DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS F | OR MEDICARE & MEDICAID SERVICES | | | "A" FO | | | |
|--|--|---|---|-------------|--|--|--|
| STATEMENT O | F ISOLATED DEFICIENCIES WHICH CAUSE | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY | | | |
| NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM | | | A. BUILDING: | COMPLETE: | | | |
| OR SNFs ANE | NFs | 345293 | B. WING | 6/9/2017 | | | |
| AME OF PRO | VIDER OR SUPPLIER | STREET ADDRESS, | CITY, STATE, ZIP CODE | | | | |
| | | HIGHWAY 177 S | S BOX 1489 | | | | |
| RICHMON | D PINES HEALTHCARE AND REHABILITATION | HAMLET, NC | | | | | |
| ID PREFIX | | | | | | | |
| TAG | SUMMARY STATEMENT OF DEFICIENCIES | | | | | | |
| F 507 | 483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS | | | | | | |
| | (a) Laboratory Services | | | | | | |
| | (2) The facility must- | | | | | | |
| | | (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of | | | | | |
| | the testing laboratory. | the testing laboratory. | | | | | |
| | This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to have copies of completed laboratory blood | | | | | | |
| | Based on staff interview and record review the facility failed to have copies of completed laboratory blood work available in the medical record for 1 of 6 residents reviewed for unnecessary medications (Resident | | | | | | |
| | #135). The findings included: | | · · · · · · · · · · · · · · · · · · · | | | | |
| | Resident #135 was admitted on 4/3/17 and rea | admitted on 4/13/2 | 7 with diagnoses including chronic kidney | I | | | |
| | disease, pneumonia, atrial fibrillation and hea | | 0 0 0 | | | | |
| | Review of the Physician 's Orders dated 4/18/17 revealed an order for CBC (complete blood count - this involves obtaining a blood sample which is then tested and can indicate signs of infection and other health concerns) and CMP (comprehensive metabolic panel - this involves obtaining a blood sample which is then tested and can be used to monitor kidney function and electrolyte balance as well as other health concerns) in the morning. | | | | | | |
| | Review of resident 's electronic and hard copy medical records from 4/3/17 through her discharge on 5/13/17 revealed the CBC and CMP laboratory reports that were ordered to be completed on 4/19/17 were not present in Resident #135 's medical record. | | | | | | |
| | On 6/8/17 at 3:15 PM the Director of Nursing (DON) was interviewed and indicated she would attempt to locate a copy of the 4/19/17 CBC and CMP laboratory reports. | | | | | | |
| | On $6/8/17$ at 5:46 PM the DON stated that she had been able to print a copy of the completed $4/19/17$ laboratory reports for Resident #135. | | | | | | |
| | On 6/8/17 at 6:00 PM the DON provided a copy of the 4/19/17 laboratory reports for Resident #135. The DON added that when the results were received, abnormal results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 laboratory reports for Resident #135 were not in her medical | | | | | | |
| | Staff person. She did not know why the 4/19/ record. On 6/9/17 at 5:35 PM a telephone interview v | | | icai | | | |

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

AH

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES | | | Al "A" FOR | | |
|--|---|--|---|---------------|--|--|
| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE | | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY | | |
| NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM | | | A. BUILDING: | COMPLETE: | | |
| FOR SNFs ANI |) NFS | 345293 | B. WING | 6/9/2017 | | |
| NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION | | HIGHWAY 177 S | STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC | | | |
| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE | s | | | | |
| F 507 | Continued From Page 1 worked on first shift (7:00 AM - 3:00 PM) on Resident #135 ' s hall and did recall the resident but did not recall if she was one of the Nurses who handled the resident ' s laboratory reports. She stated that laboratory reports were faxed to the facility and the hall nurse on duty would get them from the fax machine and put them in the doctor ' s box for review. She added that if there were abnormal results the nurse would call the physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician came to the facility twice a week and after the laboratory report was reviewed and signed by him, it was placed in a box for filing, then was filed in the medical record. Nurse #6 stated that it was her practice to file the physician reviewed laboratory reports in the medical record herself but added that there used to be a Unit Manager that would take care of having the reviewed laboratory reports filed. She stated they had not had a Unit Manager in about 6 weeks. | | | | | |
| F 513 | 483.50(b)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED (b) Radiology and other diagnostic services. (2) The facility must- (iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to have copies of a completed chest x-ray available in the medical record for 1 of 6 residents reviewed for unnecessary medications (Resident #135). The findings included: | | | | | |
| | Resident #135 was admitted on 4/3/17 and disease, pneumonia, atrial fibrillation and h Review of the Physician 's Orders dated 4/ Review of resident 's electronic and hard co | eart failure. 18/17 revealed an or opy medical records ed on 4/18/17 was no | der for repeat chest x-ray. from 4/3/17 through her discharge on 5/13/1 ot present in Resident #135 's medical record | | | |
| | On 6/8/17 at 5:46 PM the DON stated that a report for Resident #135 but that x-ray had services provider company to find a way to On 6/8/17 at 5:55 PM interview with the x- completed on 4/19/17 and the report was fa | been completed. Sh print the report and ray services provide xed to the facility at time according to th | r Supervisor revealed that the chest x-ray wa 10:59 AM that day. The DON attempted to the service provider Supervisors instructions b | y s | | |

AH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEMENT OF USER AND DEFINICIENCES WILCH CARSE PROVIDERA METTER CONSTRUCTION DATE SUBJECT OR SNEA ADD INF J42293 IF WING COMPLIFIE DOE SNEA ADD INF STATEMENT ADDRESS, CITY, STALE, 207 COL IF UNIONE 692017 RICHMOND PINES HEALTHCARE AND REHABILITATION STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES TO SUMMARY STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES TO SUMMARY STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES F513 Conford/PT the DON was interviewed and stated that when X-ray results were received at the facility, abnormal results were all of the helpsician for orders as a needed and that all the reports were reviewed by the Physician the review the main of the MicroR Record on the Sha StateMet OH and possible wire an oto or reduce on the Physician reviewed the reports he would sign that he reviewed them and possible wire an oto or reviewed sha far envirew by the physician the reports were acade to the facility wire an oto or other would staff person. She did not know why the 4/19/17 chest x-ray for Resident #135 vas not in her medical record. On 69/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had worked on first shift (7:00 AM - 3:00 PM) on Resident 43:137 's hall and direcall the resident but id not rever a review or desident the review would get them from the fact would all the reports her was and the indicated record. Nurse #6 stated that the review would get them from the fact would all the reportshe would get them from the fact would a | CENTERS FOR | MEDICARE & MEDICAID SERVICES | | | "A" FORM |
|--|------------------|---|--|--|----------------------|
| POR SNFs AND NFs 345293 B. WING 6992017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STATE, ZP CODE HIGHWAY 177 S BOX 1489 6992017 RCHMOND TVS HEALTHCARE AND REHABILITATION STREET ADDRESS, CTY, STATE, ZP CODE HIGHWAY 177 S BOX 1489 5000000000000000000000000000000000000 | STATEMENT OF IS | OLATED DEFICIENCIES WHICH CAUSE | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY |
| J45293 B. WING | NO HARM WITH O | NLY A POTENTIAL FOR MINIMAL HARM | | A. BUILDING: | COMPLETE: |
| ID HIGHWAY 177 S BOX 1489 RICHMOND PINES HEALTHCARE AND REHABILITATION HIGHWAY 177 S BOX 1489 ID SUMMARY STATEMENT OF DEFICIENCIES F513 Continued From Page 2 On 6/8/17 the DON was interviewed and stated that when x-ray results were received at the facility, abnormal results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 chest x-ray for Resident #135 was not in her medical record. On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had worked on first shift (7:00 AM - 3:00 PM) on Resident #135 's hall and did recall the resident but did not recall if she was one of the Nurse who handled the resident 's 4/19/17 chest x-ray report. She stated that x-ray reports were faxed to the facility and the hall nurse on duty would get them from the fax machine and put them in the doctor's box for review. She added that if there were abnormal results the nurse would call the physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician to report them scilet the x-ray report was reviewed and si | FOR SNFs AND NFs | | 345293 | B. WING | 6/9/2017 |
| PREFIX SUMMARY STATEMENT OF DEFICIENCIES F 513 Continued From Page 2 On 6/8/17 the DON was interviewed and stated that when x-ray results were received at the facility, abnormal results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 chest x-ray for Resident #135 was not in her medical record. On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had worked on first shift (7:00 AM - 3:00 PM) on Resident #135 's hall and did recall the resident but did not recall if she was one of the Nurses who handled the resident 's 4/19/17 chest x-ray reports. She stated that the and put them in the doctor 's box for review. She added that if there were abnormal results the nurse would call the physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician came to the facility twice a week and after the x-ray report was reviewed and signed by him, it was placed in a box for filing, then was filed in the medical record. Nurse #6 stated that the re used to be a Unit Manager that would take care of having the reviewed x-ray reports filed. She stated they had not had a Unit | | | HIGHWAY 177 S BOX 1489 | | |
| On 6/8/17 the DON was interviewed and stated that when x-ray results were received at the facility, abnormal results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 chest x-ray for Resident #135 was not in her medical record. On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had worked on first shift (7:00 AM - 3:00 PM) on Resident #135 's hall and did recall the resident but did not recall if she was one of the Nurses who handled the resident 's 4/19/17 chest x-ray report. She stated that x-ray reports were faxed to the facility and the hall nurse on duty would get them from the fax machine and put them in the doctor 's box for review. She added that if there were abnormal results the nurse would call the Physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician came to the facility twice a week and after the x-ray report was reviewed and signed by him, it was placed in a box for filing, then was filed in the medical record. Nurse #6 stated that it was her practice to file the physician reviewed x-ray reports in the medical record. She stated that it was her practice to file the physician reviewed x-ray reports in the medical record. She stated that there used to be a Unit Manager that would take care of having the reviewed x-ray reports filed. She stated that there used to hea d Unit | PREFIX | SUMMARY STATEMENT OF DEFICIENCIES | | | |
| results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 chest x-ray for Resident #135 was not in her medical record. On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had worked on first shift (7:00 AM - 3:00 PM) on Resident #135 ' s hall and did recall the resident but did not recall if she was one of the Nurses who handled the resident ' s 4/19/17 chest x-ray report. She stated that x-ray reports were faxed to the facility and the hall nurse on duty would get them from the fax machine and put them in the doctor ' s box for review. She added that if there were abnormal results the nurse would call the physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician came to the facility twice a week and after the x-ray report was reviewed and signed by him, it was placed in a box for filing, then was filed in the medical record. Nurse #6 stated that it was her practice to file the physician reviewed x-ray reports in the medical record herself but added that there used to be a Unit Manager that would take care of having the reviewed x-ray reports filed. She stated they had not had a Unit | F 513 | Continued From Page 2 | | | |
| | | results were called to the physician for orders Physician when he came to the facility. The I sign that he reviewed them and possibly write physician the reports were again reviewed by into the electronic medical record by the Med chest x-ray for Resident #135 was not in her r On 6/9/17 at 5:35 PM a telephone interview w worked on first shift (7:00 AM - 3:00 PM) on recall if she was one of the Nurses who handle x-ray reports were faxed to the facility and the put them in the doctor ' s box for review. She the physician to report them and to receive an the Physician came to the facility twice a wee was placed in a box for filing, then was filed if file the physician reviewed x-ray reports in the Manager that would take care of having the re- | as needed and that all DON said that when the a note or order on it. the nurse for implement ical Records staff per- nedical record. vas conducted with Ne Resident #135 ' s hall ed the resident ' s 4/19 e hall nurse on duty w added that if there we y new orders as deter k and after the x-ray r n the medical record. e medical record hers | the reports were reviewed by the ne Physician reviewed the reports he w She stated that after review by the entation of new orders and then scanne son. She did not know why the 4/19/1 urse #6. She indicated that she had and did recall the resident but did not v/17 chest x-ray report. She stated that ould get them from the fax machine an ere abnormal results the nurse would c mined by the Physician. Nurse #6 said eport was reviewed and signed by him Nurse #6 stated that it was her practic elf but added that there used to be a Un | vould ed 7 |

AH