional recommendations and monitoring of continued compliance in this area.</td>
</tr>
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K046 The emergency light located near the generator was replaced by the Maintenance Director on 8-8-2013. All other emergency lighting at the facility was checked by the Maintenance Director on 8-23-2013. Any areas identified were corrected as appropriate.
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| K 062         | Continued From page 2  
42 CFR 483.70(a)  
By observation at approximately noon the following automatic sprinkler system was non-compliant, specific findings include documentation dated 6/5/13 indicating sprinkler certification had deficiencies that had not been corrected. Items included sprinkler heads in the cooler needed to be changed and the dip stick for the air compressor was broken and needed to be changed. | K 062         | The Administrator Inspected on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that all emergency lighting is checked routinely to assure it is working properly. | 8-23-13         |
| K 066 SS=D    | NFPA 101 LIFE SAFETY CODE STANDARD  
Smoking regulations are adopted and include no less than the following provisions:  
(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking  
(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  
(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  
(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.  
19.7.4 | K 066         | The Executive Quality Improvement Committee will review monthly for three months then quarterly thereafter, the Emergency Lighting QI Audit Tool for additional recommendations and monitoring of continued compliance in this area. | 9-21-13         |

The Administrator Inspected on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that all emergency lighting is checked routinely to assure it is working properly.

The Maintenance Staff will check all facility emergency lighting monthly for three months then quarterly thereafter utilizing an Emergency Lighting QI Audit Tool. The Administrator will review the Emergency Lighting QI Audit Tool monthly for three months then quarterly thereafter to assure continued compliance in this area.

A sprinkler outside contractor was contacted by the Maintenance Director on 8-23-13 who will change sprinkler heads in the cooler and replace dip stick for the air compressor.

Maintenance Director and Assistant Maintenance on assuring that all deficient areas listed on sprinkler inspections are repaired timely when report is received and a copy of the report be given immediately to the Administrator for review upon completion of Inspections.

The Maintenance Director will report any inspections of sprinkler systems monthly on a Maintenance QI Audit tool to assure that all inspections have been reviewed and Administrator is aware of any needed repairs and status. The Administrator will review this audit tool monthly.

The Executive Quality Improvement Committee will review monthly for three months the Maintenance QI Audit Tool for additional recommendations and monitoring of continued compliance in this area.
K 066  Continued From page 3

This STANDARD is not met as evidenced by:
42 CFR 483.70(a)
By observation at approximately noon the following smoking regulations were
non-compliant, specific findings include both the staff smoking area and the Alzheimer's smoking area:
A. Ashtrays of noncombustible material and safe design per paragraph 3 above were not provided.
B. A metal container with a self-closing cover into which ashtrays can be emptied in the
smoking area per paragraph 4 above was not provided.
NFPA 101 LIFE SAFETY CODE STANDARD

K 144  SS=D

Generators are inspected weekly and exercised under load for 30 minutes per month in
accordance with NFPA 99. 3.4.4.1.

K 066
Ashtray of non-combustible material and safe design and a metal container with a self closing
cover into which ashtrays can be emptied in the smoking area of the staff and Alzheimer's smoking area were implemented on 8-9-2013 by the
Maintenance Director.

There are no other smoking areas at the facility to audit.

The Administrator Inservices on 8-23-2013 the Maintenance Director and Assistant Maintenance
on assuring that both smoking areas always had the appropriate ashtrays of non-combustible
material and self closing metal container for ashtrays to be emptied into accessible.

The Maintenance Staff will check the staff and Alzheimer's smoking areas monthly for three
months then quarterly thereafter utilizing an Smoking Area Safety QI Audit Tool. The
Administrator will review the Smoking Area Safety QI Audit Tool monthly for three months then quarterly thereafter to assure continued
compliance in this area.

The Executive Quality improvement Committee will review monthly for three months then quarterly thereafter, the Smoking Area Safety QI
Audit Tool for additional recommendations and monitoring of continued compliance in this area.

(K144 POC located on Building 02 page 1 of 1)
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<tr>
<td>K000</td>
<td>INITIAL COMMENTS</td>
<td>K000</td>
<td>There were no Life Safety Code Deficiencies noted at time of survey.</td>
<td>K144</td>
<td></td>
<td>9-21-13</td>
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K144

The generator test sheet was revised by the Maintenance Director on 8-7-2013 to clearly show written documentation of emergency generator exercise under load for a minimum of 30 minutes per month, not including cool down time.

The Maintenance Director will continue to exercise the generator monthly for a minimum of 30 minutes under load, not including cool down time and will document the full load on the generator test sheet.

The Administrator will review the Generator Test Sheet monthly for three months to assure continued compliance in this area.

The Executive Quality Improvement Committee will review monthly for three months the Generator Test Sheet for additional recommendations and monitoring of continued compliance in this area.