PRINTED: 07/27/2017 FORM APPROVED OMB NO. 0938-0391

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 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	33.00.2011	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	INITIAL COMMENTS		F 00	00		
		complaint survey was I/17 through 06/09/17. was identified at:				
	(J)	57 at a scope and severity				
	(J)	exx at a scope and severity				
	(J)	exx at a scope and severity exx at a scope and severity				
	(J) CFR 483.70 at tag Fx (J)	exx at a scope and severity				
		xx at a scope and severity				
	The tags F157, F221, Substandard Quality	F224, and F323 constituted of Care.				
		began on 03/4/17 and it is d survey was conducted.				
	included only the tags level. The complete s	ement of deficiencies that is that were cited at the J statement of deficiencies, be posted in EPOC at a				
F 156 SS=B	483.10(d)(3)(g)(1)(4)(RIGHTS, RULES, SE	5)(13)(16)-(18) NOTICE OF RVICES, CHARGES	F 1	56	7/25/17	
	remains informed of t of contacting the phys	st ensure that each resident he name, specialty, and way sician and other primary care sible for his or her care.				
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE	

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

07/06/2017

Electronically Signed 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.

Facility ID: 923021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING	B. WING		C 6/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/03/2317	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 156	(1) The resident has his or her rights and governing resident or during his or her stay (g)(4) The resident his notices or ally (meanically in a consideration of the facility must furn description of legal rises (A) A description of legal rises (B) A description of the personal funds, undescription of the	on and Communication. the right to be informed of of all rules and regulations onduct and responsibilities of in the facility. as the right to receive ng spoken) and in writing a format and a language he including: as specified in this section. ish to each resident a written ghts which includes - the manner of protecting ar paragraph (f)(10) of this	F 15	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		00/03/2017	
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 156	complaint with the State concerning any susper federal nursing facility not limited to resident exploitation, misapproin the facility, non-cordirectives requirement information regarding (ii) Information and count limited to the State Long-Term Care Ombe (established under sea Americans Act of 196 U.S.C. 3001 et seq) and advocacy system (as as established under Disabilities Assistance 2000 (42 U.S.C. 1500 [§483.10(g)(4)(ii) will November 28, 2017 (iii) Information regard eligibility and coverage [§483.10(g)(4)(iii) will November 28, 2017 (iv) Contact information in the Contact information in the Contact information for the Contact information in the Contact information for the Contact information in the Contact information for the Contact information in the Contact i	the resident may file a ate Survey Agency ected violation of state or a regulations, including but a abuse, neglect, opriation of resident property inpliance with the advance ats and requests for returning to the community. Intact information for State reganizations including but e Survey Agency, the State oudsman program action 712 of the Older 5, as amended 2016 (42 and the protection and designated by the state, and the Developmental e and Bill of Rights Act of 201 et seq.) It implemented beginning Phase 2)] In for the Aging and denter (established under (ciii) of the Older Americans ing Door Program; be implemented beginning	F 1	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 06/09/2017		
	PROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00/00/2011		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
F 156	Control Unit; and [§483.10(g)(4)(v) wil November 28, 2017 (vi) Information and grievances or comples uspected violation facility regulations, in resident abuse, negmisappropriation of facility, non-compliadirectives requirement information regardin (g)(5) The facility mumanner accessible are idents, resident in (i) A list of names, a and telephone number agencies and advoct Survey Agency, the protective services with in long-termination in	Il be implemented beginning (Phase 2)] contact information for filing laints concerning any of state or federal nursing including but not limited to lect, exploitation, resident property in the ince with the advance ents and requests for greturning to the community. Lest post, in a form and and understandable to epresentatives: ddresses (mailing and email), pers of all pertinent State accy groups, such as the State State licensure office, adult where state law provides for erm care facilities, the Office erm Care Ombudsman tion and advocacy network, ty based service programs, aud Control Unit; and	F 150				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00,00,2011	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 156	written information, applicants for admis information about he Medicare and Services to the admission and during (i) The facility must and in writing in a launderstands of his oregulations governing responsibilities during (ii) The facility must the State-developed obligations, if any. (iii) Receipt of such amendments to it, moriting; (g)(17) The facility rust in the facility rust in the state in the control of the state in the	must display in the facility and provide to residents and ssion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or uponing the resident's stay. Inform the resident both orally anguage that the resident or her rights and all rules and ang resident conduct and ang the stay in the facility. Also provide the resident with dinotice of Medicaid rights and information, and any must be acknowledged in	F 15	66		
	nursing facility servi	ervices that are included in ces under the State plan and nt may not be charged;				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _	B. WING		06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWA	ADDRESS, CITY, STATE, ZIP CODE AY 177 S BOX 1489 ET, NC 28345	1 00/	03/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 156	Continued From page	e 5	F ²	156				
	facility offers and for	s and services that the which the resident may be ount of charges for those						
	changes are made to	caid-eligible resident when the items and services hs (g)(17)(i)(A) and (B) of						
	 (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. 							
	items and services the facility must inform the	re made to charges for other lat the facility offers, the le resident in writing at least lementation of the change.						
	transferred and does facility must refund to representative, or est deposit or charges al per diem rate, for the	or is hospitalized or is not return to the facility, the othe resident, resident tate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODI		00/00/2011	
DICUMON	D DINES HEALTHOAD	E AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 156	Continued From pa	ge 6	F 1	56			
	discharge notice red	quirements.					
	resident representa	t refund to the resident or tive any and all refunds due 30 days from the resident's om the facility.					
	behalf of an individu facility must not con these regulations. This REQUIREMEN	admission contract by or on ual seeking admission to the efficit with the requirements of					
	by: Based on record review and staff interview the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) form a minimum of 2 days in advance of the end date of Medicare services for 2 of 3 residents (Residents #2 and #144) reviewed for liability notices. The findings included:			Richmond Pines Nursing and Rehabilitation Center acknowl receipt of the Statement of De and proposes this Plan of Cor the extent that the summary of factually correct and in order to compliance with applicable rulprovisions of quality of care of The Plan of Corrections in which the summary of the Plan of Corrections in which the plan of Corrections is when the provisions of the Plan of Corrections is when the plan of the Plan of Corrections is when the plan of the plan	ledges efficiencies rection to of findings is o maintain les and f residents.		
		admitted to the facility on discharged from skilled 3/10/17.		The Plan of Correction is subr written allegation of compliand Richmond Pines Nursing and Rehabilitation Center's respon	ce.		
	There was no documentation that indicated Resident #2 's Responsible Party (RP) was provided with a NOMNC form prior to his discharge from skilled services on 3/10/17.			Statement of Deficiencies doe denote agreement with the St Deficiencies nor does it consti admission that any deficiency Further, Richmond Pines Nurs	es not atement of itute an is accurate.		
	Business Office Ma 12:03 PM. She sta for providing the NO minimum of 2 days date. The NOMNC discharge from skill requested for review	anducted with the Assistant nager (ABOM) on 6/6/17 at steed that she was responsible DMNC form to the RP a prior to the skilled service end form for Resident #2 's sed services on 3/10/17 was w. The ABOM stated she was vidence a NOMNC form was		Rehabilitation Center reserves refute any of the deficiencies of Statement of Deficiencies through Informal Dispute Resolution, fappeal procedure, and/or any administrative or legal proceed F156	s the right to on this ough formal other		

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 06/09/2017	
NAME OF PR	ROVIDER OR SUPPLIER	_ I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	10/03/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARI	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 156	Continued From pag	ge 7	F 15	56			
F 156	provided to Residen services on 3/10/17. vacation during that Office Manager (BO her duties while she An interview was co 6/6/17 at 12:07 PM. responsible for the A was on vacation. SI recall if she had provided Resident #2's disclibration of the state	t #2 's discharge from skilled She indicated she was on timeframe and the Business M) had been responsible for was away. Inducted with the BOM on She confirmed she was ABOM 's duties when she he stated she was unable to wided a NOMNC form for harge from skilled services on Inducted with the Director of 1/6/17 at 12:34 PM. She on was for the NOMNC to be required time frame. Inducted with the Director of 1/6/17 at 12:34 PM. She on was for the NOMNC to be required time frame.	F 15	On 6/24/17, the business office notified Resident #2's resident representative (RR) of the notified Nedicare non coverage (NOMI 6/24/17, the business office manotified via telephone Resident had discharged home, of the NOn 6/23/17 through 6/24/17, undirection of the regional vice progression (RVP), the business office manaudited the NOMNC for reside have been discharged from Mecovered services from 12/1/16 6/23/17 to ensure the resident notified of the discharge within allowable time frame. The audit revealed 42 resident not notified or not notified in an time frame from 12/1/16 through The business office manager of began notifying the identified reand/or their resident representatelephone. If the resident or Runreachable by telephone, a casent via the United States (US service of the NOMNC. The mall identified residents and/or representatives was either by the or US postal service and was con 7/4/17 by the business office manager and an office manager on the review and execution of the NOMNC.	ce of NC). On anager t #144, who IOMNC. Inder the resident inager ints that edicare through or RR was the stative via R was opy was opy was opy was opy was optification of esident relephone completed e manager.		
	this form was not sig	vith the ABOM. She revealed gned within the required cated she was unable to happened.		The residents that are being di from Medicare services are be reviewed by the administrator weekly Medicare meeting to er	ing during the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C	0047
NAME OF DE	ROVIDER OR SUPPLIER	343233		STREET ADDRESS, CITY, STATE, ZIP CODE	06/09/2	2017
NAME OF PR	ROVIDER OR SUPPLIER					
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 SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	O BE CO	(X5) OMPLETION DATE
F 156	Nursing (DON) on 6/6 stated her expectation provided within the re	ducted with the Director of 6/17 at 12:34 PM. She in was for the NOMNC to be quired time frame.	F 15	residents are provided their 48 hour of Medicare non coverage- right to a and prior to exhausting their 100 day. The administrator will continue to reand initial the NOMNC notification of weekly during the Medicare meeting weeks then monthly for 2 months. A identified areas of concern will be corrected through notification of the resident/resident's representative. The business office manager or administrator will present the NOMN audit findings to the monthly Quality Improvement (QI) Committee for the months to determine if the corrective actions are effective and being sustaor if additional root cause analysis is required with subsequent intervention necessary. The business office manor administrator will present the NOI audit findings and QI committee recommendations to the quarterly executive quality assessment and assurance (QAA) committee for one quarter for review and recommendations usual in regulatory compliance.	ppeal rs. riew opies for 4 .ny C ee .nined .ns .nager MNC	
F 157 SS=J	483.10(g)(14) NOTIF (INJURY/DECLINE/R		F 15		112	25/17
	(g)(14) Notification of	Changes.				
	consult with the reside	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 6/09/2017		
	ROVIDER OR SUPPLIER	E 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 157	Continued From pag	ge 9	F 15	57				
	` '	lving the resident which has the potential for requiring on;						
	mental, or psychoso deterioration in heal	nge in the resident's physical, cial status (that is, a th, mental, or psychosocial nreatening conditions or s);						
	a need to discontinu	reatment significantly (that is, le an existing form of verse consequences, or to limit of treatment); or						
	(D) A decision to tra resident from the fac §483.15(c)(1)(ii).	nsfer or discharge the cility as specified in						
	(14)(i) of this section all pertinent informa	tification under paragraph (g) n, the facility must ensure that tion specified in §483.15(c)(2) vided upon request to the						
		also promptly notify the ident representative, if any,						
	(A) A change in roomas specified in §483	m or roommate assignment .10(e)(6); or						
	, , ,	dent rights under Federal or ons as specified in paragraph n.						
		record and periodically (mailing and email) and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		345293	B. WING		06/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DICHMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
KICHWICH	D FINES HEALTHOAKE	AND REHABILITATION CENTE		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 157	Continued From pag	e 10	F 1	57	
	This REQUIREMEN	resident representative(s). T is not met as evidenced			
		riew and staff, Nurse sician interview, the facility		F157 Notification	
		ysician when a cognitively		On 5/1/17, at approximately 4:40 a	n
		is entrapped between the		Nurse #1 entered Resident #80's ro	
		t board causing a bruise to		and observed Resident #80 facing	
		ent's neck. This was evident		footboard of the bed with Resident	#80's
	for 1 of 3 sampled re			head wedged between the footboar	
	accidents (Resident	#80).		the mattress. Resident #80 was try	
				get up. Nurse #1, a medication aide	
		began on 5/1/17 when		a nursing assistant helped to remov	
		und entrapped between the		Resident #80's head that was wedg	
		t board and the facility did		between the footboard and mattres	-
	not notify the physici			lifting Resident #80's body and pull mattress away from the resident to	make
	-	ardy is present and ongoing.		room to slide Resident #80's head to under the footboard. Resident #80	-
	Findings included:			assessed by Nurse #1. Nurse #1 assessed Resident #80 as having a	1
	1. Resident #80 was	admitted to the facility on		bruise to the back of the neck, deny	
	1/23/17 with multiple			pain or discomfort, blood pressure	126/68,
	Alzheimer's disease.			pulse 72, respirations 18, and	
	assessment dated 4/			temperature of 98.2F. Nurse #1 not	ed no
		emory and decision making		changes in Resident #80's level of	al
		d extensive assistance with		consciousness, pupils were equal,	
	secured unit.	ent #80 resided in the		and reactive to light and accommod able to move all extremities within	auon,
	Scource unit.			baseline.	
	Resident #80's incide	ent report dated 5/1/17 at		23000.	
		ed. The report revealed"		On 5/1/17, the hall nurse notified th	e
		writer facing the base board		physician by phone message at 4:5	
		head wedged between the		of the incident. On 5/1/17 at 4:50, a	
	base board and the	mattress. Writer, nurse,		hall nurse spoke with the resident	
		Nursing aide (NA) helped		representative (RR) by phone of the	;
		ead from being wedged		incident.	
		and mattress by lifting			
	resident's body and p	oulling mattress out from		On 5/16/17, 5/24/17, 5/30/17, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(C
		345293	B. WING _			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICUMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		HI	IGHWAY 177 S BOX 1489		
RICHIVION	D PINES REALI RCARE	AND REHABILITATION CENTE		H	AMLET, NC 28345		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	e 11	F 1	157			
	head out from under Bruise noted to back	ke room to slide resident's base board of their bed. of neck. (Name of ed. Responsible party (RP)			6/12/17, the treatment nurse completed full body audit on Resident #80 with no negative finding of injury related to entrapment.		
	Resident #80's nurse notes dated 5/1/17 at observed by writer far with their head wedge and the mattress. Writer, nurse, medicaremove resident's head between base board resident's body and punder the resident to resident's head out from Bruise noted to back and responsible party resident's base line, I (LOC), pupils equal, in accommodation (PEF extremities within resident Skin warm and dry to and unlabored. Lung	om under the base board. of neck. Physician notified (RP) notified. No change in evel of consciousness round, reactive to light and RRLA). Able to move all ident's normal base line. touch. Respiration even			On 6/9/17, the director of nursing (DON notified the physician concerning the incident of Resident #80's head being wedged between the mattress and the footboard. On 6/12/17, the DON re-assessed Resident #80. The DON assessed the were no bruises or other injuries noted Resident #80 s neck. On 6/9/17, Resident #80 received a nebed with a properly fitting mattress from hospice. On 6/27/17, the regional vice president replaced the hospice bed and removed the hospice bed from the facil On 6/27/17, the resident was provided new facility owned bed to eliminate any further risk of entrapment between the footboard and the mattress.	re to w n d ity.	
	No adverse reaction of 126/66, 72, 18, 98.2." On 6/8/17 at 7:55 AM Nurse #2 was assign 4/30/17 (night shift). was checking the roo Resident#80's head sof the bed. She clarif board as foot board. floor and his neck was	I, Nurse #2 was interviewed. ed to Resident #80 on Nurse #2 stated that she			On 6/16/17, the corporate consultants completed a 100% audit of all residents nursing progress notes and risk management reports from 3/1/17 through 6/16/17 to ensure all residents with bruises and/or entrapment were assessed, provided appropriate interventions, and the physician and RI were notified via phone, with voice to voice conversation (no message left for MD), and appropriate documentation is the medical records. The identified area of concern; was multiple notification to	gh R I in as	

OLIVILIV	OT OIL MEDIO, ILL G	WILDIO/ WID OLIVVIOLO					7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	_		(С
		345293	B. WING				09/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		Н	IGHWAY 177 S BOX 1489		
Talonillon	D I INCO NEAEITIOANE	AND REMADILITATION SERVE		Н	AMLET, NC 28345		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 157	Continued From page	e 12	F	157			
		in bed on downward facing			RR and/or physician were not complete	ed.	
		talking but he was alert.			two elopements were not investigated,	,	
	I -	nelped to get the resident's			there were no interventions to decrease	e or	
		ot board by lifting his body up			eliminate bruises, allegations of abuse,		
	and pulling the mattre	ess out under him. Nurse #2			misappropriation or injuries of unknowr	1	
	stated that she called	the attending physician of			injury were not being reported, and		
		t the on-call and left a			accidents and incidents were not enter		
	_	e mail. She further stated			into the system with proper intervention	IS.	
		always call the resident's			These notifications, reporting,		
		and not the after-hours			investigations or interventions were		
		2 further stated she was not			completed by the nurse consultants on		
	#80 was on vacation	ling physician of Resident			7/16/17. Any further areas of improper notification will be addressed by the		
	#60 was on vacation	at triat time.			director of nursing (DON) or corporate		
	Interview with the DC	ON was conducted on 6/8/17			consultant by 7/16/17, with RR and		
		ed that she expected the			attending physician notification and		
		after-hours procedure in			documentation in the electronic medica	al	
		The DON also indicated she			record.		
		to call her if unable to reach					
	the physician and to	send the resident to the			On 6/13/17, the corporate consultant		
		R). The DON indicated that			posted a laminated bright colored sign	at	
		ident #80, the nurse should			each nurse station as a visual guideline	€.	
		nt to ER if unable to reach			The guideline reminds nurses it is the		
	the physician.				nurse's responsibility for voice-to-voice		
					notification to the physician for incident	S,	
		's progress notes from 5/1/17			to include entrapment and changes in		
	_	conducted. There were no ed the resident's entrapment.			resident condition.		
	Hotes writer address	ed the resident's entrapment.			In-servicing of 100% of all registered		
	Interview with the Ph	ysician was conducted on			nurses and licensed practical nurses w	as	
		He stated that he was not			initiated on 6/12/17 by the DON and		
		ent with Resident #80 which			completed by 6/16/17 regarding: 1)		
		He stated that he was on			notification of Physician for Changes in		
		ek of April and was back to			Residents Condition, 2) notify Physicia		
		5/1/17. He stated that he			(speak with the physician) by telephone		
		o call the Nurse Practitioner			Acute Change in Resident Condition		
	or the on call physicia				occur, Changes in Cognitive Status oc		
	-	hat his work phone was			Changes in Behavior occur, Changes i	n	
	showing that the facil	lity had called on 5/1/17 at			Oral Intake to include fluids occur.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE S COMPL	
		345293	B. WING _			06/0	9/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE:		
DIGITAGE				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCARE	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 157	Continued From pag	ge 13	F 1	57			
F 157	4:15 AM and left and He stated that he was message on his void. Interview with the Nicconducted on 6/8/17 that she was schedule every Tuesday and Friday and the Physical between 8 AM to 5 Front informed of the interview and to call the on call her or the physical her or the physical her or the expected that she expected the nurses the physician and she physician. She addereach the physician, to the ER.	nessage on his voice mail. as unable to retrieve the be mail. urse Practitioner (NP) was at 10:50 AM. The NP stated uled to come to the facility Thursday and at times on ician came every Monday PM. She stated that she was incident with Resident #80. She expected the nurses to cian during office hours day between 8 AM to 5 PM ill number during after- hours is.	F 1	Changes in Immune Syster Changes in Normal Body F occur, PANIC laboratory va Residents Condition Warra upon nurses assessments, include, bruises of unknown entrapment, elopement, an restraints, 4) if the nurse is reach the attending physicia may call the on-call physicia is unable to reach the attendor on-call physician, the number of changes in a resident' say fax or leaving a message is acceptable! 6) documentatinotification of the physician documented in the resident the nurse is unable to reach voice-to-voice the attending on-call physician, or the method the nurse MUST call the dir nursing and the resident must he emergency department be allowed to work until recin-service on "Notification of Changes in Residents Conducted Documentation". Questionnaires were initiate and were completed by 6/1 100% of all nurses by the A Training (AIT), corporate con Nurse, and DON for validate understating regarding physicalion to include 1). He	Functioning alues occur, ints based 3) incidents in origin, individual initiation of unable to itan, the nurse itan. If the nurse may call or, 5) in of these types condition by some interest of the initial be to its chart, 6) if h, g physician, its chart, 6) if h, g physician, its chart to italian in the initial be sent to its No nurse its ceiving the of Physician indication and its consultants, R its consult	e rse ian bes y f the br, to will for 7 r in RN	
	expected the nurses the physician and sh physician. She adde reach the physician, to the ER. The administrator ar	to call her if unable to reach ne would try to call the ed that if they were unable to the resident should be sent and the DON were notified of		the nurse MUST call the dir nursing and the resident must the emergency department be allowed to work until recin-service on "Notification of Changes in Residents Conductor Documentation". Questionnaires were initiate and were completed by 6/1 100% of all nurses by the ATraining (AIT), corporate conducts, and DON for validate understating regarding physical process.	rector of ust be sent t t. No nurse of the ceiving the of Physician of dition and ed on 6/12/1 16/17 with Administrator consultants, R tion of resician and R low is the ch a change of	to will for 7 r in RN RR	

		S) DATE SURVEY COMPLETED					
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORK ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 157	Continued From page	÷ 14	F 1	a change in the resident that the would be called? 3) If you are use speak with the physician what (4) If unable to speak with the arphysician or the on-call physician would you call? 5) Where is the notification of the physician door The licensed nurse is responsit assess, document, provide appinterventions and notify the atterphysician and RR of any acute condition, to include bruises of origin, entrapment, and/or any significant clinical information in the attending physician, the on-physician must be called. If una contact the attending physician on-call physician, the nurse must be called aftered. If unable to revoice-to-voice, the attending physician on-call physician or the medical director. If unable to revoice-to-voice, the attending physician or the medical murse will implement a interventions based on the neeresident and notify the attendinand RR. On 6/16/17, the DON, quality improvement (QI) nurse, staff finall nurse, and corporate constaudit the nurse progress notes management reports in the elemedical record to ensure the pland resident RRs were notified elopement, or entrapment, and notifications are documented in electronic medical record utilizing electronic medical record utilizin	unable to do you do? ttending an, who e cumented? ble to propriate ending changes in unknown other noted. to reach -call able to or the ust call the each, nysician, dical diffied. The appropriate ds of the gphysician facilitator, ultants will and risk ctronic hysician I of bruises, I the on the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C
NAME OF D		040230	5: *****	CTDEET ADDRESS CITY STATE 7ID CODE	06/09/2017
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	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 166 SS=E	Continued From page 483.10(j)(2)-(4) RIGH TO RESOLVE GRIEV	T TO PROMPT EFFORTS	F 18	progress audit tool. The audit will be completed 5 days a week (Saturday an Sunday progress notes will be reviewed on the weekend or on Monday) for 4 weeks, then 3 times a week for 4 weeks at least 1 time a week for 4 weeks. The DON or QI nurse will present the findings of the progress note audits at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly x 6 months, identify trends, use "5 Whys" root cause analysis, and make recommendations for follow-up as needed. The DON or QI nurse will present the findings of the progress note audits regarding physician notification at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility's follow-up to the recommendations. The QAA Committee will perform additional root cause analy as needed, make additional recommendations, and provide oversig The administrator is accountable for ensuring QAA Committee recommendations are implemented and newly implemented process are sustain to maintain regulatory compliance in the area of physician notification.	d s, he e e e e e e he e he he he he he he h

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345293	B. WING _				09/ 2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	Ē	, , ,	
(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)	I SHOULD BE		(X5) COMPLETION DATE
F 166	must make prompt ef grievances the reside with this paragraph. (j)(3) The facility must to file a grievance or resident. (j)(4) The facility must to ensure the prompt regarding the resident paragraph. Upon requa copy of the grievangrievance policy must postings in prominent facility of the right to (meaning spoken) or grievances anonymoof the grievance offician be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written de grievance; and the coindependent entities be filed, that is, the positions are sided to the province of the grievance of the gri	s the right to and the facility forts by the facility to resolve and may have, in accordance at make information on how complaint available to the at establish a grievance policy resolution of all grievances ats' rights contained in this uest, the provider must give be policy to the resident. The at include: Individually or through the locations throughout the file grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone are expected time frame for wof the grievance; the right cision regarding his or her	F 1	166			
	program or protection (ii) Identifying a Griev responsible for overs receiving and tracking	ng-Term Care Ombudsman n and advocacy system; rance Official who is eeing the grievance process, g grievances through to their any necessary investigations					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 06/09/2017
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 33/35/23 17
(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 SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 166	by the facility; maint information associate example, the identity grievances submitted written grievance decoordinating with stancessary in light of (iii) As necessary, to prevent further poteright while the allegatinvestigated; (iv) Consistent with reporting all alleged abuse, including injurand/or misappropriation anyone furnishing survived provider, to the admass required by States (v) Ensuring that all include the date the summary statement the steps taken to insummary of the performance of the performed, any correct taken by the facility and the date the write write states are until the states of the residents' right or if an outside entite the State Survey Agreement of the state	aining the confidentiality of all sed with grievances, for y of the resident for those d anonymously, issuing ecisions to the resident; and ate and federal agencies as a specific allegations; aking immediate action to intial violations of any resident ed violation is being §483.12(c)(1), immediately violations involving neglect, uries of unknown source, tion of resident property, by ervices on behalf of the inistrator of the provider; and	F 16		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345293	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	343233		STREET ADDRESS, CITY, STATE, ZIP COD		6/09/2017
TO THIS COLUMN	NOVIBER OR OUT FEET			HIGHWAY 177 S BOX 1489	_	
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HAMLET, NC 28345		
(V4) ID	SLIMMARY	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	IRRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE	COMPLETION DATE
F 166	Continued From p	age 18	F 1	66		
	confirms a violatio	on for any of these residents'				
		ea of responsibility; and				
	(vii) Maintaining e	vidence demonstrating the				
		nces for a period of no less than				
	•	ssuance of the grievance				
	decision.	ENT is not met as evidenced				
	by:	INT IS HOLIHEL AS EVIDENCED				
		review, resident interview, and		F 166 Resolve Grievances		
		e facility failed to investigate and				
		s for 2 of 3 residents reviewed		On 6/30/17, the licensed prac	tical nurse	
		esidents #76 and #37). The		(LPN) admissions coordinator		
	findings included:	·		Resident #76 and discussed to	the concern	
				related to not receiving assist	ance with	
		ance policy dated 3/10/17 was		showers as scheduled. Resid		
		licy read in part "the right to		currently states satisfaction w		
	_	ally, in writing, or anonymously		two showers per week. Resid		
		, family member, or resident ports a concern to a staff		received a shower on 6/20/17 and 6/27/17. On 6/30/17, the		
	1 '	member will forward the		admissions coordinator again		
	· ·	upervisor, department head, or		Resident #76 and Resident #		
		e Administrator is responsible		assistance with two showers	-	
		ecting, and investigating		now being provided.	,	
	1	ompt mannerthe				
	Administrator will a	assure the resident or resident		On 6/30/17, the LPN admission	ons	
	representative are	notified timely of the results of		coordinator interviewed Resid	lent #37's	
		of any corrective measures		resident representative (RR)		
		vritten grievance decisions as		discussed the concern related	,	
	appropriate."			not assisting Resident #37 wi		
	4 Decident #70	and admitted to the facility on		staff not changing Resident #		
		ras admitted to the facility on		incontinence brief timely, and bathing Resident #37. Resident	•	
		le diagnoses that included , difficulty in walking, and		currently states satisfaction w		
	history of cerebral			assistance with meals, incont		
				and bathing.	,	
	The quarterly Mini	imum Data Set (MDS)				
		5/4/17 indicated Resident		On 6/29/17 and 6/30/17, the s	social worker	
		as intact. Resident #76 was		(SW) and LPN admissions co		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345293	B. WING _			C 06/09/2017	
NAME OF PE	ROVIDER OR SUPPLIER	0.0200	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	09/2017
TO UNIC OF TH	TO VIDERY OIL OUT I EIER				GHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE			AMLET, NC 28345		
				- 11/			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 166	Continued From pa	ge 19	F 1	166			
	assessed as dependenting. He had impper and lower exas not steady on his The plan of care for Resident #76 had a 8/12/16 and most rethat indicated the for assistance/potential maximum function or related to: impaired [and] weakness." For dependent on one shathing. A review of the shown 3/3/17 through 5/31 received 15 showers. An interview was considered showers the assistance of sthis preference was showers per week. Had not received his stated he had spok (DON) about his should be shown as the problem. A review of the facility as the problem.	dent on 1 staff member for apairment on 1 side of his tremities and was assessed as feet. Resident #76 was reviewed. In plan of care (initiated on ecently reviewed on 5/5/17) Incus area: "Requires I to restore or maintain of self-sufficiency for bathing mobility, physical limitations, Resident #76 was assessed as staff for assistance with			reviewed all resident concerns for the pathirty days to ensure residents and/or to RRs are satisfied with the resolution are follow-up to their grievance. Any areas concern were addressed immediately the social worker or LPN admissions coordinator. On 6/30/17, the administrator initiated in-service for the administrative staff (director of nursing, SW, admissions coordinator, AR bookkeeping, accounts payable, maintenance, activities, qualit improvement nurse, minimum data set nurses, environmental services directo therapy manager) on "Follow Up to Resident Concerns" which included: 1) When addressing resident concerns, y must include detailed information for resolution of concern to include a date and 2) any needed audits or observation to support monitoring should be documented. All newly hired administrative staff will receive the "Fo Up to Resident Concerns" in-service during new employee orientation. Beginning 6/30/17, the administrator and/or DON will review resident concerns weekly for three months to ensure concerns have been addressed and the resolution reviewed with the resident/R in a timely manner to include a written response on the concern form with detired.	he nd of of oy an s y r, ou ons llow rns e iR	
	were filed by or on to showers not bein	behalf of Resident #76 related ag provided as scheduled.			of the follow up that occurred and the date.	allo	
		onducted with the Director of 6/6/17 at 12:34 PM. She			Beginning 7/1/17, the social worker or admissions coordinator will present the	:	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING	B. WING		C 06/09/2017	
NAME OF D	ROVIDER OR SUPPLIER	343233	5:	STREET ADDRESS, CITY, STATE, ZI		09/2017	
NAME OF FI	ROVIDER OR SUFFLIER				F CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
				HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 166	Continued From pag	e 20	F 1	66			
	provided as scheduler resident. The DON rongoing problem with scheduled. She indicated as scheduled as he had not for Resident #76's reindicated a grievance completed for Resides showers not being put An interview was cor Administrator on 6/8/she expected the grie and for verbal conce	expectation for showers to be eed and as requested by the revealed the facility had an in the provision of showers as cated she was familiar with evealed she was aware of a int #76 receiving his showers had reported this to her able to recall a date). She it completed a grievance form should have been ent #76's verbal report of his rovided as scheduled. Inducted with the 1/17 at 3:02 PM. She stated evance policy to be followed rns voiced to staff to be off member and addressed as		grievance findings at the improvement (QI) comm three months. The QI co review the grievance findidentification of trends, a to determine the need for frequency of continued make recommendations continued compliance. The and/or DON will present recommendations of the committee to the quarter quality assessment and committee for one quarter recommendations and or the commendations are commendations.	ittee meeting for mmittee will dings for actions taken, and or and/or monitoring, and for monitoring for the administrator the findings and monthly QI diversity executive assurance (QAA) er for further		
	cumulative diagnose aphasia. A social worker (SW) care plan meeting was Resident #37's fam A review of the SW r PM read the care plan Resident #37's fam Nursing (DON), Dieta director (AD) and the resident care guide was department's particular support of the	admitted on 1/20/11 with s of dysphasia, anxiety and on the dated 3/23/17 read a seas scheduled for 3/31/17 with ity at 10:00 AM. Indeed the dated 3/31/17 at 7:14 and meeting was held with the ity, MDS nurse, Director of any Manager (DM), activities a SW. The note read the was used to review each iteration in Resident #37 's are guide is a brief synopsis of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION 3		TE SURVEY MPLETED
		345293	B. WING		0	C 6/09/2017
	ROVIDER OR SUPPLIER ID PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		9.00.2011
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 166	information was ker computer for the nur following while provide documented "All cost to appropriate staff" A review of the facil 12/1/16 to present on behalf of Reside dated 5/22/17 regar outcome read the b #37 's closet on 5/2 notified. Resident #37 's quay (MDS) dated 5/22/1 impairment, physica and extensive assist activities of daily living assistance of one share incontinent of both Resident #37 was lafor all of her ADL castaff. In an interview on 6 member of Resident were that the staff where that the staff where the staff wher	in Resident #37. This of in her room and in the raing assistant (NAs) to iding care.) The SW incerns addressed and given ity grievance logs from only included one intake by or int #37. The grievance was iding a missing blanket. The lanket was found in Resident 23/17 and the family was indicated severe cognitive all behaviors toward others, stance of two staff for her ing (ADLs) except extensive taff for eating. She was coded	F 16	6		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY MPLETED
		345293	B. WING _			C 06/09/2017
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		3073072011
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 166	the responsible party stated he was very use their concerns were care plan meeting but members to attend something to the RP stated none discussed had been to his knowledge. In an interview on 6/2 recalled the care planed with the care planed and the care planed in the care planed one their own griever.	iew on 6/5/17 at 10:04 AM, (RP) for Resident #37 pset with facility because not addressed. He recalled a at he asked his local family ince he worked out of town. of the issues that were addressed by management 7/17 at 8:32 AM, the SW in meeting held with Resident rated she did not complete ause the departments were ting and they could have ance forms. She stated it sibility to schedule the care	F 1	66		
F 221 SS=J	plan meanings. In an interview on 6/ Administrator stated the SW would have of during the care plan Resident #37 with a department and the onecessary follow up. 483.10(e)(1), 483.12 FROM PHYSICAL R §483.10(e) Respect The resident has a ri and dignity, including §483.10(e)(1) The rig physical or chemical	7/17 at 1:05 PM, the it was her expectation that completed grievance forms meeting on 3/31/17 for copy given to the responsible original form to her for any (a)(2) RIGHT TO BE FREE ESTRAINTS and Dignity. ght to be treated with respect	F 2	21		7/25/17

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 6/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		1 00/03/2017	
(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	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 221	Continued From pag	e 23 resident's medical symptoms,	F 2	21			
	consistent with §483.12(a)(2).	ooldonko modlodi oymptomo,					
	neglect, misappropri and exploitation as d includes but is not lir corporal punishment	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to					
	(a) The facility must-						
	or chemical restraint discipline or conveni required to treat the symptoms. When th indicated, the facility alternative for the lead document ongoing restraints.						
	Based on record revinterview, the facility in bed without considuithout a medical sy was caught between foot board causing a resident's neck. This sampled residents winches or more between the facility's limmediate jeopardy	riew, observation and staff utilized a device (foot board) lering it to be a restraint and mptom. Resident #80's head the bed's mattress and the bruise to the back of the s was evident for 1 of 3 hose beds had a gap of 4 een the mattress and the foot secured unit (Resident #80). began on 5/1/17 when und with his head entrapped		F 221 Restraints On 1/23/17, Resident #80 was the facility secured unit. On licensed practical nurse (LPI) a work order for Resident #8 a broken footboard. On 6/12 maintenance assistants were by the regional vice presider the Dimensional Limits for Id Entrapment Zones per the F Administration (FDA) Guideli footboard was missing two s	4/15/17, the N) completed 80 □s bed with 1/17 the e in-serviced nt (RVP) on dentified food and Drug ines. The		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345293	B. WING _			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICHMON	D DINEC HEALTHOADE	AND DELIABILITATION CENTE		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)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		COMPLETION DATE
F 221	Continued From page	e 24	F 2	221			
	between the mattress	and the foot board causing			right side of the board, thus causing a	gap	
	a bruise to the back of	of the resident's neck.			between the mattress and footboard		
					which was identified as an entrapment		
	The immediate jeopa	rdy is present and ongoing.			zone. The identified gap between the		
					footboard and mattress for Residents		
	Findings included:				#80 □s bed impeded his ability to rise fr		
	4 D : 1 1 1/100				the bed. The footboard for Resident #8	30	
Resident #80 was admitted to the facility 1/23/17 with multiple diagnoses including Alzheimer's disease. The quarterly Minimu					was repaired by the maintenance		
					assistant by placing two screws on the right side of the board and securing the		
		ssment dated 4/25/17			footboard to the frame and eliminating		
		nt #80 had memory and			footboard to the frame and eliminating footboard as a restraint on 6/8/17. On	uic	
		lems and needed extensive			6/9/17, hospice provided Resident #80		
		nobility. The assessment			with a newer style bed and mattress for	r	
		the resident was not using	comfort not because the bed was broken.				
		in bed and in the chair.					
	Resident #80 resided	in the facility's secured unit.			On 5/1/17, at approximately 4:40 am,		
					Nurse # 1 entered Resident #80□s roo	m	
		plan dated 4/25/17 was			and observed Resident #80 facing the		
		olan problem was "resident			footboard of the bed with Resident #80	-	
	was at risk for falls" a				head wedged between the footboard a		
		of falls through the next			the mattress. Nurse #1, a med aide, a	nd	
		ches included to assist			a nursing assistant helped remove	اء ما	
	_	obility, ensure environment ster medications as ordered			Resident #80 s head from being wedg between the footboard and mattress by		
	•	used articles within easy			lifting Resident #80 s body and pulling		
	reach.	used articles within easy			the mattress out from under the resider		
	reach.				to make room to slide Resident #80 \subseteqs		
	Resident #80's incide	nt report dated 5/1/17 at			head out from underneath the footboar	d.	
		d. The report revealed,			Resident # 80 was assessed by the ha	-	
		y writer facing the base			nurse with observation of a bruise to th		
	board of their bed wit				back of the neck, Resident #80 denied		
	between the base box	ard and the mattress.			pain or discomfort. On 5/1/17, the hall		
		tion aide and nursing side			nurse obtained Resident #80□s vital		
		resident's head from being			signs: blood pressure was 126/68, puls	e	
	_	e board and mattress by			72, respirations 18, and temperature		
		and pulling mattress out			98.2F. No changes were noted during t		
	from under resident to				assessment by the hall nurse in Reside	ent	
	resident's head out fr	om under base board of			#80□s level of consciousness, pupils		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMF		SURVEY LETED					
		345293	B. WING _			1	C 09/2017
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017
					GHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCAR	RE AND REHABILITATION CENTE			AMLET, NC 28345		
(V4) ID	SLIMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 221	Continued From pa	ige 25	F 2	221			
	•	oted to back of neck."			equal round and reactive to Light and		
	aron boa. Braico ii	oted to back of ficein			Accommodation, able to move all		
	Resident #80's nurs	se's notes were reviewed. The			extremities within baseline. On 5/1/17	at	
		at 4:40 AM revealed "resident			4:50am, the hall nurse notified the MD		
		facing the base of their bed			leaving a telephone message. On 5/1/	•	
		lged between the base board			at 4:50am, the hall nurse notified the		
		Writer asked resident, "What			resident representative (RR) by leaving	a a	
	are you doing?" Resident stated "trying to get				telephone message. A full body audit v		
	up." Writer, nurse, medication aide and NA				completed on Resident #80 on 5/16/17		
	helped remove resi	ident's head from being			5/24/17, 5/30/17, and 6/12/17 by the		
	wedged between b	ase board and the mattress by			treatment nurse with no negative finding	gs	
	lifting resident's boo	dy and pulling the mattress out			of injuries related to restraints or		
	from under the resi	dent to make room to slide			entrapment/gap. On 6/9/17, the Direct	or	
		from under the base board.			of Nursing (DON) notified the MD		
		ck of neck." This note was			concerning the incident of Resident		
	written by Nurse #2	2.			#80 □s head being wedged between th		
					mattress and the footboard. On 6/9/17		
		oserved up in wheelchair in his			hospice provided a new bed with a		
		1:20 PM. His bed had a 1/4 side			properly fitting mattress for Resident #	30.	
		nd a head board. His bed had			Resident #80 was re-assessed by the		
		e mattress, foot board and			DON on 6/12/17 with no bruises or oth	er	
	head board.				injuries noted to neck. On 6/15/17, the	_	
	Intonious with Nurs	a Aida (NIA) #2 (agaigned to			quality improvement (QI) nurse and the		
		e Aide (NA) #3 (assigned to conducted on 6/7/17 at 5:40			corporate consultant evaluated Reside #80 s new bed and footboard, to	i i t	
	,	that that the resident was			determine the footboard does not mee		
		ed mobility, transfer and			the definition of a restraint per the resid		
	•	needed constant reminder due			assessment instrument (RAI) manual.	CIII	
	to his confusion.	locada constant reminaer ade			accessment motiament (row) mandai.		
					A 100% of all residents□ beds, to inclu	de	
		AM, Nurse #2 was interviewed.			Resident #80, were audited by the		
		gned to Resident #80 on			maintenance assistants on 6/13/17 to		
	, ,). Nurse #2 stated that she			ensure there were no identified risks for		
		ooms and she found Resident			entrapment zones/gaps or potential ris	k	
		nder the base board of the			for restraining the resident (to include		
		that she meant the base board			entrapment/gap between mattress,		
		resident was facing the floor			footboard, head board entrapment wit	hin	
		inder the base of the foot			the rail, entrapment under the rail,		
	board and his head	I was hanging out. The			between the rail supports or next to a		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345293	B. WING _			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICUMON	D DINES HEALTHCARE	AND DELIABILITATION CENTE		HI	IGHWAY 177 S BOX 1489		
RICHIVION	D PINES HEALI HUARE	AND REHABILITATION CENTE		H	AMLET, NC 28345		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page	e 26	F 2	221			
F 221	resident's body was in facing position. He walert. Four staff mem resident's head out finhis body up and pullir under him. Interview with the Maconducted on 6/8/17 he didn't know that he between the mattress and side rails and he An interview with the was conducted on 6/8 stated that nobody wabetween the mattress after the incident with She further stated not the resident's entraph moved to another roon on trelated to the resident of 6/8/17 at 9:37 AM expected the maintengaps between the maleast monthly but she maintenance director. Interview with the Quiwas conducted on 6/8/10 and 16/8/10 and 16	n bed in the downward ras not talking but he was bers helped to get the om the foot board by lifting ing the mattress out from intenance Director was at 8:15 AM. He stated that had to check the gaps for foot board, head board was not told to check them. Director of Nurses (DON) 8/17 at 9:27 AM. The DON has checking the gaps had the foot board even Resident #80 on 5/1/17. Thing had been done after hent. The resident was had per family request and dent's entrapment. ministrator was conducted had She indicated that she hance director to check the hattress and the foot board at didn't know if the	F2	221	single support, entrapment between the rail and the mattress, entrapment under the rail, at the end of the rail, entrapment between the bed rails, and entrapment/gap between the end of the rail and the side edge of the head or footboard). The audit identified 3 beds that were not the correct size for the resident due to weight and multiple hear and footboards that were loose. The maintenance assistants completed the repairs of all beds on 6/13/2017. The 3 residents that were in a regular bed we provided bariatric beds on 6/13/2017 by the central supply coordinator and maintenance assistants. On 6/13/17, the maintenance assistants adjusted the mattress flaps on the two mattresses to eliminate risk for gaps between the hear and footboards. On 6/15/17, the quality improvement (QI) nurse and the corpor consultant evaluated Resident #80 st and footboard, determining the footboard does not meet the definition of a restration per the resident assessment instrument (RAI) manual and Federal Regulations. On 6/13/17, the RN facility consultants completed a 100% audit of residents we in bed to ensure the resident is free frophysical restraints by assessing the befootboard, headboard, side rails and mattresses. The audit resulted in 3 resident beds being removed from server.	r nt e ad ad are y e ad y rate ped and int t . hile m d	
		lurse #2 was conducted on he stated that she didn't rd as a restraint.			to eliminate the unintended restraining devices. The corporate consultant also ensured the resident was provided enough space while moving around in bed for repositioning and the bed was a	the	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/0	9/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE	00/0	3/2017
DICHMON	D DINES HEAT THOAE	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
KICHWION	D FINES HEALTHCAP	REAND REHABILITATION CENTE		HAMLET, NC 28345			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	E	(X5) COMPLETION DATE
F 221	Continued From pa	-	F 2				
	The Regional Vice Administrator were jeopardy on 6/9/17	notified of the immediate		a restraining device. On 3/1/17 to 6/16/17, 100% residents, to include Resider nurse progress notes and management reports from 3/06/16/2017 were reviewed for entrapment/restraint and bet corporate consultants and wormpleted by 6/16/17, to ensidentified residents with bruise entrapment/restraints and bet assessed and provide approximaterventions and that the MI were notified via phone, with voice conversation. All ident concern will be addressed by consultant or director of nurse 6/16/17 with resident reprand attending physician notified documentation in the electromecord. On 6/15/17, the corporate consultant or included the resident assessment instrument (RAI Regulatory definition of a resident symptom is defined indication or characteristic of psychological condition) and restraints to include: medical defined as an indication or close a resident is restrained plan team will determine the a specific medical symptom.	nt #80, risk /1/17 to or bruises, haviors by th vill be sure all ses, ehaviors were opriate D and RR n voice to tified areas of y the facility sing (DON) b resentative fication and onic medical consultant stered nurse rses (LPNs), estraints. This ent l) and straint d as an f a physical of lexamples o l symptom is characteristic al condition. ed, the care or presence of	es s	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(>	X3) DATE SURVEY COMPLETED
		345293	B. WING _			C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		00/03/2017
				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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	Continued From page	÷ 28	F2	the use of restraints. In determineed for restraint use, an assest resident' smedical condition, circumstances, and environment occur. The assessment and existent the medical symptom, progresident' safety and assist the in attaining or maintaining his of highest level of physical and possible to highest level of hight level of hight level of hight level of highest level of highest le	ssment of ant should valuation traint will offect the ne residen or her sychologic that required in the tation ssessmen is are and the tation seet, fabric of the test the untable for ice use. If the fabric of the test is the untable for ice use, is freedom the president off the test in the area chair or wall off the bed. President the end of the individual of the individual of the individual of the individual off the individua	at cal re It not go or

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY MPLETED
		345293	B. WING _			C 6/09/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		0/00/2011
DICUMON	ID DINES HEAT THOADE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
KICHWION	ID PINES REALI ROAKE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 221	Continued From page	÷ 29	F2	prevent possible injury or entrapt facility will provide an organized systemic method for body positic bed measurements to include gate FDA guidelines for hospital beds residents. By 6/16/17, the Regio President reviewed the Quality Improvement System for restrain Quality Improvement Manual with Administrator, Director of Nursing nurse to include the purpose in material residents with restraints and high for entrapment to ensure that phase residents with restraints and high for entrapment to ensure that phase restraints are used only as present the physician. The Administrator of Nursing and Quality Improvem Nurse are to ensure systems are functional, and maintained. The Administrator and QI nurse will reincident report form and ensure a investigation and follow up to incompropriate interventions. An in-service was initiated by the Consultant on 6/12/17, to be confolded for 100% of all staff on Entrapment/Gaps Bed entrapmocurrence involving a resident we caught, trapped, or entangled in system, which includes the space around the bed rail, bed mattress frame, to include the footboard. It body parts associated with risk for injury include the head, neck, an Who is at risk for entrapment? For who are frail or elderly or those we conditions such as agitation, deliconfusion, pain, uncontrolled body movement, hypoxia, fecal impace.	and pointing and aps per a for the anal Vice ants per the chart the grand QI monitoring and potential pysical cribed by the potential pysical proper clude. The potential pysical pys	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	' '	TE SURVEY MPLETED
		345293	B. WING _			C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/03/2017
				HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	Continued From page	÷ 30	F2	acute urinary retention that cau move about the bed or try to exbed. The absence of: timely toil position change, and frequent individualized care are factors that also contribute to the risk of entiting the risk may also increase due technical issues to include, imposized mattresses or broken equathese technical issues must be to the nurse and maintenance of immediately and work order mucompleted per policy. Interventite to dolensure that mattress fits unsure notify the Maintenance and nurse immediately to assess mattress. If a resident is noted body part, to include the head/rentrapped in any part of the best to include the footboard, immediately part out of area. Assess the entitle body par	that may trapment. e to properly uipment. e reported director ust be ions/What the bed if Director ss the to have a neck, d system, diately call tangled the speak with on-call urred and orders if esentative ccurred n was n. statements estrator/DON elf a safe in the eetween the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345293	B. WING _			C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	00/03/2017
DIGUMON	D DINES HEALTHOADE	AND DELIABILITATION OF ME		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 PREFI) TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIA	
F 221	Continued From page	÷ 31	F2	nurse must be notified im nurse must find out the rocause of the change) of vis in that position and prointerventions to ensure the safety, such as: therapy of the resident to the bathromaintenance work order, device, new bed and/or not transfer out of the bed perchoice. Questionnaires were initiated and were completed by 6 100% of all staff to include nurses, nursing assistant staff, therapy staff, dietary staff, geriatric care aides, bookkeeping, payroll, mareceptionist, and supply of Administrator in Training consultants, RN Nurse, a Nursing for validation of uregarding entrapment to it do you do if you find brok equipment? 2. What is end Can a bed cause entrapment of you do if you suspect or contrapment? 5. Who is at entrapment? 6. What are can contribute to entrapment resident is unsafe in bed between that mattress and On 6/18/17, the corporate began using questionnairs.	pot cause (the why the resident wide appropriate resident is referral, taking om, positioning lew mattress, or resident is ated on 6/12/1	or 7 ng f, te at do hat

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345293	B. WING _			C 06/09/2017
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STA HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	TE, ZIP CODE	00/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 221	Continued From page	ge 32	F2	facility nurses know what a restraint is an restraints. Any nurse pass the questionnal retested. If upon the nurse was unable to Restraint Questionneremoved from the as until the nurse is abliquestionnaire. A 100% of the nursing in-serviced by the R 6/16/17 on restraints restraints. The nursing tested on their known matter of observing changes in resident' nursing assistant that the test will be retrain upon the second attended assistant staff is unapass the restraint tester from the schedule unto pass the question. On 6/13/17, the main began auditing 100% beds to ensure there created by gaps or 66/13/17, the corporar began auditing 100% notes and risk manal ensure there are no entrapment or restraint to consultant began auditing nurse consultant began auditing the passing	and examples of the that is unable to the second attempt the consideration and the second attempt the consumers are the nurse will be successfully pass the second attempt the consumers and examples of the subject and reporting assistants will be allowed and retested. It is unable to passified and retested. It is unable to passified and retested. It is unable to passified and retested. It is unable to successfully st will be removed antil the nurse is able to successfully st will be removed and retested. It is a successfully st will be removed and retested. It is a successfully state to passistants will be removed and retested. It is a successfully state to passistants will be remo	the be e t by e t by e of f of of of of of of of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		345293	B. WING _			C 6/09/2017		
	ROVIDER OR SUPPLIER ID PINES HEALTHCARE	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 221	Continued From pag	ge 33	F 2	progress notes and risk reports in the electronic. The audit was to ensure resident' s representati notified of restraint use. documented in the elect record to include a corresphysician' s order with symptom for any restrai. The audit will be docum Progress Note Audit Too 6/26/17, the audit will be days a week for 4 week weekends (Saturday an progress notes will be reweekend or on Monday) week for 4 weeks. The DON or QI nurse w findings of the Progress the monthly Quality Imp Committee meeting. The Improvement Committee results of the audits more identify trends, use 5 W analysis, and make record follow-up as needed. The DON or QI nurse w findings of the Progress the quarterly Quality Assands Assurance (QAA) Committee recommendations. The QAA Committee will Committee recommendations. The will perform additional reas needed, make additional reasons and reasons and reasons and restrict the second restric	medical record. In the physician and live (RR) was Notifications are tronic medical esponding a medical esponding a medical esponding es			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		345293	B. WING			C
NAME OF D	DOVIDED OD GUDDUED	343293	D. WING _	CTDEET ADDRESS SITV STATE 71D CODE	06	/09/2017
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		
(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 CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE
F 221	\	НІВІТ	F 2:	recommendations, and provide over The administrator will be responsible ensuring QAA Committee concerns recommendations are addressed to further training or other intervention that newly implemented process as sustained to maintain regulatory compliance in the area of residents to be free from physical restraints.	ole for s and hrough ns so re	7/25/17
SS=J	§483.12 The resident abuse, neglect, misar property, and exploits subpart. This includes freedom from corpora seclusion and any ph not required to treat the 483.12(b) The facility implement written pole (b)(1) Prohibit and preexploitation of resider resident property, (b)(2) Establish policie investigate any such a (b)(3) Include training §483.95,	Il punishment, involuntary ysical or chemical restraint ne resident's symptoms. must develop and icies and procedures that: event abuse, neglect, and its and misappropriation of the sand procedures to				
	Based on record revi interview, the facility r cognitively impaired r	ew, observation and staff neglected to supervise a esident who was identified resulted in an unsupervised		F224 Neglect On 3/4/17, Nurse #1 assessed Res #3 was for signs of injury, with no		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		0.45000	D. MINIC			С	
		345293	B. WING _	-		06/09/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
Talon IIII On	D I INCO HEALINGAIN	AND REMADILITATION SERVE		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 224	Continued From pag	e 35	F 2	24			
F 224	exit from the facility of reviewed for accider #3 was found a few towards a busy high through a parking lot Immediate jeopardy Resident #3 exited the Immediate jeopardy Findings included: The facility's wander dated 1/16/16 was rein part "the purpose implement guidelines for inappropriate wan facility and to ensure regards to the identification of the wan should occur as indicated apply to all residents this residents who may dementia units." The were "to prevent the and to plan for the rewell-being within the included "implement to or including the appracelet, monitoring (etc.)."	for 1 of 3 sampled residents ats (Resident #3). Resident feet to the road heading way. Resident #3 had to go at to get to the road. began on 3/4/17 when the building unsupervised. is present and ongoing. ing risk potential protocol eviewed. The protocol read of this protocol is to se to identify a resident's risk andering within or outside the ear resident's safety in fied behavior. To identify this sure a resident's safety, dering risk potential protocol cated. These guidelines is within the facility including that resident's unsupervised exit	F 2	injuries due to an unsupervise 3/4/17, after assisting Resider into the facility and assessing and symptoms of injury, Nurse immediately placed Resident constant supervision (to preve further attempts to exit the factor constant supervision was provinursing assistant until Resider placed in bed at approximately Nurse #1 determined Resident in bed, was no longer at risk of facility unsupervised during the because of Resident #3's inable ambulate or rise from the bed extensive assistance. The resident representative (RR) was notifing pm on 03/04/2017 of the occuuthe licensed nurse documented time stamp at 7:45pm. On 3/4 #1 notified Resident #3's physical resident exiting the facility by message due to no injury to the Nurse #1 was drug tested and per facility policy on 6/10/17 report was completed by the and faxed to the Health Care in related to the neglect allegation 6/10/17, an investigation was the Regional Vice President (Icorporate consultants, administ director of nursing (DON) related allegation of neglect of Reside exiting the facility unsupervise	at #3 back for signs to #1 #3 on 1:1 that any ility) The vided by a nt #3 was y 8:30 pm. t #3, while of exiting the e shift bility to without ident ed at 7:35 rrence and ed per the vident elaving a ne resident. I suspended elated to a of a 24 hour administrator personnel on. On initiated by RVP), strator, and ted to the ent #3,		
	7/7/16 with multiple of fracture. The quarter assessment dated 3.	diagnoses including pelvic rly Minimum Data Set (MDS)		4/9/17, an unidentified staff pe which the DON does not reme reported to the DON that Resi an unsupervised exit through	erson of ember, dent #3 had		

	e i eit medie/ iite a	1	1			T	2. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	PLETED
						(С
		345293	B. WING _			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
D.O				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	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD E	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
					DEFICIENCY)		
F 224	Continued From page	e 36	F 2	224			
	and was independent	t with locomotion on and off			door. The previous employee (DON is	i	
	unit. The assessmer	nt also indicated that the			unable to remember the employee)		
	resident needed exte	nsive assistance with			witnessed Resident #3 heading toward	ls	
	transfer and was usir	ng a wheelchair for mobility.			the facility□'s front door. The local		
	The assessment furth	-			Emergency Services was entering the		
	resident had not exhi	bited a wandering behavior			facility and, while coming through the f	ront	
	during the assessme				door, the resident exited out the front of		
	3				with the assistance of the emergency		
	Resident #3's wande	ring risk evaluations were			medical technician (EMT) holding the	door	
reviewed. The risk evaluation form indicated that				open. The unidentified staff member			
		re of greater than 5 was at			immediately redirected Resident #3 ba	ck	
	risk for wandering.	o or grouter than o was at			into the facility. The wander guard doo		
	Tiok for wandoning.				alarm did enunciate, but the door was	•	
	The wandering risk e	valuation form dated 10/7/16			already open by the EMT□s thus allow	/ina	
	revealed that Resider				the resident to propel in the wheel cha	-	
		re of 16. The form indicated			out the door. The resident was		
	_	had one or more attempts to			immediately redirected by a staff mem	her	
		nd or wander in the past 3			back into the facility while the front doc		
	l	so indicated that the resident			wander guard alarm was still sounding		
		ement of desire or intent to			On 4/10/17, the DON spoke in person	•	
	leave the facility.	chieff of desire of intent to			with Resident #3□'s RR and requested	1	
	leave the facility.				the RR to attend a 4/11/17, 11:00am c		
	The wandering rick e	valuation form dated 3/23/17			plan meeting. The resident representa		
	_	that Resident #3 was at risk			declined to attend the care plan meeting		
		score of 19. The form			On 5/14/17, at approximately 4:00pm,	-	
	_	ident has had one or more			assigned hall Nurse #1 was at the nurs		
		ne/facility and one or more			station and observed Resident #3 at the		
	•	he form also indicated that			front door. Nurse #1 overheard Reside		
	•	le verbal statement of desire			#3 stating to a visitor "let me out". Nurs		
	or intent to leave the				#1 yelled at the visitor not to let Reside		
	or intent to leave the	racility.					
	Decident #3's sere of	an for wandering was			#3 out the front door but the visitor helf the front door open for Resident #3 an		
	,	an for wandering was			-		
		ering care plan was initiated			the resident wheeled out of the facility		
		viewed on 3/28/17. One of			the wheel chair. The alarm was sound	iig	
		ns was wandering and or at			when Resident #3 exited the facility.		
		exits from facility related to:			Nurse #1 immediately went outside to		
	· ·	t/building. The goal was the			assist Resident #3 back inside and	-1-	
		episode of unsupervised			observed Resident #3 on the front por	CII.	
	exits from facility thro	ugh next review. The			Nurse #1, a certified nursing assistant		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			71. 501251			,	2
		345293	B. WING				09/2017
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		03/2017
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 224	Continued From page	e 37	F:	224			
		to "allow resident to wander			(CNA) #1, and CNA #2 heard the front		
	· ·	ily to ensure resident has an			door alarm and came outside to assist		
		d it is functioning properly,			Nurse #1 with assisting Resident #3 ba	ck	
		of wandering per facility			into the facility. Resident #3 was		
		tification (ID) bracelet is in			combative with the staff when attempting	ng	
	place, ensure resider	nt's picture and name are on			to assist the resident back inside the	_	
	the wandering reside	nt board, ensure that alarm			facility. Resident #3 was assisted back		
	exits are functional, p	provide 1:1 staff monitoring			into the facility by Nurse #1, Nurse #2,		
	as necessary, provide				CNA #1, and CNA, #2 approximately 1		
		s, and provide resident with			minutes after the unsupervised exit. Or		
		d group activities of choice".			5/14/17, upon assisting Resident #3 to	the	
	All of these care plan				resident's room, Nurse #1 assessed		
		9/16. There were no new			Resident #3 with no injuries observed.		
	interventions added a	after 8/9/2016.			5/14/17, Nurse #1 notified the physicial and RR of Resident #3 exiting the facili		
	The nurse's notes da	ted 3/4/17 at 7:45 PM			unsupervised. On 5/15/17, the social	,	
	revealed "alarm soun	iding at front door. Upon			worker (SW) requested Resident #3□'s	;	
	investigating, visitor s	said that he had let resident			RR/family for a care plan meeting to be	,	
	(Resident #3) out of o	door because resident asked			held 5/17/17 to discuss Resident #3's		
	him to. Upon going of	outside, this nurse noted			unsupervised exits. The RR/family		
) in his chair within a few			agreed, but did not attend the 5/17/17		
	feet of roadway. This	•			care plan meeting. On 5/18/17, the		
		lding. He was yelling "I'm			Minimum Data Set (MDS) Nurse updat	ed	
		building, I'm going home."			the care guide for Resident #3, adding		
		to hold chair to prevent			that Resident #3 is at risk for wandering	-	
	1	g roadway and turned on her			written in all capital letters for immediat		
		ed facility. Advised staff of			recognition. On 5/18/17, Resident #3'	S	
		nembers came and assisted			RR/family stated to the DON that the	ont	
	_	back into building." The he resident had no injuries			RR/family would seek alternate placem due to the RR/family's decision to avoid		
	from the incident.	ne resident flad flo injulies			the facility placing Resident #3 into the		
	nom the moldent.				secured dementia unit which is		
	The nurse's notes da	ted 4/11/17 at 4:47 PM			recommended by facility and Resident		
		or 4/10/17 at 5:30 PM,			#3's attending physician. On 6/7/17, the		
	1	OON) and Social Worker			SW followed-up with Resident #3'		
		to inform her that the			RR/family about placement of Residen	t #3	
		pervised exit and that the			to another facility. On 6/7/17, the famil		
		t with her and the family to			made no decision regarding alternate		
		sparks (secured unit) unit.			facility placement for Resident #3 but		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 t. BOILDI			، ا	С
		345293	B. WING _				09/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 224	Continued From pag	e 38	F 2	224			
	She stated that we c	ould go ahead and plan a			continued to refuse for the resident to b	ре	
		uld make sure the family was			moved to the secured dementia unit to		
	present."				prevent future unsupervised exits. On		
					6/7/17, at approximately 2:00pm, the		
	The nurse's notes da	ated 4/14/17 at 1:59 PM			administrator directed the DON to place	Э	
		front door yelling trying to			Resident #3 on 1:1 constant observation	n	
	_	to lunch with good results.			while the resident is out of bed. The		
		udly yelling for his wife and			resident's RR agreed to move the resid		
	son."				to the designated secured dementia ca	re	
					unit on 06/14/2017 to prevent further		
The nurse's notes dated 4/14/17 at 3:02 PM					unsupervised exits from the front door.		
		PM, Resident #3 was still			The resident will remain on 1:1		
	wanting to leave the	racility.			supervision until adjusting to the room	•	
	The nurse's notes do	ated 5/15/17 at 4:26 PM			change and to provide for the resident's psychosocial wellbeing.	5	
		was notified that resident was			psychosocial wellbeilig.		
		building by a family member			On 6/15/17, the administrator and DON	J	
		lent. The nurse asked the			concluded a thorough investigation whi		
	_	esident out but they did it			determined Resident #3 had an	011	
		nt made it out the door but			unsupervised exit on 3/4/17, 4/9/17, an	d	
		supervised by the nurse the			5/14/17.		
	entire time."	,					
					On 6/15/17, the administrator complete	ed :	
		ated 5/16/17 at 4:40 PM			the 5 day investigations for the three		
	revealed "resident pr	opelling self-up and down			occurrences of an unsupervised exit ar	ıd	
	halls in wheelchair ye	elling and screaming for			the 5 day reports were sent to the Heal	th	
		and that he needs a ride			Care Personnel office via fax. The 5 da	ıy	
		eatedly asking visitors to let			investigation revealed the facility		
	him out so he can fin	id a ride home."			neglected to supervise a cognitively		
					impaired resident (Resident #3) who w		
		ated 5/23/17 at 3:37 PM			identified as a wanderer which resulted		
		ed that the resident has been			an unsupervised exit on 3/4/17, 4/9/20	17	
		all day. The wife stated that			and 5/14/17.		
	allowed to exit facility	ill not come back if he is			On 5/14/17, the administrator changed	the	
	anowed to exit iacility	y.			front door sign color from white to yello		
	The nurse's notes do	ated 5/24/17 at 1:53 PM			for higher visibility to visitors. The sign		
		ident "attempts to leave			requested visitors not to assist resident		
		premises. Is cognitively			out the front door unattended. On 6/9/1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER	1 0.0200		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	09/2017	
	101.02.1 01.00.1 2.2.1				GHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 224	F 224 Continued From page 39		F 2	224				
	impaired and cannot protect himself from	make good decision to danger."			the maintenance director changed the front door code, verified the wander gu alarm sounded upon a wander guard			
		ited 6/4/17 at 10:20 PM tting in wheelchair propelling			nearing the front door, and the front do closure arm tightened securely when the			
		nird shift reports that resident			door closed. The RVP, administrator,			
		t, he has been up all night			DON also verified the wander guard			
	wandering about faci	lity in his wheelchair."			system and closure arm on the front do was operating correctly.	oor		
	Resident #3 was obs	erved up in wheelchair in his						
	room on 6/5/17 at 4:2	20 PM. A wander guard was			On 6/11/17, 11x7 inch signs were orde			
	observed attached to	his wheelchair.			by the corporate consultant for the from door from the print shop. The 11x7 inc			
	Interview with NA #1	(assigned to Resident #3 on			signs state "please assist us with resid	ent		
	-	cted on 6/6/17 at 12:05 PM.			safety by NOT HOLDING the door ope	n		
		sident #3 was independent			for any resident not accompanied by a			
		g a wheelchair. She stated			staff member. Please notify the nurse i			
		always out of bed around 10			someone goes out or if an alarm is hea			
	_	e propelled his wheelchair			for better visibility to visitors". On 6/13/	17,		
		to other residents. NA #1			the RVP placed the signs inside and			
		ident was a wanderer and			outside of the front door and around the			
		d wandered outside during			facility for visibility to visitors. On 6/11/	17,		
		she didn't know the date of			the corporate consultant ordered post			
	NA on the hall.	stated that she was the only			cards that states "please assist us with			
	NA OII the Hall.				resident safety by NOT HOLDING the door open for any resident not			
	An interview with Nu	rse #1 was conducted on			accompanied by a staff member. Pleas			
		Jurse #1 stated that she			notify the nurse if someone goes out of			
		She indicated that she			an alarm is heard for better visibility to	"		
		d to a front door alarm twice			visitors." The front door monitor began			
		dates). She indicated that a			passing the post cards out on 6/13/17			
		et Resident #3 out the door.			all visitors who entered the facility. The			
	•	mber the exact time but it			SW sent 100% of all RRs and the family			
		ng. She found the resident			members notification via the United Sta	•		
		the highway (highway 177) in			(US) postal service on 06/09/2017			
		resident refused to come			regarding "Do not assist any resident of	ut		
		e her cell phone to call the			of the facility, if you are unsure if the			
		cause the resident would not			person is a resident please ask a staff			
		. The nurse claimed that			member."			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF AND PLAN OF CORRECTION IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			، ا	С
		345293	B. WING _				09/2017
NAME OF PI	ROVIDER OR SUPPLIER	1	1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	, ,,	00.2011
				н	GHWAY 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	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 224	Continued From page	e 40	F:	224			
		long the resident was	' '				
		the alarm was sounding			The Monthly newsletter for June/July w	126	
	_	it. She indicated that she			revised by the Activity Director on 6/11/		
		nt report and informed the			with an increase in font size (26 font) to		
	physician, responsibl				stress the importance of "before assisti		
		ncident. Nurse #1 further			a resident out of the building, check with	•	
		d responded also to another			staff member." Also, "please be sure th		
		found the resident on the			doors close completely behind you upo		
		at a family member had let			your exit so a resident is not able to fol		
	-	se #1 claimed that she didn't			you outside." The order of the newslett		
		esident was outside on the			was revised to address this important		
	porch. She also indic				message first. The newsletter was mail	ed	
	·	and times of the incidents.			to all the alert and oriented residents a		
	Nurse #1 also claime	d that she didn't remember if			100% of RRs by the Activities Director		
	she was assigned to	the resident on the days			6/13/17.	•	
	Resident #3 was four	nd outside.					
					On 6/11/17, the Minimum Data Set (MD	OS)	
		Resident #3 was found on			Nurse #1, MDS Nurse #2, Admission □	S	
	3/4/17 was measured				Coordinator, and treatment nurse		
		36 feet (78 yards) away from			completed 100% audit of all resident□		
	the facility's front doo	r.			progress notes and behavior sheets,		
					including Resident #3, for the past six		
		ound report revealed that			months to identify residents with		
	-	e area where Resident #3			exit-seeking behaviors (to include		
		e low 40's degree Fahrenheit			wandering in and out of resident rooms		
	(F) on 3/4/17 betwee	n 7:30 PM and 7:45 PM.			wandering around the facility, and mak comments about exiting the facility) to	ing	
	An intorvious with the	DON was conducted on			ensure appropriate interventions were	nut	
		he indicated that she had			into place for the prevention of actual	put	
		family member to move			unsupervised exit. Interventions were p	n it	
		ecured unit but the family			into place to include 1:1 constant	, ut	
		. She stated that she posted			supervision as necessary immediately		
		minding visitors not to let any			during the audit by the Maintenance		
		didn't work. She also stated			Director and/or the MDS Nurse #1, MD	S	
	that the resident had				Nurse #2, Admission ☐s Coordinator, a		
		gadia.			treatment nurse for any identified areas		
	Interview with NA #2	was conducted on 6/6/17 at			concern. By 6/16/17, the corporate	. . .	
		assigned to Resident #3 on			consultants completed 100% audit of a	II	
		n the second shift. NA #2			residents' nursing progress notes and		

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 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017	
					IGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345			
0/0.15	CHMMADY C	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 224	Continued From pag	e 41	F 2	224				
	stated that she had k	known Resident #3 as a			incident reports from 3/1/17 to present	for		
	wanderer. NA #2 rev	realed that she was the only			residents with actual supervised and			
	NA on the hall that d	ay.			unsupervised exits to ensure any resid	ent		
					that had exited the facility unsupervise	d		
		Iministrator was conducted			was not neglected (the exit could not h	ave		
		The Administrator stated			been prevented by staff, the exit was			
		e of the day that Resident			appropriately handled and appropriate			
		orst, trying to leave the			interventions were put into place) and t	inat		
		hat she had met with the permission to move the			an investigation was completed to determine the root cause of the			
		ed unit if it was necessary			supervised or unsupervised exit. The			
		esident was safe if only the			protocol and policy for neglect will be			
		him and responding to the			immediately initiated during the audit b	V		
		ely. The Administrator			the administrator and followed-up on fo	-		
		ere was a staff member			any resident identified with a supervise			
	(receptionist) in the I	obby until 9 PM every day			or unsupervised exit that could have be	een		
	who could monitor th				prevented by staff.			
		indicated that incident						
		ed during the morning			100% of all residents' Wandering			
	_	ntions were discussed and			Assessments were reviewed by the MI	JS		
		responsible to update the owledged that completion of			nurses by 6/9/17 for accuracy. All	_		
		an issue as evidenced by			inaccurate wandering risk assessments were revised on 6/9/17 by the MDS	5		
		ering incidents on 3/4/17 and			nurses. A second audit of the wanderir	na		
		ent report completed.			assessments was completed on 6/11/1	-		
					and compared to the resident progress			
	The administrator an	d the DON were notified of			notes and behavior sheet for accuracy			
	immediate jeopardy	on 6/7/17 at 1:23 PM.			and revised on second time 6/11/17 by			
					MDS nurses. There was one wandering	g		
					assessment that was updated by the M	1DS		
					nurse on 6/11/17. By 6/12/17, the MDS	3		
					nurses updated the residents'□ care			
					plans, and care guides as appropriate	tor		
					all residents identified as at risk for			
					wandering and to ensure appropriate interventions were addressed on the			
					resident care plan and resident care gu	uide		
					with oversight by the MDS Consultant.			
					total of twenty-six (26) residents were	/\		

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 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/03/2017	
DIG: 11401				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 CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	÷ 42	F2	identified as at risk for wandering 06/15/2017, the MDS Nurse and corporate consultant notified the care staff (nurses, nursing assist activity staff, social worker, dieta administrator and DON)of any of the list of residents included in the wandering program. Beginning on 6/12/17 at approximation, the administrator directed staff member was placed at the tomonitor the front door 24 hour days a week, to prevent resident unsupervised exits through the fill on 6/12/17, the corporate consuminitiated an in-service with 100% (to include license nurses, nursimassistants, housekeeping staff, the staff, dietary staff, activity staff, care aides, social worker, book in pay roll, maintenance staff, rece and supply clerk) regarding the fill have a person tomonitor it 2 day, 7 days a week. The monitor ensure no resident with a wander device is allowed to exit the facil unsupervised for ninety days. Afford days the monitor will be replaced relocated reception desk adjaced front door for continued monitorical All residents upon admission will assessed for wandering type of the wandering assessment trigg score of greater than five (5) for risk for elopement. The resident plans will be updated to include a serior of the staff.	the direct tants, any hanges in he mately 12 that a front door as a day, 7 tront door. Itants all staffing therapy geriatric keeping, ptionist, ront door 4 hours a r will er-guard lity fter ninety d by the nt to the ng. I be behavior. gers at a being at care		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345293	B. WING		0611) 09/2017
NAME OF P	ROVIDER OR SUPPLIER	1,1,2,0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/0	09/2017
			HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	e 43	F2	preventive interventions and measures implemented for the prevention of elopement. Any resident that is identi in the wandering risk assessment as a wanderer and at risk for an unsupervise exit will have their picture placed on the wandering board and in the wandering binder. For residents that have the diagnosis of Alzheimer's or residents we dementia that are cognitively declining that do not have a wander guard, the facility will implement the following: 1) upon increased agitation leading to verbalization or behavior to exit the fact the nurse will immediately remove from the egress location, 2) the nurse will assess the resident for wandering utilize the wandering risk assessment, 3) the resident's representative, the DON and administrator will be notified immediate 4) the attending physician will be notified from the wandering risk assessment resures 5) The resident will be placed within the secured dementia unit, if appropriate at that time. At no time can the front door monitor turn their back away from the front door. The front door must be in exist at all times. The monitor cannot leave the monitoring station until there relief. If the monitor is found in violation appropriately monitoring the front door any time, retraining and disciplinary act will be taken. There will be a notebook kept at the monitoring station to identification to the exist are not to exit the facility without supervision. Visitors and residenter and exit through the front door. Other exits are locked and require code to enter or exit. All exit door alarms are	fied ed e vith sility n zing dely, ed alts, e at r yes' is n of at tition ents All es	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017		
	ROVIDER OR SUPPLIER ID PINES HEALTHCARE	AND 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 BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 224	Continued From pag	e 44	F2	audited daily by the during the week and duty (MOD) on which absence of the Comment of the comme	d oriented residents we e social worker with ing 1. Do you know whe glected? If no, please of neglect to resident, the facility has been uring your safety to se? There are 31 alert as that were interviewe egative findings from the serious of the facility has been uring your safety to se? There are 31 alert as that were interviewe egative findings from the facility of the facility	e extor der ere nat 2. and d. he as nts, ry RN in in in inent		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	<u>'</u> E	00/00/2011	
				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 PREFI) TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	DATE	
F 224	Continued From page	÷ 45	F2	staff member's responsibility the nursing home residents do into situations which may put to or others at risk of bodily harm FOR ELOPMENT: Any member nursing home population may some point in time. There are traits that accompany elopements however esident' smental and physic may come into play when it consider the start of the	o not enter themselver. REASO over of a relope at no definirent among ever, a cal attributiones to andpoint, mentia, forms of ore likely to the office. The office of the office. The office of the of	r es DN es D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	00/00/2011	
				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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	÷ 46	F2	of the day and need to be watch closely at that particular time of When elopement does take platoften a result of too little superwhich are not intended to be or nursing home residents should locked securely or equipped with line addition to keeping a close of residents, it is important for nurstaff to make sure that the alarm work correctly. It is also the restof nursing home staff to responsing the event that a door alarm of NURSING ELOPMENT AND NEAR Failure to enforce the necessar measures to avoid patients from wandering could be a case of residenting the nursing home. A example of negligence is if the not act quickly when an alarm of signaling a possible wandering Wandering can also trigger a second injuries such as falls, bruises, a bones. Elopement could even the some cases, thus the important prevention. Facility staff needs that all cases of elopement or pelopement are reported immed the nurse. CODE ORANGE/PREVENTION OF ELOPMENT: Provide diversions for residents who attempt to exit the prevent actual unsupervised expresidents who attempt to exit the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility of the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility in the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility in the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility in the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility and the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility in the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility in the prevent actual unsupervised expresident is constantly exit seek commenting on leaving the facility in the prevent actual unsupervised expresident is constantly exit seek comments.	f the day. ace, it is vision. Exit perated by I be either ith alarms. eye on rsing home ms on exit sponsibility ad promptly goes off. IEGLECT: ry security m neglect on Another staff does goes off I patient. eries of and broker be fatal in ace of to ensure potential diately to all activitie include the facility to	ts / e ss / y	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		0.45000	D WING		С	
		345293	B. WING _		06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRION DEFICIENCY)	DATE	
F 224	Continued From page	e 47	F2	experience activities and/or socially appropriate interactions in a group set The exit seeking behavior must be reported to the nurse immediately. It is nurse' seeking behavior assess the resident to find out the cause of the exseeking behavior and ensure appropri interventions are provided and docum in the medical records. It is also the responsibility of ALL nursing home starespond promptly in the event that a dalarm goes off. If you observe a reside exiting the facility but cannot respond timely manner then a code orange mube called. A code orange is an emerge situation that indicates missing resident/resident elopement and summons medical aides as indicated using a room number or location. Agaicode orange is used to alert staff and/summons help. The unsupervised exit must be reported to the nurse immediately. An in-service was initiated with 100% license nurses on 6/12/17 and will be completed by 6/16/17 by the Facility Consultants, RN Nurse, and Director of Nursing regarding NURSES RESPONSIBILITIES FOR SUPERVIS OR UNSUPERVISED EXITS. It is the NURSE Seresponsibility to: "Assess the resident from head to for any injuries "Provide appropriate interventions include initiate wandering protocol if resident was not previously at risk for wandering (update wander guard on	the it ate ent if to cor ont n a st ency Of of ED toe	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		345293	B. WING		0,	C 6/ 09/2017
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00	5109/2017
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	Continued From pag	e 48	F 22	resident' s ankle or chair if not a place on ankle, picture on wands board, add resident' s name to transmittal log book), Q 15 minu 1:1 CONTSTANT SUPERVISION necessary to prevent reoccurren If an intervention is already related to wandering risk, an add intervention must be put into pla an actual elopement to prevent reoccurrence. The resident care guide and must be updated for any new/add interventions Notify the Medical Doctor (Notesident representative) Notify the DON/Administrated occurrence and intervention initially. Complete an incident report Document in the medical reduction of all staff to include will be completed by 6/16/17 100% of all staff to include will be completed with all staff to include nurses, nursing assistants, hous staff, therapy staff, dietary staff, staff, geriatric care aides, social book keeping, pay roll, maintenar receptionist, and supply clerk by Administrator in Training (AIT), For Consultants, RN Nurse, and Direct Nursing for validation of understare regarding elopement to include the Elopement? 2. If a resident feet over the threshold what is that care a resident is trying to exit the fact constantly commenting on leaving facility, what are some things the	ering the te checks, N as nce. In place ditional ce after d care plan Iditional MD) and or of ated t cords 16/12/17 7 with e e license sekeeping activity worker, ance staff, the facility ector of ating 1. What is crosses alled? 3. If cility or ng the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 6/09/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0/00/2011	
			HIGHWAY 177 S BOX 1489				
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	e 49	F 2	do? 4. What code is utilize to aler and summons help for a missing resident/elopement. 5. How often there be a monitor at the front down When should you report to the nual resident has exit seeking behave commenting on leaving the facility actually exited the facility? A 100% of the licensed nurses, nuassistants and non-licensed staff their questionnaires reviewed by RN-nurse consultant. The subject that is reviewed on the questionnabe reviewed by the RN-nurse consultant is unable to pass the test will retrained and retested. If upon the attempt the licensed nurses, nurses assistants and non-licensed staff is unable to successfully pass the significant change test will be rem from the schedule until remediation provided. A 100% of the Nursing Assistants non-nursing staff will be in serviced RN Facility Consultant by 06/16/2 Observing and Reporting Change Resident's Condition. The nursing assistants and non-nursing staff will be in serviced in their knowledge of the smatter of observing and reporting changes in resident on the second is unable to pass the test will be rand retested. If upon the second is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second the nursing assistant or non-licensed is unable to pass the test will be rand retested. If upon the second	should or? 6. rse that rior, y, or ursing will have the a matter aire will esultant. Irsing member be esecond ing member es second in s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0250		STREET ADDRESS, CITY, STATE, ZIP CODE		06/09/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	e 50	F2	is unable to successfully pass the significant change test will be refrom the schedule until remediate provide. On 6/7/17, the RVP completed a re-training for all department man (administrator, DON, QI nurse, Murses, treatment nurse, SW, maintenance director, medical reaccounts payable, accounts receadmissions director, activity directive dietary manager, environmental director, and therapy manager) of the Action Check list for Unsuper Exits. Beginning on 6/7/17, for all unsuexits, the facility will complete the Checklist for Unsupervised Exit for Unsupervision of the resident at risk exiting the building and also what when the alarm sounds to make thorough search is done, to make thorough search is done, to make the staff find the resident if they door. The checklist will include be limited to: 1. Missing Resident Search conca. In-House Search b. Out of Facility Search 2. Notification of CEO or other constaff as appropriate 3. Notification of attending MD 4. Notification of appropriate autiliarizeted by RVP such as law enforms. Assessment of resident with	moved ion is a 100% nagers MDS ecords, eivable, ctor, services regarding rvised apervised e Action for atte k of at to do sure a exited the out is not ducted brities as		

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZI	P CODE	00/03/2017	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		OF CORRECTION ACTION SHOULD BE O THE APPROPRIATI ENCY)	(X5) COMPLETION DATE	
F 224	Continued From pag	e 51	F	documentation of conditive record 7. Implementation of conton to protect resident (i.e., and 1:1 monitoring, etc.) 8. Review resident' so we assessment and complemecessary; verify resider on wandering residents so. Review resident' so carevise as indicated 10. If present, check residented to the proper function of th	rective measure alarm bracelet, andering risk te new form as nt 's placement board are plan and ident' s alarm ioning ent QI Reporting incident record, at that have been dering to include a ictures, as a corrective other residents to be affected by the as necessary ents alarm oper functioning larms checked for alarms are not considering of nurse ms as indicated in programs for intation on	s or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u> <u>-</u> <u>-</u>	00/03/2017	
DICUMON	ID DINES HEAT THOAD	E AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489			
KICHIVION	ID PINES REALI RCAR	E AND REHABILITATION CENTE		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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDESICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	ge 52	F 2	19. Initiation of QI monitoring a consistent audits related to iss indicated (i.e., preventative int appropriate/ in place, alarm br place, functioning door alarms care guides; at risk wandering evaluations, etc.) 20. Checklist completed and for appropriate leadership (Regio president, Vice president of CI Operations, President of Operations of CI Operations, President of Operations of CI Opera	sues as terventions racelets in specifications. The converted to the conve	ck its	

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 _			· ·	09/ 2017	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COL	DE	1 00/	00/2011	
DICHMON	D DINES HEATTHCADE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489				
RICHWON	D FINES HEALTHOAKE	AND REHABILITATION CENTE		HAMLET, NC 28345				
(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 CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 224	Continued From pag	e 53	F 2	24				
				On 6/23/17, the supply clerk, assistant, accounts payable, administrator, DON, QI nurse nurses, and/or corporate conbegan monitoring the front do front door monitor, wandering books, wander guard locking all doors, resident care plans guides, staff response times alarms, and staff knowledge orange to ensure cognitively wandering residents are supeneglected, and prevented frounsupervised exits from the funsupervised exits from the funsupervised exit audit tool required replacement. Further was provided by the corporated by 7/25/17 and the door alarming repaired by maintenance ass 7/6/17. The monitoring will be documented on the Unsupervaudit Tool. Beginning 6/26/17 will be completed 5 times a way weeks, then weekly for 8 weeks and the monthly Quality In (QI) Committee meeting. The Committee will review the resaudits monthly x 6 months, ic use 5 Whys root cause analy make recommendation for for needed.	e, MDS nsultants oor, signag g board an g system or s and care to door of code impaired, ervised, no facility. The revealed th cing on coo the front d er in-servic te consulta m was sistant on be vised Exit 7, the audit week for 4 eks, then esent the Exit Audit mprovemen ee QI sults of the dentify tren ysis, and	ge, and n ot e ne de loor sing ant t		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ODE	00/03/2017	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE	
F 224 F 241 SS=D	resident in a manner promotes maintenance her quality of life recoindividuality. The faci promote the rights of This REQUIREMENT by: Based on record revistaff interview, the faci showers as schedule feeling unimportant for	Y AND RESPECT OF reat and care for each and in an environment that ce or enhancement of his or gnizing each resident's lity must protect and the resident. is not met as evidenced rew, resident interview, and		The DON or QI nurse will p findings of the Unsupervise Tool at the quarterly Quality and Assurance (QAA) Commeeting. The QAA Commit the QI Committee recommendations. The QA will perform additional root as needed, make additional recommendations, and proof the administrator will be reensuring QAA Committee or recommendations are addressed further training or other intees that newly implemented procustained to maintain regulations in the area of restore to be free from abuse, negligible misappropriation of resident exploitation. F 241 Dignity and Respective for the procuse of the second procused in the area of resident exploitation.	d Exit Audit Assessment inittee Itee will review andations and A Committee cause analys I vide oversigh sponsible for concerns and essed through rventions so cess are atory esidents righ ect, t property, an It It It It It It It It It I	w d d d d d d d d d d d d d d d d d d d	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 09/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017	
				н	IGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Resident #76 was ac 8/9/16 with multiple of muscle weakness, di of cerebral infarction. The quarterly Minimulassessment dated 5/1's cognition was inta rejection of care and required extensive as with bed mobility, tra assessed as depend bathing, personal hydresident #76 had im upper and lower extra not steady on his. The plan of care for Resident #76 had a proper and lower extra as not steady on his. The plan of care for Resident #76 had a proper and lower extra as not steady on his. The plan of care for Resident #76 had a proper and lower extra as not steady on his. The plan of care for Resident #76 had a proper and lower extra as not steady on his. The plan of care for Resident #76 had a proper and lower extra as lower extra indicated the focus assistance/potential maximum function of related to: impaired rel	lmitted to the facility on diagnoses that included fficulty in walking and history and Data Set (MDS) 4/17 indicated Resident #76 ct. He was assessed with no no behaviors. Resident #76 esistance of 1 staff member insfers, and toileting. He was ent on 1 staff member for giene, and dressing. pairment on 1 side of his emities and was assessed feet. Resident #76 was reviewed. Dan of care (initiated on cently reviewed on 5/5/17)		241		, (N) s all eir vo a	DATE	
	Fridays. A review of from 3/3/17 through 9 #76 received 15 show #76 received 4 show 3/31/17 (3/6, 3/13, 3/ from 4/1/17 through 4 and 4/28), and 6 sho	the shower documentation 5/31/17 revealed Resident wers in 90 days. Resident ers from 3/3/17 through 20, and 3/30), 5 showers 4/30/17 (4/4, 4/7, 4/12, 4/25, wers from 5/1/17 through 2, 5/16, 5/23, and 5/30).			residents assistance with showers according to the shower schedule. On 6/29/17, the DON, QI nurse and corpor consultant initiated a Grievance Proces and Resident Rights in-service which covers My Rights including the right to respected, make choices, and to receive good care. The two in-services will be	rate ss be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(
		345293	B. WING _			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICHMON	D DINES HEALTHOADE	AND DELIABILITATION CENTE		Н	IGHWAY 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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 241	Continued From page		F	241	completed by 7/7/17. After 7/7/17, no		
	An interview was conducted with Resident #76 on 6/5/17 at 12:25 PM. Resident #76 indicated he required the assistance of staff with showers. He				nursing staff will be allowed to complete shift until they have completed and sign the Showers per Schedule in-service.	ned	
	reported his schedule	ed shower days were			newly hired licensed nurses and certific		
		s. Resident #76 revealed he			nursing assistants will receive the		
		showers as scheduled. He			in-service during new employee		
	stated he had been in				orientation.		
	occasions by staff (unable to recall staff names) that they were unable to complete his shower				On 6/30/17, the DON, QI nurse, staff		
	•	ot enough staff on duty. He			facilitator, minimum data set (MDS)		
		e me feel like I wasn ' t			nurses, charge nurses, activities staff,		
	important enough to be showered because the				payroll bookkeeper, ward clerk, and/or		
	staff didn 't have the				social worker began resident care		
		ken with the Director of			observations and interviewing alert and		
	Nursing (DON) about	t his showers not being			oriented residents and Resident		
	provided as schedule	ed in the past, but it had still			representatives (RR) for cognitively		
	been a problem.				impaired residents to ensure they have		
	An intension was sen	dusted with the Director of			been bathed/showered, provided privac	Σу,	
		iducted with the Director of			and treated with dignity and respect	_	
		6/17 at 12:34 PM. She expectation for showers to be			according to the resident □'s preference and/or needs through resident or RR	;	
		ed and as requested by the			interviews, observation for cleanliness	and	
		she expected showers to be			record review of refusals utilizing a	and	
		n of twice per week. The			Dignity/Staffing Audit tool. These audit	s	
		cility had an ongoing problem			will be completed with 20% of the		
		showers as scheduled. She			residents weekly for 4 weeks, then onc	e	
		ere had been difficulty filling			weekly for 8 weeks, then once monthly		
		ed off of work. She reported			months.		
		reviously implemented a				ſ	
	shower team, four N	A's assigned specifically to			On 7/1/17, the administrator began		
		the problem of showers not			reviewing the Dignity/Staffing Audit too	3	
	.	heduled. The DON revealed			times weekly for 4 weeks, then once	ſ	
	the implementation of the shower team had not				weekly for 4 weeks, then monthly for 1	ſ	
	•	She explained that if an NA			month and initialing to acknowledge	ſ	
		I they were unable to fill in			completion and follow-up.	ſ	
		no was assigned to the			0 7047 4 450	ſ	
		assigned to the floor. She s constantly hiring new NAs,			On 7/3/17, the MDS nurses completed care plan/care guide updates which		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			١,	C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0200	1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	06/09/2017	
					GHWAY 177 S BOX 1489			
RICHMON	ID 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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 241	Continued From page	e 57	F 2	241				
	but they were unable NAs.	to sustain a full roster of			included all bath/shower preferences.			
	at 12:44 PM. She inconsection Resident #76. She reproblem with Resider as scheduled as he has verbally (she was una An interview was con 6/7/17 at 10:39 AM. at the facility for about there had been times complete the showers due to time limitations sometimes her residently high needs residents complete showers as revealed this was an	ducted with NA #12 on She stated she had worked It 2 years. She revealed When she was not able to Is that were assigned to her Is. She reported that Internal that a lot of Which made it difficult to			On 7/12/17, the corporate consultant completed the review and shower schedule updates according to the resident/RR preferences for resident showers. The MDS nurses or DON will review we the monthly QI Committee the results of the Dignity/Staffing Audit Tool for 6 months for identification of trends, active taken, and to determine the need for and/or frequency of continued monitorial and make recommendations for monitoring for continued compliance. MDS nurse or DON will present the Dignity/Staffing Audit Tool findings and Committee recommendation to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.	of ons ng, The QI		
	10:43 AM. She indical Resident #76 and she multiple occasions when showers. She report when she was unable shower as scheduled stated when she was Resident #76 's show with him and explained get to his shower due offered him a bed bat A follow up interview DON on 6/7/17 at 11:	ver as scheduled, she spoke ed that she was not able to to time limitations and she						

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 06/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE COMPLETION		
F 241 F 242 SS=D	which he indicated h were unable to provi was reviewed with the was unaware that Resource that the sum of the right to receive 483.10(f)(1)-(3) SEL RIGHT TO MAKE CITY (f)(1) The resident has chedules (including health care and provict consistent with his of and plan of care and of this part. (f)(2) The resident has about aspects of his are significant to the (f)(3) The resident has members of the community activities facility. This REQUIREMENT by: Based on resident, observations and received to honor a family required as stated by the diet with the first part of the community activities. The resident family required as stated by the diet with the first part of the community activities. The resident family required as stated by the diet with the first part of the community activities. The resident family required as stated by the diet with the first part of the community activities. The resident family required as stated by the diet with the first part of the community activities. The resident family required to provide the first part of the community activities facility. The resident family required to provide the first part of the community activities facility. The resident family required to provide the first part of the community activities facility. The resident family activities facility.	erview with Resident #76 in e felt unimportant when staff de his shower as scheduled to DON. She revealed she esident #76 had felt that way, brised by his feelings as he ve his shower as scheduled. F-DETERMINATION - HOICES as a right to choose activities, sleeping and waking times), iders of health care services or her interests, assessments, other applicable provisions as a right to make choices or her life in the facility that resident. as a right to interact with munity and participate in both inside and outside the T is not met as evidenced family and staff interviews, cord review, the facility failed uest for a cooler in the room ary department (Resident ovide showers as scheduled of 3 residents reviewed for	F 24		om,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	J6/U9/201 <i>1</i>	
TO UNIC OF T	TO VIDER OIL OUT I EIER			HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARI	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	Continued From pag	ge 59	F 24	2			
	(MDS) dated 5/22/1 impairment, physical extensive assistance of daily living (ADLs of one staff for eatin Resident #37 was later all of her ADL call staff. Staff were to exit meals and encount history of urinary transport of urinary transport of the top	ast care planned on 5/23/17 re to be provided by facility incourage her to drink fluids burage extra fluids related to a ct infections. It #37 diet orders from March cated she was on double ds with thin liquids. 3/24/17 at 11:09 AM read the P) called and requested a in the room with some juices I's dry mouth and for read Resident #37 was on oreference would be 4/17 at 5:00 PM, a family it #37 stated the RP party manager in March about the hall cooler in the room with the staff and family to provide led to keep her hydrated. Stated for a while the cooler in a cold pack inside but after oler disappeared. She stated the care plan meeting in		On 6/28/17, the social worker of interviews with all alert and ories residents, to include Resident # regarding preferences for bathin Resident #76 prefers to receive two times per week. The direct nursing (DON) and corporate or revised the shower schedule on through 7/11/17 to include their preferences. On 7/10/17 through 7/11/17, the results of the intervious and corporate consultant based residents preferences. On 6/28/17, the DON initiated a in-service of licensed nurses are assistants regarding the residence choose activities, schedules, and care consistent with his or her if and to make choices about asport her life in the facility that are to the resident. The in-service the resident' s/resident representations and to have a minimum showers per week. The in-service the resident' shower and to document baths/showers provided, the reright to decline a shower, report nurse when a resident declines bath/shower, and documenting resident' schoice in the elector record. The Resident	ented #76, ng. e a shower or of onsultant n 7/10/17 residents ugh views were dule was ing (DON) d on the ugh views were dule was ing (Ugh views were		
	cooler. There was n	unsure what happened to the o observed cooler in the room water pitcher was empty.		Self-Determination-Right to Ma in-service will be added to new orientation.			

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		0.	C 6/ 09/2017	
NAME OF P	ROVIDER OR SUPPLIER	1.0200		STREET ADDRESS, CITY, STATE, ZIP CODE		0/09/2017	
	(0.1.01.1.01.1.2.1.1.1.1.1.1.1.1.1.1.1.1.			HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	Continued From pag	e 60	F 24	2			
	Assistant (NA) #5 stathe juices and drinks stated she began wo 3/30/17 and she rem Resident #37 's root it. She recalled the fa	m with extra juices inside of amily wanted the staff to ds. NA #5 stated she offered		On 6/29/17, the social worker of interviews with all resident represent (RR) for non-alert/non-oriented to determine the bathing prefer 7/10/17 through 7/11/17, the resinterviews were compiled and to schedule was updated by the conursing (DON) and corporate of based on the residents prefer (according to the RRs).	resentatives I residents rence. On esults of the the shower director of consultant		
	room on 6/5/17, 6/6/ In an interview on 6/ assistant dietary man to the RP on 3/24/17 cooler in Resident #3 simply forgot about in coolers were reserved liquids which Reside and that was likely wa in the first place. She cooler in her room on were putting it in her assistant DM stated at present and she was	nere was no observed cooler in Resident #37 's om on 6/5/17, 6/6/17 or 6/7/17. an interview on 6/7/17 at 3:30 PM, the esistant dietary manager (DM) recalled speaking the RP on 3/24/17 and she agreed to put a poler in Resident #37 's in room. She stated she mply forgot about it. She stated normally the polers were reserved for residents on thickened quids which Resident #37 was on at one time and that was likely why the cooler was removed the first place. She stated she was putting the poler in her room on weekdays and the cooks here putting it in her room on the weekends. The esistant DM stated the cooler was in the kitchen present and she would go put it back into here in the sident #37 's room.		By 7/3/17, social worker, the quimprovement (QI) nurse, treath MDS nurse, director of nursing and/or corporate consultant wil 100% audit for all residents, to resident #76, to ensure each receiving the bathing type of that the frequency of their choice 100% audit will be documented Bathing/Shower/Choices QI to identified issues are addressed immediately by the auditor to e resident is given the type of bathrequency of bathing according preference and the shower schupdated as required by the DO	nent nurse, (DON) Il complete include esident is ieir choice e. The d on a iol. All d ensure each thing and it to their inedule in.		
	stated it was her exp DM would have disc her before promising since the coolers we thickened liquids.	7/17 at 5:46 PM, the DM sectation that the assistant sussed the RP 's request with to put the cooler in the room re reserved for residents on 8/17 at 2:22 PM, the it was her expectation that		Beginning 7/3/17, social worke quality improvement (QI) nurse nurse, MDS nurse, administrate corporate consultant will comple Bath/Shower/Choices audit too Resident #34 s choice to have the room and Resident #76 s be assisted with 2 showers per The audit tool will be completed of resident care observations a	e, treatment or, and or lete a ol, to include e a cooler in choice to r week. d with 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			C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARI	E 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		CORRECTION DN SHOULD BE HE APPROPRIATE (')	(X5) COMPLETION DATE	
F 242	honored and the assincluded the DM in tooler in her rooms thickened liquids. 2. Resident #76 was 8/9/16 with multiple muscle weakness, cofficerebral infarction. The quarterly Minimassessment dated 5 's cognition was interjection of care and required extensive awith bed mobility, transpection of care and required extensive awith bed mobility, transpection of care and required extensive awith bed mobility, transpection of care and required extensive awith bed mobility, transpection of care and required extensive awith bed mobility, transpection of care and lower extensive awith as not steady on his the plan of care for Resident #76 had a 8/12/16 and most rethat indicated the for assistance/potential maximum function or related to: impaired [and] weakness." R	sistant DM would have the decision of placing a since they were for resident on diagnoses that included difficulty in walking and history that it was assessed with no ano behaviors. Resident #76 act. He was assessed with no ano behaviors. Resident #76 assistance of 1 staff member ansfers, and toileting. He was dent on 1 staff member for giene, and dressing. Inpairment on 1 side of his remities and was assessed feet. Resident #76 was reviewed. plan of care (initiated on cently reviewed on 5/5/17) cus area: "Requires to restore or maintain f self-sufficiency for bathing mobility, physical limitations, esident #76 was assessed as	F 24	interviews or RR on non-ale residents to include Resider Resident #76, 3 times per w weeks, then weekly for 4 we monthly for 1 month. Any condition addressed immediately by the aresident concern form initial auditor. As of 7/11/17, the minimum (MDS) nurses had updated care plans, to include reside reflect the residents bathin preferences. Beginning 7/25/17, the DON administrator will review and Bathing/Shower/ Choices Auweekly for 8 weeks then mo month to signify the audit has reviewed, completed, and all areas of concern were addressed beginning 7/25/17, the QI nuwill present the findings of the Bathing/Shower/Choices Aumonthly QI committee for 3 review of results, trends, rocanalysis of deficiencies, and recommendations. The DO the findings, trends, and QI recommendations and follow	rt and oriented of #37 and reek for 4 reeks, then concerns will be the auditor and ated by the data set the resident rent #76, to reg land or do initial the resident rent resident residen		
	dependent on one staff for assistance with bathing. The shower schedule for Resident #76 indicated he was scheduled for showers on Tuesdays and Fridays. A review of the shower documentation from 3/3/17 through 5/31/17 revealed Resident #76 received 15 showers in 90 days. Resident			committee recommendation quarterly executive quality a and assurance (QAA) commadditional review and recom	s to the essessment nittee for		

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 06/09/2017	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COL HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•	010312011	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 242	3/31/17 (3/6, 3/13, 3 from 4/1/17 through and 4/28), and 6 sh 5/31/17 (5/2, 5/9, 5/5). An interview was co 6/5/17 at 12:25 PM. preferred showers the assistance of sthis preference was showers per week. shower days were Resident #76 revea showers as schedulinformed on several recall staff names) to complete his shower enough staff on duthad spoken with the about his showers rescheduled in the paproblem. An interview was conversely and the paproblem. An interview was conversely and the paproblem. An interview was conversely and the paprovided as scheduled a minimum DON revealed the found that the provision of indicated at times the shifts if an NA called	wers from 3/3/17 through 3/20, and 3/30), 5 showers 4/30/17 (4/4, 4/7, 4/12, 4/25, owers from 5/1/17 through 12, 5/16, 5/23, and 5/30). Inducted with Resident #76 on Resident #76 indicated he to be baths and he required aff with showers. He stated to have a minimum of 2. He reported his scheduled fuesdays and Fridays. Iled he had not received his led. He stated he had been a loccasions by staff (unable to that they were unable to the because there was not by Resident #76 indicated he is Director of Nursing (DON) and being provided as st, but it had still been a separation for showers to be led and as requested by the dishe expectation for showers to be led and as requested by the dishe expected showers to be une of twice per week. The acility had an ongoing problem of showers as scheduled. She here had difficulty filling in did off of work. She reported	F 2-	42			
	shower team, four N showers, to address being provided as s	previously implemented a NA's assigned specifically to s the problem of showers not cheduled. The DON revealed of the shower team had not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•	00/03/2017	
(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)	N SHOULD BE	(X5) COMPLETION DATE	
F 242	solved the problem. called off of work and the call off, an NA wh shower team was rea stated the facility was but they were unable 's. The interview with the at 12:44 PM. She ince	She explained that if an NA I they were unable to fill in o was assigned to the assigned to the floor. She is constantly hiring new NAs, to sustain a full roster of NA e DON continued on 6/6/17 dicated she was familiar with	F2	242			
	problem with Resider as scheduled as he had verbally (she was unated as he had been times complete the shower due to time limitations sometimes her residently high needs residents complete showers as revealed this was an had done the best shassigned tasks.	ducted with NA #12 on She stated she had worked at 2 years. She revealed when she was not able to s that were assigned to her s. She reported that ent assignment had a lot of which made it difficult to scheduled. NA #12 ongoing problem, but she e could to complete her					
	Resident #76 and she multiple occasions when she was unable shower as scheduled stated when she was Resident #76 's show with him and explaints	ated she was familiar with e had worked with him on then he was scheduled for ed there had been times a to complete Resident 76 's due to time limitations. She unable to complete wer as scheduled, she spoke ed that she was not able to a to time limitations and she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARI	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 33/00/2311	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 244 SS=E	at 12:00 PM. She s facility for about 3 w had been times whe complete the showe the facility was runn indicated if she was as scheduled she of instead. 483.10(f)(5)(iv)(A)(B GRIEVANCE/RECO (f)(5) The resident h participate in resident (iv) The facility must resident or family gr the grievances and groups concerning is in the facility. (A) The facility must response and ration (B) This should not be facility must implement request of the resident by: Based on review of and interview with the resident council failed to respond to	ath instead. Inducted with NA #6 on 6/7/17 tated she had worked at the eeks. She revealed there in she was not able to rs that were assigned to her if ing short on staff. She unable to complete a shower if fered the resident a bed bath about the inguitable of the	F 24		icern	
	that were voiced in t	<u>-</u>		related to not receiving assistance w showers as scheduled. Resident #76 currently states satisfaction with rece	6	

				(3) DATE SURVEY COMPLETED			
		345293	B. WING			С	
NAME OF D	DOVIDED OD CUIDDUED	343233	B. WING_		TREET ADDRESS CITY STATE ZID CODE	06/	09/2017
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 244	Continued From page	e 65	F	244			
	Findings included:				two showers per week. Resident #76 received a shower on 6/20/17, 6/23/17, 6/27/17. On 6/30/17, the social worker		
	over four consecutive March, and April 2017	sident council meetings months (January, February, 7) were reviewed. The			again interviewed Resident #76 and Resident #76 agreed assistance with tw showers weekly is now being provided.		
	had voiced concerns and no variety. The r	7 revealed that the residents regarding food being cold minutes dated 2/23/17 dents had voiced concerns			On 6/9/17, the social worker interviewe Resident #37s resident representative (RR) and discussed the concern related		
	with ice machine not working. The minutes dated 3/23/17 revealed that residents had voiced concerns regarding room temperatures, short				to: 1) staff not feeding, changing the bi or bathing; 2) Resident #37. Resident #37 s RR currently states satisfaction		
	staff, cold food, call light timely and missing ite	ghts not being answered ems. The resident council 7 revealed that the residents			with receiving meal assistance, incontinence care, and bathing.		
	had voiced concerns baths/showers, cold f	regarding not getting their ood and call lights not being			On 6/29/17, the social worker (SW) reviewed all resident council meeting	4.0	
	meeting in May 2017.	ere was no resident council			minutes for the past 6 months, to include January 2017 through April 2017. The admissions coordinator reviewed the	ie	
	resident council) was AM. Resident #12 sta	nt #12 (president of the conducted on 6/7/17 at 9:10 ated that the facility was still			resident council meeting minutes for March, April, and June of 2017 (no May 2017 meeting was held). The review		
	only one nursing aide stated residents had	ly on the second shift with (NA) on the hall. She also to wait a long time for the			identified the resident council to include short staff, food, ice machine not working room temps, call lights, and missing	ng,	
	that the issue with she response had been b	ered. Resident #12 stated ort staff, food and call bell rought up in the resident			items. The purpose of the review was a ensure concerns from a resident or fam group meetings were responded to and	nily I	
	council meetings and	were still an issue. ector of Nursing (DON) was			the residents/RRs are satisfied with the resolution and follow-up to the grievand The review of the resident council		
	conducted on 6/7/17 stated that she didn't	at 9:15 AM. The DON know that the resident			grievances revealed the concerns were on-going related to assistance with incontinent care, assistance with	;	
	indicated that she had	every month. She also d never seen the minutes of noluding their concerns.			bathing/showers, and comfortable roon temperatures.	n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
	345293	B. WING_		C 06/09/2017
NAME OF PROVIDER OR SUPPLIER	0.0200	1 -	STREET ADDRESS, CITY, STATE, ZIP CODE	00/09/2017
RICHMOND PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			_D BE COMPLETION
conducted on 6/7/17 that she was responsiviting notes during a She stated that after write the concerns andepartment heads, for the DON any nursing head would address corrective action and The SW was unable the concerns voiced meetings had been a heads. Interview with the Add on 6/8/17 at 3:05 PM that the SW was responsive that after the responsible for addressed by the stated that after the responsible for addressed in the Administrator. The responsible for addressed council meeting and	de 66 decial Worker (SW) was at 3:12 PM. The SW stated sible in setting up and in the resident council meeting. The meeting, she had to and had to give it to the for example, she would give go concerns. The department the concerns, document the fitten return the form to her. To provide information that during the resident council addressed by the department department was conducted for the minutes and had department heads. She resident council meetings had the department heads including the department head was desing the concerns in and document the corrective trator indicated that she had for the minutes of the resident so she was not aware of the last had voiced during the	F 2	On 6/29/17, the administrator initiat in-service for the DON, SW, quality improvement nurse, activity assista admission coordinator, and busine office staff on Listen/Act on Group Grievances which included: 1) The must consider the views of a reside family group and act promptly upon grievances and recommendations of groups concerning issues of reside and life in the facility, 2) When there resident council minutes or interview residents indicate there are concern grievances, the facility must respon and resolve grievances in a timely manner, 3) While the grievances a being addressed, the social worker director of nursing, and/or administs shall keep the resident or family groupdated on the progress with resolve the grievance/recommendation. An needed audits or observations to sumonitoring should be documented. in-service was completed 6/30/17 by Quality improvement (QI) nurse. All hires will receive the grievance the grievance in-service during their orientation by the QI nurse. On 7/7/17 and 7/13/17, the admissi coordinator/social worker facilitated additional resident council meetings the resident council to get updates previous group grievances and exp new concerns. The activity director/assistant, social	facility nt or the of such nt care e ws with ns or d to re fator oup ving ny upport This y the new ons as for llow for on ress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 6/09/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0/03/2017
				HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
F 244	Continued From page	e 67	F 2	document grievances from the rescouncil meeting. The admission coordinator/social worker will ensignievances are logged and routed respective department heads for investigation and resolution. The grievance will be investigated und direction of the social worker/adm within 3 days of the date of the grievances, including group grieva are addressed and resolved. The administrator will ensure all grievances, including group grieva are addressed and resolved. The administrator and/or DON will resident concerns and resident concerns weekly for six months to concerns have been addressed a resolution reviewed with the residents/RRs/resident council in manner. The response will be in dated, and include details of the fethat occurred. The social worker or admissions coordinator will present all finding monthly QI committee meeting for months. The QI committee will reminutes and grievances of the rescouncil meeting monthly for 6 monidentification of trends, actions take to determine the need for and/or frequency of continued monitoring make recommendations for monit continued compliance. The social worker or admissions coordinator will present the finding recommendations of the monthly committee to the quarterly execut	der the inistrator devance. I review buncil or ensure and the a timely writing, follow up s at the r six view the sident or the for the and oring for the grand oring for the six oring for the grand oring for the six or th	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		3.00.2011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 244	Continued From pag		F 24	committee for six months for recommendations and overs				
F 249 SS=C	483.24(c)(2)(i)(ii) QU ACTIVITY PROFESS		F 24	49		7/25/17		
	a qualified profession	orogram must be directed by nal who is a qualified n specialist or an activities						
	(i) Is licensed or registered, if applicable, by the State in which practicing; and							
	recreation specialist	ognized accrediting body on						
	(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or							
	(C) Is a qualified occ occupational therapy	upational therapist or assistant; or						
	the State. This REQUIREMENT	training course approved by Γ is not met as evidenced						
	a qualified activities provision of activities findings included: An interview was cor	view, the facility failed to have professional to direct the to the residents. The aducted with the Director of 12:34 PM. She revealed the		F 249 Qualified Activity Prof On 6/10/17, the administrato the uncertified activity direct assistant. The activity assist scheduled to take the activity certification class on 9/11/17	r demoted or to activity ant is v director			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2011	
				ніс	GHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HA	AMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE				
F 249	Continued From page	e 69	F 2	249				
	facility's Activities Diractivities professional An interview was condification on 6/6/17 at had been the facility's years. She stated she certifications that quaprofessional. She industriough the facility's she had no other quaprofessional. She rescheduled to attend a 2017, but it had been reported she had been program in 2015, but Activities Director induscheduled for August attending as long as explained that the tra	ducted with the Activities 3:12 PM. She indicated she s Activities Director for 3 or 4 e had no training or lified her as an activities dicated she had gone orientation for activities, but diffications as an activities corted she had been a training program in January cancelled. She additionally en scheduled for a training it had been cancelled. The icated the next training was 2017 and she planned on it was not cancelled. She			community college. The activity assistate will remain under the direction of a certified activity director until the completion of their training. The certified activity director, employed by a sister facility, will review the monthly activity calendars, weekly 1:1 documentation a activity programming weekly for further recommendations and follow up as indicated. On 6/30/17, the administrator placed a help wanted advertisement with an online recruitment agency and posted the activitient of the community. On, 6/29/17, the regional vice president (RVP) in-serviced the administrator and director of nursing on employing a qualified activities professional to direct the provision of activities to the resident	ed and ine ivity t d t t tsts.		
	qualified activities pro that she had tried to genrolled in a training recent training progra 2017 was cancelled of student enrollment. An interview was condificated she had wo Assistant Activities D 2017. She stated this				Beginning 7/10/17, the certified activity director will assist in the development of the monthly activity calendar and specialized dementia calendar until a qualified activity professional is employ by the facility. The activity assistant will remain under the direction of a certified activity director until the completion of their training or until a certified activity director is hired. The certified activity director will review the monthly activity calendars, weekly 1:1 documentation a activity programming weekly for further recommendations and follow up as indicated. Beginning 7/10/17, the certified activities	of ved I d		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONST IG	RUCTION	(X3) DATE COMP	SURVEY PLETED
		345293	B. WING _				C 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		1 00	00/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 249 F 257 SS=D	483.10(i)(6) COMFORTEMPERATURE LEV (i)(6) Comfortable and Facilities initially certismust maintain a temporal degrees F. This REQUIREMENT by: Based on observation interviews and record maintain comfortable with acceptable range (Room # 118, Room room reviewed for contemperatures. Findings included: In an interview on 6/4 member for Resident her room was drafty as	RTABLE & SAFE /ELS d safe temperature levels. fied after October 1, 1990 perature range of 71 to 81 is not met as evidenced ns, resident, family and staff I review, the facility failed to resident rooms temperature es of 72 to 81 degrees for 3 #104 and Room #112) of 5	F2	direct and/mon cour cour fede resid The and mee The qual with mee char 157	ctor, social worker, administrator, for corporate consultant will review thly calendars with the resident noil president during the resident noil monthly meeting to ensure the trail requirements are met and the dent choices for activities are met. review will be completed for 3 mondocumented in the resident counciting minutes. administrator will review the iffications of the new activity directed the monthly quality improvement of the monthly quality improvement of the formal for further recommendation or the mages as indicated. 57 Comfortable Temperatures ms 118, 104 and 112 were inspecting the Maintenance Director on 6/30/1 the thermostats were adjusted to a coperating the identified rooms. The resident # 37 second reviews with Resident #	nths il or (QI) red 7 the ent d ons be	7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C	
NAME OF D	OVIDED OD CURRUED	343233	1 2: *******		TREET ADDRESS CITY STATE ZID CODE	1 06/	/09/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489		
				Н.	AMLET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 257	Continued From page	ge 71	F 2	257			
	blankets due to her	constant jerking movements.			comfortable.		
		ly had made multiple request					
		oom or temperature			On 6/29/17, the maintenance director		
		ated the facility staff stated			completed an audit of each resident ro	om	
	there was no way to				to ensure temperatures are within		
		there was no thermostats in			comfortable limits. Any areas outside		
	the rooms.				those limits were addressed immediate	: ly	
					by the Maintenance Director by adjusti	ng	
	In an interview on 6	6/5/17 at 11:13 AM, Resident			the thermostat operating those residen	t	
		m #104 was cold most of the			rooms.		
		no place to regulate it. She					
		ed staff to turn the thermostat			The Maintenance Director was in-servi		
	•	anything about it. A man			by the regional vice president (RVP) or		
		nd looked at the vent at the			6/30/17 on ensuring comfortable reside	ent:	
	-	said it was broken and he			room temperatures.		
		ent #15 stated she asked staff			The Administrator and DON were		
	to put her to bed ea	rly because she got cold.			in-serviced by the RVP on 6/27/17		
	In an interview on 6	5/5/17 at 5:10 PM, Resident			regarding ensuring comfortable resider	nt.	
		s uncomfortable because it			room temperatures.	11	
		oom #112. He stated the			room temperatures.		
		nis room but it only blew hot air			Administrator will review the Resident		
		improve the temperature. He			room temp Audit Tool weekly to ensure		
		sked the maintenance director			comfortable resident room temperature		
	to look into the exce	essive heat in his room since			Any identified areas of concern will be		
	they put the fan in h	nis room.			corrected by the maintenance director	or	
					heating and air conditioner contractor		
	In an observation w	ith the maintenance director			upon identification.		
	on 6/6/17 at 4:30 PI	M, the temperature in the					
		was testing using an infrared			The maintenance director, social worker		
		he temperature was 70.4			dietary manager, DON and/or corporat		
	_	vall thermostat read 73			consultants will check 5 resident rooms	;	
	_	tenance director stated there			per hall (to include room 118, 104 and		
		hermostats in the resident			112) 5 days weekly, including weekend	iS,	
	·	perature was controlled from			for 4 weeks, then 3 times weekly for 4		
	_	stat. The following rooms were			weeks, then weekly for 4 weeks utilizin		
		frared gun: Room #118 read			the Resident Room Temp Audit Tool. T	ne	
		n 104 read 68.3 degrees and 5 degrees. He stated he was			Administrator will review and initial the resident room temperature audit tool		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	D. WING				C		
		345293	B. WING		06	/09/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEAT THOARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
KICHWICH	D FINES HEALTHOANE	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 257	Continued From page	÷ 72	F 25	57			
	not aware of any probunit and had not received rooms being cold or has unable to provide temperature checks of the maintenance direct temperatures should and 81 degrees. He saw Ventilation and Air Colto the facility tomorrow. In an observation on a maintenance director.	olems with the air conditioner ived any complaints about not since January 2017. He evidence of resident room luring his weekly rounds. Ector stated the room be between the 72 degrees said he would get Heating, anditioning (HVAC) team out w.		weekly for 12 weeks for completion ensure all areas of concern were addressed. The maintenance director or admin will review with the monthly quality improvement (QI) Committee the Resident Room Temp Audit Tool resmonthly x 3 months for any recommendations, take action as appropriate and to monitor for conticompliance.	istrator sults nued		
	gun on 6/7/17 at 9:20 temperature was 72.0 72.3 degrees and Rod In an interview on 6/8 Administrator stated ir resident rooms were to no more than 81 de stated was further her be made to ensure th acceptable range.	eassessed using the infrared AM. Room #118 of degrees, Room #104 read form #112 read 72 degrees. If at 2:22 PM, the the transfer as her expectation that maintained from 72 degrees egrees for comfort. She respectation a weekly round the building remained within		The maintenance director or admini will review with the quarterly assess and assurance (QAA) Committee the Resident Room Temp Audit Tool restor 1 quarter for any recommendation take action as appropriate and to me for continued compliance in the are comfortable temperatures.	sment ne sults ons, onitor		
F 272 SS=D	. ,	ssessments nent Instrument. A facility	F 27	72		7/25/17	
	resident's needs, stre preferences, using the instrument (RAI) spec	nensive assessment of a ngths, goals, life history and e resident assessment cified by CMS. The ude at least the following:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017
	PROVIDER OR SUPPLIER	E AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	00/03/2017
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 272	(ii) Identification are (iii) Customary rour (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical fu problems. (ix) Continence. (x) Disease diagno (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pu (xiv) Medication (xv) Special treatme (xvi) Discharge (xvii) Document regarding the addition (xviii) Document regarding the addition (xviii) Document assessment. The a include direct observation the resident, as wellicensed and non-licensed on all shifts. The assessment pro observation and cor as well as communi non-licensed direct shifts. This REQUIREMEN by:	avior patterns. well-being. unctioning and structural psis and health conditions. ritional status. s. rsuit. hs. ents and procedures. planning. ation of summary information onal assessment performed s triggered by the completion	F 272	F 272 Comprehensive Assessments	

		T SELECTION OF SEL				Ī	7. 0000 0001
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	ΓIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAN OI	CONNECTION	IDENTIFICATION NOWBER.	A. BUILDI	NG _			
						(C
		345293	B. WING			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICUMON	ID DINEC HEALTHOADE	AND DELIABILITATION CENTE		Н	IGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	Χ	(EACH CORRECTIVE ACTION SHOULD BI		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΈ	DATE
					22. 10.2.10.1		
E 070							
F 272	pag-		F	272			
		rehensively assess residents					
	I .	a Set (MDS) assessment in			On 6/27/17, The Minimum Data Set		
		n and mood for 3 of 22			(MDS) assessment for Resident # 140,		
	,	Resident #140, #59 and #60).			#59, and #60 were reviewed by the MD		
	The findings included	1:			Coordinator and corporate consultant to		
					include the areas of cognition and moo		
		s admitted to the facility on			The admission MDS with ARD 5/30/17	tor	
		sion Minimum Data Set			Resident #140, Annual MDS with ARD		
	(MDS) assessment dated 5/30/17 indicated Resident #140 had clear speech, was usually				4/9/17 for Resident #59, and the Quarte	•	
					MDS with ARD 5/7/17 for Resident #60	1	
		understood, and was			will be modified to reflect the correct		
	1	stand others. Section C, the			information by 7/25/17. Resident #140		
	Cognitive Patterns se				was discharged from the facility on 6/6/ and has not returned.	17	
	1	sessed for Resident #140. s coded to indicate Resident			and has not returned.		
		er understood and the			On 6/30/17, Resident #140, #59, and #	·60	
	resident Brief Intervie				were reviewed by the MDS coordinator		
		ough C0500) was not			with oversight of the corporate consulta		
	' '	D, the Mood section, was not			to ensure the current cognitive status a		
		sessed for Resident #140.			symptoms of mood are appropriately		
		coded to indicate Resident			addressed in the resident's plan of care) .	
		er understood and the					
	_	ew (questions D0200			A 100 % audit of the most recent MDS		
	through D0300) was				assessments by the MDS nurses, with		
					oversight of the corporate consultant, w	/as	
	An interview was con	nducted with the Social			completed on 6/29/17 to review coding	for	
		17 at 9:25 AM. The SW			sections C and D of the MDS, and that		
		sponsible for the completion			resident mood symptoms and cognition	1	
		n the MDS assessment.			were appropriately and accurately		
		ne admission MDS dated			addressed in the MDS assessments for	г	
		#140 was reviewed with the			each resident.		
	,	ne attempted the resident					
		ns C and D with Resident			All comprehensive, quarterly, or signific	ant	
	I .	able to answer the questions			change MDS will be coded accurately		
	1	ndicated this was the reason			through the next quarterly review to be		
	I .	lent #140 as rarely/never			completed by 10/17/2017.		
		realed that Resident #140				_	
		understood even though he			On 6/26/17, an in-service was initiated	tor	
	was not able to answ	er the questions			the Care Plan Team to include MDS		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345293		345293	B. WING			C 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017	
					GHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE						
				ПА	MLET, NC 28345			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 272	Continued From page	e 75	F 2	272				
F 272	appropriately during to the 5/30/17 MDS. The unaware of the coding the Resident Assessmanual for the complemental forms and the Resident Assessmanual for the complemental forms and the Resident Assessmanual for the complemental forms and the Resident Amount of the MDS assessmanual for the code for the code for the MDS assessmanual for the Resident for the code for the MDS assessmanual for the code for the code for the MDS assessmanual for the MDS assessmanual for the code for the code for the MDS assessmanual for the code for the code for the MDS assessmanual for the MDS assessmanual for the code for the code for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the code for the code for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the code for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the code for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the Code for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the Code for the MDS assessmanual for the MDS assessmanual for the Code for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the MDS assessmanual for the Code for the Code for the MDS assessmanual for the Code for the Code for the MDS assessmanual for the MDS assessmanual for the Code for th	the resident interviews for the SW stated she was go instructions specified in ment Instrument (RAI) etion of Sections C and D. ducted with the Director of B/17 at 2:35 PM. She attion was for all residents to cassessed in all areas of the management of the section was for all areas of the management of the section was for all areas of the management of the section was not essed for Resident #59. coded to indicate Resident understood and the resident with the section of the section of the section was not essed for Resident with the section of the section was not conducted.	F2	272	Nurses, Activities, Social Services, Dietary, and the Director of Nursing by corporate consultant regarding comple comprehensive assessments per the Resident Assessment Instrument (RAI) Manual to include conducting and codic correctly, the resident interviews for cognition and mood, and was complete on 6/27/17. When coding the MDS assessment, the MDS Nurse and the Care Plan Team to include Activities, Social Services and Dietary will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual a ensure that the assessment accurately reflects the resident' surrent condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks then 10% month 2 months by the Director of Nursing to ensure compliance and accuracy of the MDS to include coding for cognition an mood utilizing a MDS Audit Tool. All Identified areas of concern will be addressed immediately by the Director Nursing through retraining and by modification or significant correction of MDS Assessment by the MDS Nurse to accurately reflect the resident' surrecondition.	ting) ng ed e o and o n. o the o the o nt		
	reviewed with the SW attempted the resider	I. She reported shent interviews for Sections C#59, but she was unable to			reviewed by the Administrator weekly. MDS nurse or DON will take the results the MDS Audit tool to the monthly Qual Improvement (QI) Committee that will	The s of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C / 09/2017	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•	103/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 272	Resident #59 as rare revealed that Reside understood even the answer the question resident interviews from the stated she was unavinstructions specified completion of Section An interview was co 6/8/17 at 2:35 PM. Swas for all residents assessed in all area. 3. Resident #60 was 7/7/16. The quarter 5/7/17 indicated Reswas able to make hi able to understand of Cognitive Patterns somprehensively as Question C0100 was #60 was rarely/neve Brief Interview for M C0200 through C050 Section D, the Mood comprehensively as Question D0100 was #60 was rarely/neve mood interview (que was not conducted. An interview was co 6/8/17 at 9:25 AM. responsible for the conthe MDS assessing quarterly MDS dated.	e reason she had coded ely/never understood. She ent #59 was not rarely/never ough she was not able to s appropriately during the or the 4/9/17 MDS. The SW ware of the coding d in the RAI manual for the ens C and D. Inducted with the DON on She indicated her expectation to be comprehensively sof the MDS. Is admitted to the facility on y MDS assessment dated sident #60 had clear speech, mself understood, and was others. Section C, the ection, was not sessed for Resident #60. Is coded to indicate Resident runderstood and the resident ental Status (questions 00) was not conducted.	F 27	review all audit results mont for further recommendations as appropriate, and to moni compliance. The MDS nurse take the results of the MDS the quarterly quality assurar assessment (QAA) Commit review, recommendations a as needed for sustaining recompliance in the area of coassessments.	s, take action tor continued e or DON will Audit tool to nce and tee for further nd follow up gulatory		

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	<u> </u>		C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, HIGHWAY 177 S BOX 14 HAMLET, NC 28345	,	1 06/	09/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278 SS=D	and D with Resident: answer the questions indicated this was the Resident #60 as rare revealed that Resident understood even thou answer the questions resident interviews fo stated she was unaw instructions specified completion of Section An interview was con 6/8/17 at 2:35 PM. S was for all residents to assessed in all areas 483.20(g)-(j) ASSES ACCURACY/COORD (g) Accuracy of Asses must accurately reflect (h) Coordination A registered nurse meach assessment wit participation of health (i) Certification (1) A registered nurse the assessment is co (2) Each individual with	nt interviews for Sections C #60, but he was unable to s appropriately. She e reason she had coded ly/never understood. She int #60 was not rarely/never ugh he was not able to s appropriately during the or the 5/7/17 MDS. The SW rare of the coding in the RAI manual for the ins C and D. Inducted with the DON on the indicated her expectation to be comprehensively s of the MDS. SMENT DINATION/CERTIFIED ssments. The assessment ct the resident's status. ust conduct or coordinate th the appropriate in professionals. e must sign and certify that impleted. tho completes a portion of the in and certify the accuracy of sessment.		272			7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345293 B. WING			C 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	06/09/2017	
(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)		
F 278	who willfully and known (i) Certifies a material resident assessment penalty of not more thassessment; or (ii) Causes another in and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreem material and false states This REQUIREMENT by: Based on record revisiterview and resident to accurately code the in the areas of dental (Resident #71 and Reassessments reviewer included: 1. Resident #71 was a cumulative diagnoses	and false statement in a is subject to a civil money ann \$1,000 for each dividual to certify a material a resident assessment is ey penalty or not more than assment. The ent does not constitute a tement. The is not met as evidenced ew, observations, and staff to interview, the facility failed a Minimum Data Set (MDS) and diagnoses for 2 asident #100) of 22 MDS d for accuracy. Findings	F 278		vas o	
	His significant change 5/17/17 indicated mod and no behaviors. He assistance with his hy (Oral/Dental Status so any missing or broken In an observation and	e MDS assessment dated derate cognitive impairment required extensive rgiene and section Lection) was not coded for a teeth. Interview on 6/5/17 at 1:13 ted he was experiencing no		Nurse and accepted into the National repository on 7/5/17. On 6/27/17, The MDS nurse reviewed MDS assessment for Resident #100 ar the appropriate modifications were made to include coding of diagnoses on 6/27 and accepted into the National reposition 6/28/17. A 100 % audit of the last completed MI	the nd de /17, ory	

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 / 09/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				н	IGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 278	Continued From pag		F 2	278				
	observation, his teeth multiple missing teet	n were noted discolored with h.			assessment for all residents to include Residents #71 and Resident #100 was initiated on 6/26/17 by the corporate	5		
	In an interview on 6/8	3/17 at 2:22 PM, the			consultants, director of nursing (DON),			
		it was her expectation the			and staff facilitator to ensure the most			
	MDS assessment be	accurate and reflect			recent MDS assessment accurately			
	Resident #71 's curr	ent status and needs.			reflects the residents□ current conditio	n		
					to include coding of dental status and			
	In an interview on 6/8/17 at 2:37 PM. MDS nurse #2 stated section L of the significant change MDS dated 5/17/17 was coded with no missing or				diagnoses, to be completed by 6/30/1	7.		
					For all areas of concern identified, a			
					modification or significant correction of			
		re a Care Area Assessment			prior assessment			
		red. She stated the MDS be based on observation,			(Quarterly/Comprehensive) was completed by the MDS nurses as			
		erviews and record review.			indicated by the Resident Assessment	+		
	Stall and resident into	civiews and record review.			Instrument (RAI) manual by 7/6/17. Al			
	In another interview	on 6/8/17 at 2:50 PM, MDS			comprehensive, quarterly, or significan			
		went and assessed Resident			change MDS will be coded accurately			
	#71 's teeth and not	ed multiple missing teeth and			through the next quarterly review to be			
		d discoloration. She stated			completed by 10/17/17.			
	his dental concerns s	should have been noted on						
	the MDS assessmen	t dated 5/17/17, a CAA			On 6/26/17, an in- service was initiated	l for		
	completed and a der	ital care plan completed.			the Care Plan Team to include MDS			
					Nurses, Activities, Social Services,			
		s admitted to the facility on			Dietary, and the Director of Nursing by	the		
	4/8/16 with multiple of				corporate consultant regarding proper			
		dent (CVA) and depression.			coding of the MDS assessments per th			
	The quarterly Minimu	, ,			Resident Assessment Instrument (RAI	•		
	assessment dated 3/				Manual, and was completed on 6/27/1	<i>i</i> .		
		eceived an antidepressant oagulant medications during			When coding the MDS assessment, th	_		
		essment period. Review of			MDS Nurse and the Care Plan Team to			
	•	revealed that depression			include Activities, Social Services and	-		
		oded under the diagnoses.			Dietary will follow the instructions for			
		 			proper coding found in the Resident			
	Review of the doctor	's order revealed that			Assessment Instrument (RAI) Manual	and		
	Resident #100 was o	on Lexapro (antidepressant			ensure that the assessment accurately			
		mgs) by mouth daily since			reflects the resident□'s current condition	n.		
	9/20/16 and Xarelto	(anticoagulant drug) 15 mgs			An audit of 25% of completed Minimun	า		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345293	B. WING		C 06/09/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2017	
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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
F 278	by mouth daily since of Interview with the MD on 6/7/17 at 12:25 PN acknowledged that RI Lexapro for depression the MDS assessment for Depression and C it was not. Interview with the Direct conducted on 6/8/17 at 12:25 PN acknowledged that RI Lexapro for depression and C it was not.	4/9/16. S Nurse #2 was conducted //. MDS Nurse #2	F 27	Data Set (MDS) assessments will conducted weekly x 4 weeks, then bi-weekly for 4 weeks then 10% m 2 months by the Director of Nursin ensure compliance and accuracy of MDS to include coding for dental s and diagnoses utilizing a MDS Aud All Identified areas of concern will addressed immediately by the Director Nursing o through retraining and b modification or significant correction MDS Assessment by the MDS Nur accurately reflect the resident' so condition. The results of the MDS Audit tool of the reviewed by the Administrator weed DON will take audit results to the Committee review all audit results monthly x 4	onthly x g o to of the tatus dit Tool. be ector of y on of the ese to current will be kly. The Quality e will	
F 279 SS=D	COMPREHENSIVE (483.20 (d) Use. A facility mu assessments complemenths in the resident results of the assessments.	st maintain all resident ted within the previous 15 t's active record and use the nents to develop, review nt's comprehensive care	F 27	for further recommendations, take as appropriate, and to monitor con compliance.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 33/35/2317		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION		
F 279	comprehensive perseach resident, consset forth at §483.10 includes measurable to meet a resident's and psychosocial recomprehensive asseare plan must describe for maintain the resident's and psychosocial recomprehensive asseare plan must describe for maintain the resident physical, mental, and required under §483.24, §48 provided due to the under §483.10, inclutereatment under §483.10, inclutereatmen	develop and implement a son-centered care plan for istent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental eeds that are identified in the essment. The comprehensive cribe the following - are to be furnished to attain dent's highest practicable d psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its dent's medical record.	F 27	79			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/09/2017	
	345293		B. WING			
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	06/	09/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Continued From page local contact agencial entities, for this purpose. (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on medical reinterviews, the facility comprehensive and three of nineteen sate of inappropriate behactivities of daily living (Pre-Admission Screen and psychotropic measure of anticoagulant Findings included: 1a Resident #91 with 12/1/16. Cumulative Alzheimer's disease behavioral disturbant An Admission Minimal 12/12/16 indicated Filippaired in cognition were noted as having assessment period, during the assessment security in the security of t	ge 82 es and/or other appropriate ose. in the comprehensive care in accordance with the th in paragraph (c) of this T is not met as evidenced ecord review and staff y failed to have a individualized care plan for mpled residents in the areas aviors (Resident #91), and (ADL) PASRR ening and Resident Review) edication (Resident #76) and medication (Resident #100). As admitted to the facility on ediagnoses included e and dementia with ce. The state of the state of the facility on ediagnoses included e and dementia with ce. The state of the state of the facility on ediagnoses included e and dementia with ce. The state of the state of the facility on ediagnoses included e and dementia with ce.	F 27	F 279: Develop Comprehensive Oplans The care plan for Resident # 91 wereviewed and updated on 6/26/17 minimum data set (MDS) nurse were oversight of corporate consultants included inappropriate behaviors to wandering in and out of other regrooms and exit seeking behaviors. The care plan for Resident # 76 wereviewed and updated on 6/15/17 MDS Nurse with oversight of corporation of Resident #76's preadmission screening and residence (PASRR) level II for serious illness to include any feelings of fedown, depressed, hopeless, difficing asleep, sleeping too much, appetite/over eating, appropriate to	Care vas by the ith and relating esidents' . vas by the orate ent s mental eeling ulty poor pehavior	
	medication dated 12 received Seroquel (a milligrams every nig noted. Proceed to c	ment (CAA) for psychotropic //14/16 stated Resident #91 antipsychotic medication) 25 ht with no adverse reactions are plan for the use of the state		for use of antipsychotic medication individualized needs for personal. The care plan for Resident # 100 reviewed and updated on 6/7/17 b MDS Nurse to include the use of a anticoagulant medication.	hygiene. was by the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	COMPLETE	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		06/09/2	2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.00.1		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CC	(X5) DMPLETION DATE	
F 279	Continued From pag	e 83	F 27	9			
	while minimizing the medication side effect			A 100% audit of all residents' care was completed on 6/15/17 by corp consultants, including the plan for Resident # 91, Resident #76, and	orate		
	A care plan dated 12/14/16 indicated Resident #91 received psychotropic drugs. Interventions included, in part: Administer medications per physician orders. DISCUS (Dyskinesia Identification System condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. The			Resident #100. The audit was to comprehensive care plans have be developed per the comprehensive assessment, to include any reside identified with inappropriate behavior	een nt		
				relating to wandering in and out of residents rooms, exit seeking beha incorporating PASRR level II for se mental illness for any feelings of fe	other aviors, erious		
	behaviors.	ecify or identify any targeted note dated 1/10/17 stated		down, depressed, hopeless, difficulting asleep, sleeping too much, appetite/overeating, appropriate befor use of antipsychotic medication	poor ehaviors		
	Resident #91 was seand actions. Labora	een for inappropriate behavior tory tests were ordered and a chiatric served was ordered		individualized needs for personal hand/or the use of an anticoagulant medication. The care plans were used for any identified areas of concern	nygiene, ipdated		
		cal record revealed the ion was not obtained.		corporate consultants on 6/15/17. The MDS nurse will know to update/initiate a care plan for new			
	A Quarterly Minimum Data Set (MDS) dated 3/4/17 indicated Resident #91 was moderately impaired in cognition. Mood indicators stated Resident #91 was noted 2-6 days during the			behaviors/anticoagulant meds and PASRR level 2 when the MDS nur and/or director of nursing (DON) re the pink slips (new physician order	se eviews		
	slowly that other peo opposite of being so moved around a lot i			during the clinical meeting. The M nurse will also know to updated/ini care plan for new behaviors and/o PASRR level 2 when the social wo	tiate a r orker		
	the assessment period			forwards to the MDS any level 2 P Recognizing that reviewing the			
		A, an interview was e #2. She stated she worked most of the time. She said		comprehensive assessments will rensure the deficient practice will repeated, any behavior noted in the	ot be		

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			l	C 09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HIG	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 177 S BOX 1489 AMLET, NC 28345	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 279	behaviors at times. Seresponded to redirect on 6/6/17 a 3:46 PM with NA #4. She statinappropriate behavious wandered in and out there was an in-servithe inappropriate behavious the inappropriate behavious remember the date of the inappropriate behavious the inappropriate with the Distated she would expinappropriate behavious #91. On 6/7/17 at 11:07 A conducted with MDS #2. They stated they and update care plan plan for Resident #91 aware of the inappropriate behavious aware of the inappropriate in May and that a car developed at that times	own to have inappropriate She stated Resident #91 tion most of the time. , an interview was conducted ed Resident #91 had ors at times. She said he of resident rooms. She said ce held regarding some of laviors and staff were told to closely. She was unable to of the in-service. I, an interview was irector of Nursing. She lect to see a care plan for the ors exhibited by Resident M, an interview was Nurse #1 and MDS Nurse worked together to initiate s. They reviewed the care l. Both stated they were not oriate behaviors exhibited by ose behaviors should have MDS Nurse #1 said she was oriate behavior that occurred the plan should have been e.	F2	279	progress note review will be communicated to the MDS nurse at the daily department head and/or clinical meeting. Additionally, the problem couoccur from new behaviors, medications adjustments, anticoagulant medication and/or psychotropic medications, the MDS nurses and DON will review mon pharmacy recommendations and medication administration records. The Care Plan Team to include the MDN urses, DON, activity director, dietary assistant manager and social services director were in-serviced on care plant requirements, per instructions provided the RAI Manual on 6/26/17 by the corporate consultant. The DON will review all triggered Care Area Assessments on all subsequent comprehensive assessment, 24 hour reports, shift change notes, progress notes, current interventions and physic telephone orders to ensure any newly identified areas to include wandering, a seeking behaviors, behaviors relating to PASSRR level II for serious mental illing antipsychotic medications, and individualized needs for personal hygic and/or anticoagulant medications has been addressed on the residents' care plans 5 x week for 4 weeks, then audit	ild s s s thly ian exit o ess ene		
	12/1/16. Cumulative Alzheimer 's disease behavioral disturband An Admission Minimu	e and dementia with ce. um Data Set (MDS) dated			10% of care plans weekly x 3 months ensure that care plans reflect the resident's current medical, nursing, mental and psychological needs utilizing care plan audit tool. The MDS nurse w	to ng a ill		
	12/12/16 indicated R	esident #91 was moderately			immediately update the care plan for a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			1	C / 09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0200	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	09/2017	
NAME OF T	TOVIDER OR OUT FIER				GHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345			
				ПА	AWLET, NC 20345			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 279	Continued From pag	e 85	F 2	79				
	were noted as having assessment period.	Medications administered			identified areas of concern and provide re-education as needed.			
	days of antipsychotic				The results of the Care Plan Audit Tool be reviewed by the Administrator week The MDS nurse or the DON will review	ly.		
	A Care Area Assessment (CAA) for psychotropic medication dated 12/12/16 stated Resident #91 received Seroquel (antipsychotic medication) 25 milligrams every night with no adverse reactions noted. Proceed to care plan for the use of psychotropic medications to maximize the resident 's functional potential and well-being				the results of the care plan audits with monthly Quality Improvement (QI) Committee for 3 months for any recommendations, take action as	tne		
					appropriate, and monitor for continued compliance. The MDS nurse or the DO will review the results of the care plan	ON		
	while minimizing the medication side effect	hazards associated with the sts.			audits also with the quarterly Quality Assessment and Assurance (QAA) Committee for 1 quarter for any	rly Quality ce (QAA)		
	#91 received psycho included, in part: Ad physician orders. DI Identification System evaluation per facility steadiness, balance	condensed User Scale) r protocol. Observe gait for and muscle coordination, turn. Pharmacy review of			recommendations, take action as appropriate, and monitor for continued compliance.			
	was in the television unit. He opened the window into the fence was noted. No injurie #91. The responsible were notified. Mainte	1/29/17 stated Resident #91 room of the locked dementia window and climbed out of ed in area. No broken glass es were noted to Resident e party and the physician enance was called and he e to the facility and place an						
	3/4/17 indicated Res	Data Set (MDS) dated ident #91 was moderately Mood indicators stated						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NI IMBED:		MULTIPLE CONSTRUCTION ILDING		
		345293	B. WING _				C / 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY	DDRESS, CITY, STATE, ZIP CODE 177 S BOX 1489 , NC 28345	1 00/	03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	e 86	F 2	279			
	observation period of slowly that other peo opposite of being so moved around a lot n behaviors were noted the assessment period	d as having occurred during od.					
	the care plan until 5/8 added for wandering unsupervised exits frattempts to leave uni Interventions include medications as order resident has an alarm functioning properly. place. Ensure reside	no revisions or additions to 8/17 when a care plan was and/ or at risk for om facility related to t/ building if not redirected. d, in part, Administer ed. Check daily to ensure in bracelet on and that it is Ensure ID bracelet is in ent's picture and name are on oard (as consent for allows).					
	on the dementia unit stated Resident #91	1, an interview was e #2. She stated she worked most of the time. She did not wander and had he tried to leave or get out of					
	wandered in and out knowledge, Resident the building and she	1, an interview was 4. She stated Resident #91 of resident rooms but, to her #91 had never tried to exit had not heard about him and getting outside in the					
	On 6/6/17 at 5:03 PM conducted with the D	1, an interview was irector of Nursing. She					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			l	09/ 2017		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCY	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE		
F 279	elopement when Re window in the deme courtyard. On 6/7/17 at 11:07 A conducted with MDS #2. They stated the and update care pla plan for Resident #9 working at the facility ago and said she was exiting the building to Nurse #2 stated she episode of 1/29/17 a had a care plan for existing the building to Nurse #2 stated she episode of 1/29/17 a had a care plan for existing the building to the properties of the properties with multiple major depressive dis with psychotic feature behavioral disturbantal The admission Minimassessment dated 8 #76 had moderate coassessed as PASRF Illness (SMI). Resid down/depressed/hoj	to see a care plan for the sident #91 went out of the ntia unit into the enclosed MM, an interview was Nurse #1 and MDS Nurse worked together to initiate ins. They reviewed the care 1. MDS Nurse #1 began wapproximately 3 months as not aware of Resident #91 shrough the window. MDS remembered going over the ind Resident #91 should have belopement at that time. It is admitted to the facility on diagnoses that included sorder, single episode, severe res and dementia with ce. In the was Reverted to Serious Mental ent #76 indicated he felt beless, had trouble falling	F2	279					
	MDS review period. behaviors and no re received antipsycho antidepressant medi the MDS review peri	on 2-6 days during the 14 day He was assessed with no lection of care. Resident #76 tic medication and cation on 7 of 7 days during							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		345293	B. WING _				09/ 2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		, 33	VV , ZV 1.1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page indicated he received		F 2	279				
	Worker (SW) on 6/7/Resident #76 was a I A review of Resident of care, most recently revealed no identificate PASRR level II determined to the company of the comprehensive, a stated MDS Nurse #7	ducted with the Social 17 at 11:25 AM. She verified PASRR level II for SMI. #76 's comprehensive plan v reviewed on 5/5/17, tion or incorporation of his						
	on 6/6/17 at 5:22 PM responsible for the or MDS assessments, a care for Resident #76 Nurse #1. Resident \$5MI was reviewed wiverified there was no PASRR in Resident \$indicated she was un for ensuring the level incorporated into Res An interview was comin 6/6/17 at 5:25 PM. Resident #76 was reviewed with MDS News no incorporation	ducted with MDS Nurse #1 She stated she was versight of MDS Nurse #2, nd care plans. The plan of was reviewed with the MDS 476's level II PASRR for th MDS Nurse #1. She incorporation of the level II 476's plan of care. She sure who was responsible II PASRR for SMI was ident #76's plan of care. ducted with MDS Nurse #2 The plan of care for viewed with MDS Nurse #2. III PASRR for SMI was lurse #2. She verified there of the level II PASRR in of care. She indicated she						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			l	C 09/2017
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	DE		
(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 CC ((EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 279	level II PASRR for SI Resident #76 's plan 2b. Resident #76 wa 8/9/16 with multiple of major depressive dis with psychotic feature behavioral disturband. The quarterly MDS a indicated Resident # Resident #76 receive and antidepressant in review period. His and dementia and depression that indicated the food drugs related to the orgait/balance. An interview was core 6/6/17 at 12:34 PM. expectation that plan accurate, and follower #1 and MDS Nurse # responsible for initiatic care. An interview was core on 6/6/17 at 5:22 PM responsible for the ormal managements of the orgait/balance.	responsible for ensuring the MI was incorporated into a of care. s admitted to the facility on diagnoses that included order, single episode, severe es and dementia with ce. ssessment dated 5/4/17 76's cognition was intact. ed antipsychotic medication medication during the MDS ctive diagnoses included esion. Resident #76 was reviewed. Each of care (initiated on cently reviewed on 5/5/17) us area of psychotropic diagnosis of unsteady aducted with the DON on She indicated it was her so f care be comprehensive, ed. She stated MDS Nurse est were ultimately ing and revising the plans of aducted with MDS Nurse #1. She stated she was versight of MDS Nurse #2, and care plans. The plan of otropic drugs for Resident e psychotropic medications	F 2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 06/09/2017		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		30/09/2017		
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 279	She stated unstead appropriate diagnos psychotropic care p care related to psychotropic care posterior for Reside An interview was confined in 6/6/17 at 5:25 PN psychotropic drugs indicated the psychotropic drugs indicated to the diagnosas reviewed with lunsteady gait/balandiagnosis for Residiplan. She explaine for psychotropics with medical records systematical records and systematical	viewed with MDS Nurse #1. y gait/balance was not an sis for Resident #76 ' s lan. She revealed this plan of chotropic drugs was not nt #76. Inducted with MDS Nurse #2 of the plan of care related to for Resident #76 that cotropic medications were losis of unsteady gait/balance with gait balance with gait balance with gait balance with the plan of care as entered into the electronic letern a drop down box with lable and they were required a diagnosis/diagnoses. MDS incorrect diagnosis was nt #76 ' s care plan for She indicated Resident #76 liagnoses that related to his lations, such as, depression,	F 2	79				
	8/9/16 with multiple muscle weakness, of cerebral infarction. The quarterly Minimassessment dated sometimes of the constitution of the constitutio	as admitted to the facility on diagnoses that included difficulty in walking and history n. num Data Set (MDS) 5/4/17 indicated Resident #76 act. Resident #76 was dent on 1 staff member for Resident #76 had impairment er and lower extremities and ot steady on his feet.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STAT HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	TE, ZIP CODE	00/03/2017	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIATE SFICIENCY)	(X5) COMPLETION DATE	
F 279		Resident #76 was reviewed.	F	279			
	8/12/16 and most rec that indicated the foc	plan of care (initiated on ently reviewed on 5/5/17) us area of personal hygiene. ted to require assistance ion.					
	6/6/17 at 12:34 PM. expectation that plans accurate, and follower #1 and MDS Nurse #	ducted with the DON on She indicated it was her s of care be comprehensive, d. She stated MDS Nurse 2 were ultimately ng and revising the plans of					
	6/6/17 at 4:58 PM. Hake up. Observation this interview reveale An interview was conton 6/6/17 at 5:22 PM responsible for the own MDS assessments, a care related to person that indicated he required and application where we was not required a application. MDS Nucare related to person was not accurate or in An interview was contin 6/6/17 at 5:25 PM. personal hygiene for he required assistant was reviewed with the	vas reviewed with the MDS ated she was familiar with had not worn make up and assistance with makeup arse #1 revealed this plan of hal hygiene for Resident #76					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.10200	1	STREET ADDRESS, CITY, STATE, ZIP CO		06/09/2017	
DICUMON	D DINES HEAT THEADE	AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489			
RICHIVION	D PINES REALITICARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 279	Continued From page	92	F 2	279			
	MDS Nurse #2 verifie	vith makeup application. ed this plan of care related to Resident #76 was not					
	4/8/16 with multiple d cerebrovascular accident The quarterly Minimulassessment dated 3/2 Resident #100 had resident #10	dent (CVA) and depression. m Data Set (MDS)					
		s order revealed that n Xarelto (anticoagulant mgs) by mouth daily since					
		plan dated 3/24/17 was no care plan developed for agulant medication.					
	on 6/7/17 at 12:25 PM that if a resident was medication, a care pladeveloped. She revie electronic care plan a care plan developed anticoagulant medical	an should have been ewed the resident's and stated that there was no for the use of the tion, it was missed.					
	conducted on 6/8/17	ector of Nursing (DON) was at 11:15 AM. The DON sted a care plan developed					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	.	0.00.2011		
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 279	Continued From pag	e 93	F 2	79				
	when a resident was medication.	started on anticoagulant						
F 280 SS=J		3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP	F 2	80		7/25/17		
	and implementation of plan of care, including (i) The right to particification including the right to be included in the plan revisions to the personal city. The right to participate in the plan revisions to the personal city.	pate in the planning process, identify individuals or roles to anning process, the right to						
		and duration of care, and any to the effectiveness of the						
	(iv) The right to recei included in the plan o	ve the services and/or items of care.						
		ne care plan, including the nificant changes to the plan						
	right to participate in	all inform the resident of the his or her treatment and dent in this right. The st						
	(i) Facilitate the inclu resident representati	sion of the resident and/or ve.						
	(ii) Include an assess	sment of the resident's						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		06	C 5/09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	, ,	70072011
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (i) Developed within the comprehensive (ii) Prepared by an includes but is not li (A) The attending p (B) A registered nur resident. (C) A nurse aide wit resident. (D) A member of for the resident and the An explanation mus medical record if the	resident's personal and s in developing goals of care. Care Plans e care plan must be- 7 days after completion of assessment. interdisciplinary team, that imited to	F 28	,		
	not practicable for the resident's care plant (F) Other appropria	he development of the te staff or professionals in mined by the resident's needs				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER	1.0220	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/09/2017
TO UNIC OF T	TO VIDER OR OUT FEEL			HIGHWAY 177 S BOX 1489	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 280	Continued From pag	e 95	F 28	0	
	team after each assecomprehensive and cassessments. This REQUIREMENty:	Γ is not met as evidenced		F280 Comprehensive Care Plan	
	facility failed to revise for a cognitively impaidentified at risk for ean unsupervised exifor 1 of 3 sampled reaccidents (Resident revise the care plant resident who had repsampled residents (February of D. The faand oriented resident process for 2 (Residents)	#3.) The facility also failed to of a cognitively impaired		Based upon a thorough investigation was concluded on 6/15/17, it was determined the Resident #3 had an unsupervised exit on 03/04/2017, 04/09/2017 and 05/14/2017. On 6/15/17, the Care Plan and Resident Gare Guide for Resident #3 was upod by the MDS Nurse under the supervision of the MDS corporate consultant for and elopements. A 100% audit of all resident care plan	dent lated ision falls
	Resident #3 exited the facility failed to update	pegan on 3/4/17 when the facility unsupervised and the the care plan. Output Description of the property of the care plan. Output Description of the property of the propert		was completed on 6/15/17 by MDS N #1 and MDS Nurse #2 to ensure the plans are reviewed and revised periodically, quarterly and annually a needed with any changes, to include updates and revised wandering assessments and the services provided.	Nurse care and as ded
	7/7/16 with multiple of fracture. The quarter assessment dated 3/Resident #3 had more and was independent unit. The assessment resident needed external exte	derate cognitive impairment t with locomotion on and off nt also indicated that the ensive assistance with		were arranged must be consistent weach resident's written plan of care. MDS corporate consultant #1 and M corporate consultant #2 reviewed an validated the care plans that were completed by the MDS nurse #1 and nurse #2 on 6/15/17. On 6/13/17, the MDS consultants in conviced the care plan toom many	The DS d
		ng a wheelchair for mobility.		On 6/13/17, the MDS consultants in-serviced the care plan team members (to include the MDS nurses, Social	pers

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 5012511	.~_		، ا	2
		345293	B. WING _				09/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	,	00/2011
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 280	Continued From page	e 96	F 2	280			
	resident had not exhi	bited a wandering behavior			Worker, and Dietary manager) regardir	ıg	
	during the assessme	nt period.			updating the resident care plans and	-	
					resident care guides to ensure resident	:S	
	-	lan for wandering was			at risk for falls and wandering have		
		ering care plan was initiated			interventions in their comprehensive plants		
		eviewed on 3/28/17. One of			of care to address the potential for falls		
		ns described the resident at			and elopement and invitation to attend	tne	
		d for unsupervised exits ed to: attempts to leave			resident care plan meeting. The in-services also included when a Care		
	-	al was the resident will have			Plan/Resident Care Guide (RCG) is		
	no episode of unsupe			updated: When an incident occurs (to			
		The approaches included to			include a fall or unsupervised exit) and	an	
	_	nder on units, to check daily			intervention is put into place, the care p		
		as an alarm bracelet on and it			and RCG will be updated by the MDS		
	is functioning properl	y, documents episodes of			nurse each time an incident occurs.		
	wandering per facility				When a new intervention is put into pla		
		celet is in place, ensure			by the DON or quality improvement nur	se,	
	· ·	d name are on the wandering			the MDS nurse will add the new		
	· ·	re that alarm exits are			intervention to the care plan and RCG		
	functional, provide 1:	-			within 72 hours. The MDS nurses will		
	necessary, provide s	s, and provide resident with			attend the daily department head meetings and clinical meetings to		
		id group activities of choice."			participate in discussion related to		
	All of these care plan				incidents, including falls and unsupervi	sed	
	initiated/started on 8/	• •			exits, to ensure care plans are revised		
	revisions to the care	plan approaches after 8/9/16			a timely manner for cognitively impaire	_	
	or after 3/4/17 when	the resident had exited the			residents at risk.		
	facility unsupervised.						
					The care plan/RCG will be updated at t	hat	
		ted 3/4/17 at 7:45 PM			time. Per the Resident Assessment		
		nding at front door. Upon			Instrument process the care plan must	be	
		said that he had let resident			reviewed and revised periodically,		
	, ,	door because resident asked			quarterly and annually and as needed	vith	
		outside, this nurse noted			any changes, to include updates and		
	feet of roadway. This	i) in his chair within a few			revised wandering assessment and the services provided were arranged must		
		Iding. He was yelling "I'm			consistent with each resident written pl		
		building, I'm going home."			of care. To include invitations for the ale		
		to hold chair to prevent			and oriented resident and resident	J. 1.0	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245202	D. MINIC			С	
		345293	B. WING _			6/09/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
TAIOT IIII OT	DI INCO ILLACITIOAN	EARD REHABILITATION SERVE		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280	Continued From pag	ge 97	F 2	80			
	cell phone and phor	ng roadway and turned on her ned facility. Advised staff of members came and assisted		representative to attend the r of care meeting.	esidents plan		
	writer to get residen notes indicated that	t back into building." The the resident had no injuries urse #1 was the author of this		On 6/15/2017, the Director of Administrator reviewed the 3 Schedule to determine the further plan meetings. The 30 day can indicated 26 residents that re-	0 day MDS ture care alendar		
	revealed "late entry Director of Nursing (SW) spoke with wif resident had an uns team needed to mediscuss the move to She stated that we directly meeting and she wo present." The DON The nurse's notes directly revealed resident "a get out. Redirected Returned to door, lo	ated 4/11/17 at 4:47 PM for 4/10/17 at 5:30 PM, (DON) and Social Worker the to inform her that the upervised exit and that the tet with her and the family to sparks unit (secured unit). could go ahead and plan a fould make sure the family was the author of this note. ated 4/14/17 at 1:59 PM t front door yelling trying to to lunch with good results. udly yelling for his wife and esurance (QA) Nurse was the		indicated 26 residents that reinvitation to a care plan meet Administrator verified the invisent on 06/16/2016 to the residents and oriented residents and representatives. On 06/14/20 worker invited alert and oriented #74 and #82 to the care plan be held on 06/16/2017. The omeeting for Residents #74 are scheduled for 06/16/2017 by interdisciplinary care plan teat the residents current plan of updates and changes as indicated on 06/10/17, the regional vice corporate consultants, and according to the invitation of the corporate consultants, and according to the invitation of the corporate consultants, and according to the invitation of the corporate consultants, and according to the care plan the corporate consultants, and according to the corporate consultants, and according to the care plan the corporate consultants, and according to the care plan the corporate consultants, and according to the care plan the care	cing, the ditations were espective alert esident of the social ated resident meeting to care plan and #82 is the fam to review care for cated.		
	author of this note. The nurse's notes d revealed that at 2:09 wanting to leave the the author of this not the nurse's notes d revealed that "DON notified that residen building by a family resident. The nurse the resident out but resident made it out	ated 4/14/17 at 3:02 PM 5 PM, Resident #3 was still facility. The QA Nurse was		began providing oversight to and monitoring to ensure the systems in place to 1) honor right to participate in the development of care, 2) revise care plans a prevent elopement, and 3) replans timely to prevent accide including falls. On 6/23/17, DON, QI nurse, facilitator, hall nurse, MDS nowerer, and/or corporate con began auditing nurse progres risk management reports in the	the facility facility has resident's elopment and centered plan timely to evise care ents, staff urse, social sultant es notes and		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI			، ا	
		345293	B. WING _				09/2017
NAME OF P	ROVIDER OR SUPPLIER	•	,	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DICHMON	ID DINES HEAT THOADE	AND REHABILITATION CENTE		HIC	GHWAY 177 S BOX 1489		
KICHWICK	ID FINES HEALTHCARE	AND REHABILITATION CENTE		HA	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	revealed "resident prhalls in wheelchair yesomeone to pay him home. Resident repehim out so he can fin Nurse #2 was the au The nurse's notes darevealed "wife notifietrying to exit building she knows that he will allowed to exit facility of this note. The nurse's notes darevealed that the resifacility to vacate the impaired and cannot	of this note. Inted 5/16/17 at 4:40 PM Impelling self-up and down the self-up and down the self-up and that he needs a ride the seatedly asking visitors to let d a ride home." The MDS	F	280	medical record. The audit is to ensure interventions are in place to prevent cognitively impaired, wandering resider from unsupervised exit/elopement, to protect residents who fall, and ensure residents/resident representatives are invited to care plan meetings. Any concerns are immediately addressed by the auditor to include reporting to the administrator and/or DON. Beginning 6/26/17, the audit is documented on the Care Planning Participation and Revisi Audit Tool, which covers: 1) if the progress notes were reviewed, 2) if the care plan assessment was completed, comprehensive, accurate, and care gui updated, and 3) if a care plan invitation postcard was offered to the resident/resident representative. The audit tool will be completed weekly x 3 months, then monthly x 3 months.	y on e on	
	revealed "resident sit self about facility. The didn't sleep last night wandering about facility wandering about facility was the author of linterview with the MI conducted on 6/6/17 Coordinator stated the Nurse in March 2017 MDS experience in the received MDS training consultant and not free	atted 6/4/17 at 10:20 PM ting in wheelchair propelling hird shift reports that resident to the has been up all night lity in his wheelchair." Nurse this note. DS Coordinator #1 was at 3:45 PM. The MDS hat she started as MDS on the past and she had			On 6/26/17, the administrator, regional vice president, and/or corporate clinical director will begin a weekly review of the completed Care Planning Participation and Revision Audit Tools to ensure the systems for care plans and care plannic invitations remain in place and are functioning properly. The review will be completed, as indicated by initialing the audit tool, for four weeks to ensure adequate supervision and oversight. The MDS nurse and/or the social work will present the findings of the Care Planning Participation and Revision Auton at the monthly Quality Improveme Committee meeting. The Quality	l ne ng e e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			1	C (09/2017
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011
DIO	D DIVISO 115 41 5110 4 D.S.			Н	IIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	e 99	F 2	280			
	She stated she was a wandering episodes. reviewed the resident wandering and stated to the care plan appround interview with the DC conducted. The DON	g their morning meeting. ware of Resident #3's The MDS Nurse had t's electronic care plan for that there were no revisions baches since 8/9/16. N on 6/8/17 at 2:15 PM was I stated she expected the the care plan after every fall			Improvement Committee will review the results of the audits monthly x 6 month identify trends, use "5 Whys" root caus analysis, and make recommendation for follow-up as needed. The MDS nurse and/or social worker was present the findings of the Care Planning Participation and Revision Audit Tool at the quarterly Quality Assessment and	s, e or vill ng	
	or unsupervised exit.	d the DON were notified of			Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility's follow-up to the recommendations. The QAA Committee will perform additional root cause analy		
	7/7/16 with multiple of fracture. The quarterl assessment dated 3/2 Resident #3 had mod and was independent unit. The assessment resident needed external ex	lerate cognitive impairment it with locomotion on and off at also indicated that the insive assistance with a wheelchair for mobility. The indicated that the ce admission or prior			as needed, make additional recommendations, and provide oversig The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed throut further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of resident's rig to participate in the development and implementation of the plan of care and have the care plan revised.	ght. or d gh o	
	The falls care plan was reviewed on 3/28 was "risk for falls charelated to: weakness, was "resident will be review." The approact transfer and mobility,	an for falls was reviewed. as initiated on 8/9/16 and 8/17. The care plan problem racterized by history of falls back surgery." The goal free of falls through next ches included "assist during bed in lowest position, o participate in activities that ysical activity for					

	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	· /	ATE SURVEY OMPLETED
	345293	B. WING			C 06/09/2017
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND F			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	I	06/09/2017
(X4) ID SUMMARY STATEMEI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280 Continued From page 100 strengthening and improve protocol, have commonly useasy reach, keep assistive (wheelchair) within reach on call light within reach and at these approaches were init 8/9/2016. There were no replan approaches after 8/9/2 incidents of falls. Resident #3's incident report The resident had 10 falls frob/2017. The dates of the 11/11/16, 11/17/16, 12/7/16 2/7/17, 4/23/17, 4/29/17 and Interview with the MDS Coconducted on 6/6/17 at 3:4 Coordinator stated that she Nurse in March 2017. She MDS experience in the pass received MDS training from consultant and not from the The MDS Nurse indicated were discussed during mor stated that she was aware repeated falls. The MDS Nesident's electronic care post that there were no revision: approaches since 8/2016. Interview with the DON on conducted. The DON states the MDS Nurse to revise the fall or unsupervised exit.	sed articles within ambulation devise of the resident and keep inswer timely." All of iated/started on evisions to the care 2016 and after the corts were reviewed. Om 10/2016 through falls were 10/17/16, is, 12/19/16, 1/4/17, id 5/30/17. Ordinator #1 was 55 PM. The MDS estarted as MDS stated that she had no it and she had in the corporate estate MDS training. The incident reports rhing meeting. She of Resident #3's lurse had reviewed the lan for falls and stated is to the care plan.	F 2			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ISTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345293	B. WING _				C 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHV	T ADDRESS, CITY, STATE, ZIP CODE VAY 177 S BOX 1489 LET, NC 28345	<u>, oo,</u>	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	depressive disorder. assessment dated 4/ #82 had moderate or assessment also indino behavior, she has comprehension and understood. On 6/5/17 at 10:02 A PM, Resident #82 was that she didn't feel in involved in the care pure from 6/1/16 through of any care planning #82. Interview with the So conducted on 6/7/17 she was responsible party (RI She stated that she of when the care plan in RP or the resident has SW provided addition that she could not find care plan meeting was linterview with the DO at 2:15 PM. The DO the residents and the care planning process. Interview with the MI on 6/8/17 at 3:20 PM that it has been an is	e diagnoses including Major The quarterly MDS 6/17 indicated that Resident ognitive impairment. The icated that the resident had ic clear speech, she had clear she was able to make self - M and on 6/7/17 at 12:43 as interviewed. She stated cluded and had not been olanning process. Togress notes were reviewed 6/7/17. There were no notes process held for Resident cial Worker (SW) was at 3:12 PM. The SW stated for inviting residents and b) to the care plan meeting. documented electronically neeting was held and if the ad attended the meeting. The hal information and stated d any documentation that a as held for Resident #82. DN was conducted on 6/8/17 N stated that she expected a RP to be involved in the	F	280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345293	B. WING			l	09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	for inviting residents that was not happeni stated that there were facility's staff, resider care planning proces indicated that adminissue. 3. Resident #74 was 5/10/16 with multiple disorder, major depredisorder. A review of Resident revealed his most received his most received on 10/18/16. The annual Minimum assessment dated 4/ #74's cognition was in An interview was core 6/5/17 at 10:17 AM. he was included in detherapy, or other treatlast care plan meetin. An interview was core	ss. The SW was responsible and RP to the meeting but ng. MDS Nurse #2 further e no meetings held with the nts and RPs to discuss the stration was aware of this admitted to the facility on diagnoses including bipolar essive disorder, and anxiety #3's medical record cent care plan meeting was a Data Set (MDS) 24/17 indicated Resident	F	280	ICIENCY)		
	indicated the facility usincorporate the residence (RP) in the care plan her expectation was held quarterly with the as needed if an issue Social Worker (SW) as scheduling care plan	utilized care plan meetings to ent and/or Responsible Party ning process. She stated for a care plan meeting to be e resident and/or the RP and e arose. She indicated the was responsible for meetings and for inviting the The DON revealed the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COL HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•	0.00.00.00.00.00.00.00.00.00.00.00.00.0	
(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 280	6/7/17 at 12:53 PM. meetings were utilized and/or RP in the care stated care plan meetings and as needed if an she was responsible meetings and for inv. The SW indicated she to be included in all of She reported she was #74's last care plan in reported she needed. A follow up interview on 6/7/17 at 3:12 PM #74's last care plan in 10/18/16. She indicated a care plan meeting that time. She stated why Resident #74 has meeting since 10/18. An interview was contained and MDS Nurse #2 on Nurse #1 and MDS Nurse #2 on Nurse #1 and MDS Nurse #2 on Nurse #1 and MDS Nurse #3 plan meetings were resident and/or RP in They both indicated supposed to be held revealed that quarter not occurring consists she had been in her	an meetings. Inducted with the SW on She indicated care plan and to include the resident are planning process. She etings were held quarterly assue arose. She reported for scheduling the care plan atting the resident and/or RPs. It was his own RP and he was soft his care plan meetings. It is sunsure of when Resident meeting was held. She is to review her records. Was conducted with the SW is to review her records. Was conducted with the SW is to review her records. Was conducted with the SW is to review her records. In She revealed Resident meeting was held on atted there should have been held with Resident #74 since if she was unable to explain and not had a care plan in the care planning process. Survive #2 reported that care utilized to incorporate the in the care planning process. Care plan meetings were quarterly. The MDS Nurses #2 stated position at the facility for so was an ongoing problem for	F 28	80			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 06/09/2017		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		06/09/2017		
(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 : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 309 F 309 SS=E	FOR HIGHEST WE 483.24 Quality of life Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain or practicable physical well-being, consiste comprehensive ass 483.25 Quality of ca Quality of care is a applies to all treatm facility residents. Ba assessment of a res that residents receiv accordance with pro practice, the compre care plan, and the r but not limited to the (k) Pain Manageme	PROVIDE CARE/SERVICES CLL BEING e Indamental principle that Ind services provided to facility Isident must receive and the Index the necessary care and Indiamental principlest Indiamental, and psychosocial Indiamental, and psychosocial Indiamental principle that	F 30	9		7/25/17		
	provided to resident consistent with profit the comprehensive and the residents' g (I) Dialysis. The fact residents who requiservices, consistent of practice, the compared plan, and the repreferences.	ts who require such services, essional standards of practice, person-centered care plan, oals and preferences. cility must ensure that are dialysis receive such a with professional standards uprehensive person-centered						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		0.0	C	
NAME OF PE	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	1 06	5/09/2017	
TAPAWIE OF TH	COVIDER OR OUT FEILER			HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	309 Continued From page 105		F 309				
	practitioner and star to obtain a psychiat ordered for one of fi			F 309 Provide Care/Services for Well Being On 6/8/17, the nurse practitione	r (NP) was		
	ordered for one of five residents reviewed for unnecessary medications resulting in ongoing behavioral issues (Resident #91). Findings included: Resident #91 was admitted to the facility on 12/1/16. Cumulative diagnoses included Alzheimer's disease and dementia with behavioral disturbance.			notified Resident #91 did not hat psychiatric consultation that was on 1/10/17. On 6/13/17, Reside was evaluated by the psychiatric	s ordered ent # 91 c NP. On		
				6/14/17, the following new order transcribed: complete blood coudifferential, Valporic Acid Level, Depakote to 500 mg by mouth (times daily and to discontinue S	int with increase po) two		
	revealed Resident # (antipsychotic medi	n orders dated 12/1/16 ‡91 received Seroquel cation) 25 milligrams by		The resident is scheduled to be the psychiatric NP on 07/17/17.			
		nd Ativan (anti-anxiety ram by mouth three times a anxiety.		A 100% audit was initiated by the consultants, director of nursing and staff facilitator of all residen include Resident #91, for the time	(DON), ts, to		
	12/12/16 indicated impaired in cognitio were noted as havir assessment period. during the assessm	num Data Set (MDS) dated Resident #91 was moderately n. No mood or behaviors ng occurred during the Medications administered ent period included seven		of 1/10/17- 6/31/17 to ensure all resident with a physician order for a psychiatric consultation will be evaluated by a psychiatric NP, by 7/25/17. There were 1 residents identified that require psychiatric consultation and will be evaluated by			
	A Care Area Assessment (CAA) for psychotropic medication dated 12/14/16 stated Resident #91 received Seroquel (antipsychotic medication) 25 milligrams every night with no adverse reactions			7/25/17. Any recommendations psychiatric consultation will be a by the hall nurse, quality improv (QI) nurse, or DON timely after to consultation.	iddressed ement		
	noted. Proceed to a psychotropic medic resident 's function while minimizing the medication side effects.	care plan for the use of ations to maximize the al potential and well-being e hazards associated with the		On 6/29/17, the corporate consu DON initiated a 100% in-service registered nurses (RNs) and lice practical nurses (LPNs) regardir when a resident has a physician a psychiatric consultation, it is the responsibility of the nurse transce	e for ensed ng: 1) n order for ne		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345293	B. WING _			C 06/09/2017	
ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD	-	00/03/2017	
D PINES HEALTHCAF	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
#91 received psychincluded, in part: A physician orders. I Identification Syste evaluation per facil steadiness, balance ability to position a medications month care plan did not subshaviors. Psychia included in the interest A nursing note date #91 displayed inapport A nurse practitione Resident #91 was and actions. Labor consultation with pat that time. A physician order of (name) psychiatry manage behaviors A nursing note date climbed out of the enclosed courtyard. A pharmacy chart in stated psychiatric of A nursing note date displayed inappropriate that the part of the stated psychiatric of the part of the stated psychiatric of t	notropic drugs. Interventions administer medications per DISCUS (Dyskinesia om Condensed User Scale) ity protocol. Observe gait for e and muscle coordination, and turn. Pharmacy review of ally and/or as ordered. The pecify or identify any targeted atric consult was not added or reventions. ed 12/19/16 indicated Resident propriate behaviors. In note dated 1/10/17 stated seen for inappropriate behavior ratory tests were ordered and a sychiatric services was ordered dated 1/10/17 stated consult to review medications and in the delivery of the delevision room window into the late of 1/29/17 stated Resident #91 television room window into the late of 2/11/17 stated Resident #91 television pending.	F3	order to provide a copy of the social worker for implementat order and 2) a copy of the ord be provided to the DON to en referral is followed up on. All I RNs and LPNs will be educat orientation by the quality impr (QI) nurse. No nurse will be a work after 7/25/17 until complin-service. The DON or QI nurse will reviphysician orders to ensure all consultations have been place inpatient Consultations book are completed and document Consultation Audit Tool. The occur 5 times a week for 4 we other week for 4 weeks, then 1 month. The results of the Caudit Tool will be reviewed by Administrator weekly. The QI nurse or DON will revipe monthly Quality Improvement the Consultation Audit Tool remonthly x 3 months for trendic cause analysis and recomme The QI nurse or DON will revipe quarterly Quality Assessment Assurance (QAA) Committee Consultation Audit Tool results Committee recommendations progress with recommendations progress with recommendations quarter for additional root cause	ion of the der will also sure the newly hired ed during rovement allowed to deting this detailed in the and referrals ed on the review will eaks, every monthly for consultation of the detailed in the accommittee sults and referrals ed on the review will eaks, every monthly for consultation of the detailed in the accommittee sults and referrals ed on the review with the accommittee sults and referrals ed on the detailed in the sults and the sults and facility ons for 1 use analysis,		
			monitoring requirements as n	eeded. The		
	SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM PAREGULATORY CONTINUED FROM PAREGULATO	ROVIDER OR SUPPLIER D PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 #91 received psychotropic drugs. Interventions included, in part: Administer medications per physician orders. DISCUS (Dyskinesia Identification System Condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. The care plan did not specify or identify any targeted behaviors. Psychiatric consult was not added or included in the interventions. A nursing note dated 12/19/16 indicated Resident #91 displayed inappropriate behaviors. A nurse practitioner note dated 1/10/17 stated Resident #91 was seen for inappropriate behavior and actions. Laboratory tests were ordered and a consultation with psychiatric services was ordered	A BUILDIN 345293 B. WING _ B. WINC _ B. WINC L. B. WI	ROUDER OR SUPPLIER D PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 #91 received psychotropic drugs. Interventions included, in part: Administer medications per physician orders. DISCUS (Dyskinesia Identification System Condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. The care plan did not specify or identify any targeted behaviors. Psychiatric consult was not added or included in the interventions. A nursing note dated 1/19/16 indicated Resident #91 displayed inappropriate behaviors. A nurse practitioner note dated 1/10/17 stated Resident #91 consultation with psychiatric services was ordered at that time. A physician order dated 1/10/17 stated Resident #91 climbed out of the television room window into the enclosed courtyard. A pharmacy chart review note dated 1/30/17 stated psychiatric evaluation pending. A nursing note dated 2/11/17 stated Resident #91 displayed inappropriate behaviors. A nursing note dated 1/29/17 stated Resident #91 displayed inappropriate behaviors. A nursing note dated 1/29/17 stated Resident #91 displayed inappropriate behaviors. A nursing note dated 2/11/17 stated Resident #91 displayed inappropriate behaviors. A nursing note dated 2/211/17 stated Resident #91 displayed inappropriate behaviors. A pharmacy chart review note dated 1/30/17 stated psychiatric evaluation pending. A nursing note dated 2/211/17 stated Resident #91 displayed inappropriate behaviors. A pharmacy chart review note dated 2/27/17 stated recommendations: follow up psych consult. A pharmacy chart review note dated 2/27/17 stated recommendations: follow up psych consult. B the consultation Audit Tool result consultation Audit Tool result consultation Audit Tool result consultation Audit Tool result consultatio	A BUILDING 345293 B. WING GROUDER OR SUPPLIER D PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DETICIONICES GEAR DEFICIENCY MISS EMPLICATION INFORMATION) COntinued From page 106 F 309 CONTINUED FROM STOLUS (Dyskinesia Identification System Condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. The care plan did not specify or identify any targeted behaviors. Psychiatric consult was not added or included in the interventions. A nursing note dated 12/19/16 indicated Resident #91 displayed inappropriate behaviors and actions. Laboratory tests were ordered and a consultation with psychiatric services was ordered at that time. A physician order dated 1/10/17 stated Consultation with psychiatric services was ordered at that time. A physician order dated 1/10/17 stated Consultation with psychiatric services was ordered at that time. A physician order dated 1/10/17 stated Consult (name) psychiatry to review medications and manage behaviors. A nursing note dated 1/10/17 stated Consult (name) psychiatry to review mote dated 1/30/17 stated consult (name) psychiatry to review mote dated 1/30/17 stated psychiatric evaluation pending. A nursing note dated 2/11/17 stated Resident #91 climbed out of the television room window into the enclosed courtyard. A pharmacy chart review note dated 1/30/17 stated psychiatric evaluation pending. A nursing note dated 2/11/17 stated Resident #91 displayed inappropriate behaviors. A pharmacy chart review note dated 2/27/17 stated Resident #91 displayed inappropriate behaviors. A pharmacy chart	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED	
		345293	B. WING				C 09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489 AMLET, NC 28345	, 55.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	impaired in cognition. Resident #91 was no observation period of slowly that other peop opposite of being so moved around a lot in behaviors were noted the assessment period. A physician order dat psychiatry or refer to management. A pharmacy chart review ne follow up psych/ Seron A nursing note dated #91 displayed inapproved Health and two thus far in Market and two	dent #91 was moderately Mood indicators stated ted 2-6 days during the moving or speaking so ble could have noticed or the fidgety or restless and hore than usual. No das having occurred during od. ed 3/9/17 stated verify psychiatry for medication riew dated 3/30/17 stated ote dated 4/28/17 stated ote dated 4/28/17 stated of duel. 5/17/17 revealed Resident opriate behaviors. Int note dated 5/23/17 stated d Seroquel 25 milligrams at sis of Alzheimer 's with se. One episode of od during the month of April ay. cal record revealed the on was not obtained. I, an interview was e #2. She stated she worked most of the time. She said own to have inappropriate She stated Resident #91	F	309	QAA Committee recommendations are implemented and for reporting back to QAA Committee.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/03/2017	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	with NA #4. She sinappropriate beh wandered in and of there was an in-set the inappropriate monitor Resident remember the data on 6/6/17 at 5:03 conducted with the stated (name) psy facility every othe stated she was refor the psychiatric thought Resident psychiatric services. On 6/7/17 at 10:14 was re-interviewed psychiatric services seen by psychiatric discovered in Jan were being kept/ It	PM, an interview was conducted stated Resident #91 had aviors at times. She said he out of resident rooms. She said ervice held regarding some of behaviors and staff were told to #91 closely. She was unable to e of the in-service. PM, an interview was e Director of Nursing. She rchiatric services came to the reweek. The Director of Nursing sponsible for writing the orders consultations. She said she #91 had been seen by es. After reviewing the medical he could not find where been seen by psychiatric 4 AM, the Director of Nursing d. She stated she had notified es yesterday and he would be ic services today. She said she uary 2017 that many orders hidden under the calendar and ompleted. She stated she	F3		Y)		
	from the previous morning meeting. given to the MDS The Director of Nonurse until the micresponsible for encarried out and codirector of Nursin	ndars and all physician orders day were reviewed in the A copy of the orders were nurses for care plan revisions. ursing stated she had a charge ddle of March who had been suring physician orders were ompleted. After that time, the g stated she assumed the he physician orders which					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345293	B. WING _			C /09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		7.00,2011
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 312 SS=D	in January when the services available dupsychiatric staff. She dates when psychiat She said there were services available be other than (name) psecontinued to come to Nursing said the phypsychiatric consultate overlooked and the phave been obtained. On 6/8/17 at 7:54 AM Practitioner was conknowledge, there has obtaining psychiatric come to the building problem with obtaining problem with obtaining she said she was not seen. The Nurse Prexpected the order for be followed and the have been obtained behaviors displayed she also expected the orders could not 483.24(a)(2) ADL CADEPENDENT RESID	ing stated there were weeks re were no psychiatric ue to unavailability of e was unable to give exact ric services were unavailable. additional psychiatric eginning in February 2017 sychiatric services and they of the facility. The Director of sician order for the ion must have been psychiatric consult should in January as ordered. M. an interview with the Nurse ducted. She stated, to her dispense and having them a problem with services and having them. Because there was a night psychiatric consult should prior to now with the psychiatric consult to psychiatric consult should prior to now with the by Resident #91. She stated the nursing staff to notify her if be done. ARE PROVIDED FOR	F3			7/25/17
	personal and oral hy	good nutrition, grooming, and giene. T is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345293	B. WING		00	6/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DIGUMON	ID DINES HEALTHO	ARE AND RELIABILITATION OF ME		HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)	
PRÉFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE	
F 312	Continued From p	page 110	F 31:	2			
	by:						
	•	ations, staff and resident		F 312 ADL Care Provided for De	ependent		
		cord review, the facility failed to		Residents	,		
		showers as scheduled for 1 of 5					
	•	nt #37) who required staff		On 6/20/17 and 6/23/17, the nurs	sing		
	assistance with b	athing and reviewed for activities		assistant assisted dependent Re	sident		
	of daily living (AD	Ls). Findings included:		#37 with a shower, as scheduled	l on		
				Tuesday and Friday.			
	Resident #37 was	admitted on 1/20/11 with					
	cumulative diagno	oses of dysphasia, anxiety and		On 6/28/17, the director of nursir	ng (DON),		
	aphasia.			quality improvement (QI) nurse,			
		quarterly Minimum Data Set		admissions coordinator, and corp	•		
		0/17 indicated severe cognitive		consultants initiated a 100% aud			
		ical behaviors toward others,		residents shower records for the	•		
		sistance of two staff for her		14 days to ensure residents are	-		
		iving (ADLs) and total		a bath/shower according to their			
	assistance of two	staff with bathing.		preference. The shower audit w completed on 6/29/17. The audit			
	Posidont #37 was	s last care planned on 2/21/17		several residents were not assist			
		e of two facility staff members		showers as scheduled and those			
		owers. Her hair was to be		identified residents were assisted			
	washed on her sh			bath/shower according to the res			
				preference. When a resident refu			
	A review of the el	ectronic and written aide		shower or bath the nursing assis			
	documentation fo	r showers from 3/1/17 to		immediately notify the nurse. The			
	present indicated	the following:		will immediately follow-up with th	ie		
				resident upon notification of refu	sal to		
	-Tuesday 3/7/17-ı	no shower		ensure the resident receives a sl	nower or		
	-Friday 3/10/17-n			document continued refusal.			
	-Tuesday 3/14/17						
	-Friday 3/17/17-n			On 6/29/17, the director of nursir	•		
	-Tuesday 3/21/17			admissions coordinator (a licens			
	-Tuesday 3/28/17			practical nurse), quality improver	` ,		
	-Friday 3/31/17-n			nurse, and corporate consultants			
	-Tuesday 4/4/17-ı			a 100% in-service for all nurses			
	-Tuesday 4/11/17			nursing assistants regarding: all			
	-Friday 4/14/17-n			who are unable to carry out activ			
	-Tuesday 4/18/17			daily living will receive the neces			
	-Friday 4/21/17-n	o snower		services to maintain good nutrition	n,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		0	C 6/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0/03/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAF	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR 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 312	Continued From pa	age 111	F 3	12			
	-Tuesday 4/25/17-ı	no shower		grooming, personal and oral l	hvaiene, to		
	-Friday 4/28/17-no			include showers. When the n			
				completes the resident'□s sh			
	Resident #37 's m	ost recent Resident Care		aide will initial the shower she			
		read bathing was to be		the nurse station. If the resi	•		
		staff with total dependence.		chooses not to be assisted w			
	,	•		the nurse aide will notify the r	nurse		
	A review of the Sho	ower Schedule last revised		immediately. When a residen			
	4/24/17 read Resid	lent #37 was have her showers		shower or bath the nursing as			
	on Tuesdays and F	ridays on first shift.		immediately notify the nurse.	The nurse		
				will immediately follow-up with	h the		
	In an observation of	on 6/4/17 at 5:00 PM, a family		resident upon notification of r	efusal to		
	member stated Re	sident #37 relied on facility		ensure the resident receives	a shower or		
		DLs. She stated she did not		document continued refusal.			
		was getting her showers					
		ently smelled of urine and her		Beginning 07/17/17, charge r			
		and unwashed. She stated the		nurse, admissions coordinate			
		staff. They are always short on		and/or corporate consultant v			
		#37 appeared clean and well		the residents daily with obser			
	groomed on 6/4/17	at 5:00 PM.		bath/showers and/or review of			
		0/7/47 - 1 40 40 DN4 NA //7		documentation to validate the			
		6/7/17 at 12:10 PM, NA #7		received a bath/shower accor	-		
		assigned Resident #37 on		resident preferences 5 times	•		
		7. She stated when there were rouble completing her		weeks, then 3 times weekly for then weekly for 4 weeks. The			
		7 stated sometimes the shower		be documented on the	z auuito Wiii		
	_	the floor and that might be		Bath/Shower/Choices Audit to	nol to ensure		
		4/14/17 and 4/28/17.		residents are receiving shows			
	what happened on	4/14/17 and 4/20/17.		scheduled based upon intervi			
	In an interview on t	6/7/17 at 12:20 PM, NA #5		resident, resident'□s represe			
		vorking at the facility on		or observation of bath/showe			
	_	ought the shower team gave		of the audit tools will be revie			
		showers. She stated she was		administrator weekly x 12 we	•		
		as no shower team in March		administrator will initial the co			
		e to offer an explanation as to		audit tools to signify administ	•		
		did not receive her shower on					
	4/21/17.			The QI nurse and/or DON wil	I present the		
				findings of the Bath/Shower/0	•		
	In an interview on	6/7/17 at 12:30 PM, NA #8		tool at the monthly Quality Im	provement		

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 / 09/2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADD	PRESS, CITY, STATE, ZIP CODE	1 00/	103/2017
					77 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE					
				HAMLET, N	1C 20345		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 312	Continued From page	e 112	F3	12			
	stated when she star shower team that did but they did away wit after she started. NA assigned Resident #3 3/28/17 but due to ca shortages, she may recomplete Resident #5 In an interview on 6/8 (SA) #1 stated she started to shower teams but do shower teams were constant to their shower showers on Tuesday. In an interview on 6/8 scheduler stated she 4/25/17, Prior to that, team that was dismant staffing issues. The stated she started wor 12/6/16 and was hire she stated in Februa dismantled because of the started she started because of the started she started in Februa dismantled because of the started she started she started because of the started she started she started because of the started she she started she she started she started she she started she started she she started she	Resident #37 's showers h the shower team not long #8 confirmed she was 87 on 3/14/17, 3/17/17 and all outs and staffing not have been able to 87 's shower on these days. 8/17 at 8:17 AM, shower aide arted on the shower team there were two separate ue to staffing shortages, the dismantled in February 2017. wer team was restarted when Resident #37 was r list. SA #2 stated prior to s were responsible for her and Fridays.		Comming Improvements identify analysis follow-to the adding tool at a and As meeting responsion concern addression other in implements implements in the soul and the soul and the soul addression of the soul and th	ittee meeting. The Quality rement Committee will review the of the audits monthly x 6 monthly trends, use 5 Whys root cause is, and make recommendations up as needed. Iministrator or DON will present sof the Bath/Shower/Choices Athe quarterly Quality Assessme issurance (QAA) Committee g. The administrator will be asible for ensuring QAA Committens and recommendations are used through further training or interventions so that newly mented process are sustained to in regulatory compliance in the fADL care provided for dependents.	ns, e for the Audit nt	
		the first of March. 3/17 at 4:10 PM, the Director ted she started her position					

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 06/09/2017
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	۱	TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 177 S BOX 1489 IAMLET, NC 28345	33.00.2011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 312 F 322 SS=D	big issue. One the slifebruary and the oth floor. Resident #37 'completed by the floor floor aides must have shower team completed it was her expended it was her expe	ans 2016 and staffing was a nower aides resigned in her aide was needed on the s showers were then or aides. The DON stated the eassumed there was a sting her showers. The DON hectation that Resident #37 her showers as scheduled. TREATMENT/SERVICES - SKILLS and hydration. It is and gastrostomy tubes, and oscopic gastrostomy and copic jejunostomy, and don a resident's assment, the facility must not here is not fed by enteral resident's clinical condition interal feeding was clinically noted to by the resident; and fed by enteral means iate treatment and services and president feeding including prication pneumonia, diarrhea, and metabolic abnormalities, all ulcers. To is not met as evidenced for, staff interviews and	F 312		7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 6/09/2017	
NAME OF PE	ROVIDER OR SUPPLIER	1 3323	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (•	6/09/2017	
TO UNIC OF TH	TO VIDER OR GOTT EIER			HIGHWAY 177 S BOX 1489	0052		
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 322	Continued From page	ge 114	F 3	22			
	medications via gas sampled residents of pass observation (R included:	trostomy tube for one of one observed during medication desident #49). Findings		On 6/7/17, Resident # 49 medications via the gastro from the hall nurse. On 6/2 physician was notified by the Nursing (DON) that the resident is the second of the second	stomy tube 23/17, the the Director of sident's		
	with a diagnosis of aphasia. An Annua indicated Resident a decision-making. H	eadmitted to the facility 3/8/17 cerebrovascular accident and I Minimum Data Set 5/16/17 #49 was severely impaired in e required extensive ng. Diagnoses included		gastrostomy tube was not checked for placement price administration on 6/7/17. Corporate consultant verification had a stabilized gastrostore.	or to medication On 6/23/17, the ed the resident		
	speaking). Feeding and fluid intake 51-			A 100% audit of all resider gastrostomy tubes, to inclu #49, was completed by the quality improvement (QI) r	ude resident e DON and nurse to ensure		
	resident's medication via the gastrostomy	n orders revealed all of the ins were to be administered tube. There was not an order the gastrostomy tube.		that no resident had exper complications related to gap placement or medication a through a gastrostomy tub was completed on 7/6/17 a	astrostomy tube administration e. The audit		
	during medication p stethoscope and list quadrants for bowel milliliter syringe to th and pulled back on residual. Nurse #8	M, Nurse #8 was observed ass. Nurse #8 used her sened to all four stomach sounds. She attached a 60 ne gastrostomy tube opening the syringe checking for poured 30 milliliters of water y tube and administered the		concern were identified wit gastrostomy tubes. On 7/17/15/17, the audit was repropriate consultants to elewith a gastrostomy tube an appropriate treatment and prevent complications relafeeding and medication and The second audit identified concern.	th the 14/17 through eated by the nsure residents re receiving the services to ted to enteral Iministration.		
	placement when shoon the gastrostomy On 6/7/17 at 9:56 A conducted with the stated she expected.	se #8. She stated she verified e aspirated and pulled back tube.		On 6/27/17, the corporate DON, and QI nurse provid for 100% of licensed nurse Nurse #8. The in-service if facility policy: 1) for stabilize Gastrostomy Tubes (surging stabilized by external device amount of water, 1-2 ounce	ed an in-service es, to included reviewed the zed cally placed or ce), pour small		

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 06/09	9/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (CODE	1 00/03	7/2017	
D.O				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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	-	(X5) COMPLETION DATE	
F 322	Continued From page		F 3	into the swringe to verify tu	ho natoney s	and		
F 322	through a gastrostom check the tube for pla administration by asp	y tube which included to		into the syringe to verify tu moisten tubing to prevent feeding/medication from actube, 2) for unstabilized Ga Tubes: test for placement I stomach contents. Verify the instilling small amount of wounces (30-60 ml) in the sin-service will be complete On 6/27/17, a 100% audit of all Licensed Nurses was corporate consultants, DO to ensure all nurses can concept placement of gastrostomy medication administration completed on 7/6/17. All needucated during orientation improvement nurse. No not allowed to work until proper demonstration of gastrostomy placement prior to medicate administration is verified. The DON or QI nurse will concept the monthly for 4 weeks weekends (Saturday and Sahifts, then every other weethen monthly for 1 month to proper verification of place gastrostomy tube is compliadministration of medication will be documented on the Tube Verification Audit Toc.	dhering to the astrostomy by aspiration ube patency vater, 1-2 yringe. The d by 7/17/17 of observations initiated by N, and QI nu orrectly verify tubes prior to that was ew hires will be eromy tube tion. Observe 5 or to include Sunday) and sek for 4 weel or ensure that ement of eted prior to on. The audit Gastrostomy of.	e of by consthe urse cobe lity all ks, tt		
				by the Administrator weekl or Director of Nursing will r Gastrostomy Tube Verifica results with the monthly Ql	review the Ition Audit To			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		345293	B. WING _				C / 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HIG	REET ADDRESS, CITY, STATE, ZIP CODE HWAY 177 S BOX 1489 MLET, NC 28345	1 00/	03/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		JLL PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	p - g		F3		monthly for 3 months for any recommendations, take action as appropriate and to monitor for continue compliance. The QI nurse or DON will review the results with the quarterly Quality Assurance and Assessment (Q Committee for further recommendation and follow-up as indicated.	AA)	7/05/47
F 323 SS=J	(d) Accidents. The facility must ensure facility must ensure (1) The resident environment from accident hazard (2) Each resident recand assistance device (n) - Bed Rails. The appropriate alternative bed rail. If a bed or somust ensure correct in maintenance of bed into the following element (1) Assess the resident from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beaupropriate for the resident or the resident o	ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and rails, including but not limited ents. Int for risk of entrapment installation. and benefits of bed rails with ant representative and obtain or to installation.	F3	323			7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			7 BOILDIN			С	
		345293	B. WING _		06	6/09/2017	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COL		700/2011	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 323	Continued From p	page 117	F 3	23			
	Based on record	review, observation and staff		F323 Accidents			
		lity failed to prevent a cognitively					
		from exiting the facility		On 1/23/17, Resident #80 wa	s admitted to		
	-	sident #3) and also failed to		the facility's secured dementi			
		ely impaired resident from bed		4/15/17, the licensed practical			
	entrapment between	een the mattress and the foot		(LPN) completed a work orde			
	board (Resident #	480). The facility also failed to		Resident #80'□s bed with a b	oroken		
	reassess and to it	ntervene to prevent repeated		footboard. On 6/12/17, the m	aintenance		
	falls (Resident #3) at a scope and severity of D.		assistant was in-serviced by			
		ent for 2 (Residents #3 and #80)		vice president (RVP) on the "			
	of 3 sampled resid	dents reviewed for accidents.		Limits for Identified Entrapme			
				per the Food and Drug Admir			
		dy began on 3/4/17 when		Guidelines. The footboard wa	•		
	Resident #3 exite	d the building unsupervised.		two screws on the right side of			
				thus causing a gap between			
		dy began on 5/1/17 when		and footboard. The identified			
		ead was found caught between		the footboard and mattress fo			
		d the mattress causing a bruise		#80' s bed impeded the resi	•		
	to the back of nec	:к.		to rise from the bed. The foo			
	Immodiate iconor	dy is present and ongoing.		Resident #80 was repaired b maintenance assistant by pla	-		
	ininediate jeopai	dy is present and origonity.		screws on the right side of the			
	Findings included			securing to the frame and eli			
	i indings included	•		footboard as a restraint on 6/	-		
	1. Resident #80 v	as admitted to the facility on		6/9/17, hospice offered to pro			
		ple diagnoses including		Resident #80 with a newer st			
		se. The quarterly MDS		mattress for comfort, not bec	•		
		d 4/25/17 indicated that		broken. On 6/27/17, the resid			
		memory and decision making		placed on a new bed owned			
		eded extensive assistance with		for continued safety and com			
	bed mobility. Res	sident #80 resided in the					
	secured unit.			On 05/01/17, Nurse #1 enter	ed Resident		
				#80□'s room and observed F			
	Resident #80's ca	re plan dated 4/25/17 was		facing the foot board of the b	ed with		
	reviewed. The ca	re plan problem was resident		Resident #80'□s head wedge	ed between		
		s and the goal was the "resident		the footboard and the mattres			
	will be free of falls	through the next review." The		a medication aide, and a nurs	sing assistant		
		ded to assist during transfer and		helped remove Resident #80			
	mobility, ensure e	nvironment free of clutter,		from the footboard and mattre	ess by lifting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 09/2017
NAME OF PE	ROVIDER OR SUPPLIER	0.0200		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	09/2017
TO UNIC OF TH	TO VIDEN OIL OUT FEIER				IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARI	AND REHABILITATION CENTE			AMLET, NC 28345		
					 		I
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	ge 118	F 3	323			
	administer medication	ons as ordered and have			Resident #80'□s body and pulling the		
	commonly used artic	cles within easy reach. The			mattress out from under the resident to)	
		dress the resident's bed			make room to slide Resident #80'□s he	ead	
	mobility.				from under the footboard. Resident #80)	
	·				was assessed by the nurse with		
	Resident #80's incid	ent report dated 5/1/17 at			observation of a bruise to the back of the	ne	
	4:42 AM was review	ed. The report revealed"			neck. Resident #80 denied pain or		
	resident observed by	y writer facing the base board			discomfort. No changes were noted		
	of their bed with their	r head wedged between the			during the assessment by the Nurse #	l in	
	base board and the	mattress. Writer, nurse,			Resident #80 's level of consciousnes		
		Nursing aide (NA) helped			pupils were equal, round and reactive t	0	
		ead from being wedged			light and accommodation (PERRLA).		
		I and mattress by lifting			Resident #80 was able to exhibit		
		pulling mattress out from			movement in all extremities without pai	n.	
		ake room to slide resident's			On 5/1/17, the Nurse #1 notified the		
		base board of their bed.			Medical Director by leaving a telephone		
	Bruise noted to back				message. On 5/1/17, Nurse #1 notified	İ	
		ed. RP notified." The			the resident representative (RR) by a		
	•	aled that Resident #80			telephone call. A full body audit was		
	resided in room 413	B on 5/1/17.			completed on Resident #80 on 5/16/17	,	
	D : 1 / //00!				5/24/17, 5/30/17, and 6/12/17 by the		
		e's notes were reviewed. The			treatment nurse with no negative findin	gs	
		at 4:40 AM revealed "resident			of injuries related to restraints,		
	•	acing the base of their bed			entrapment/gap or falls. On 6/9/17, the	3	
		ged between the base board			Director of Nursing (DON) notified the		
		Vrite asked resident "what are			physician concerning the incident of Resident #80□'s head being wedged		
		nt stated "trying to get up." ation aide and NA helped			between the mattress and the footboar	d	
		ead from being wedged			between the mattress and the lootboar	u.	
		I and the mattress by lifting			100% of all residents□ beds, to include	1	
		pulling the mattress out from			Resident #80, were audited by the	•	
		make room to slide			maintenance assistants on 6/13/17 to		
		from under the base board.			ensure there were no identified risks for	r	
		of neck. Physician notified			falls, entrapment zones/gaps or potent		
		ty (RP) notified. No change in			risk for restraining the resident (the rail		
		level of consciousness			entrapment under the rail, between the		
		round, reactive to light and			supports or next to a single support,		
		RRLA). Able to move all			entrapment between the rail and the		
		sident's normal base line.			mattress, entrapment under the rail, at	the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00/03/2017	
NAME OF T	TOVIDER OR SOLT LIER					
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 323	Continued From page	e 119	F 32	3		
	Skin warm and dry to	touch. Respiration even		end of the rail, entrapment between	the	
		sounds clear. No shortness		bed rails, and entrapment/gap between		
	_	ies any pain or discomfort.		the end of the rail and the side edge		
		noted. Vital signs (VS)		head or footboard).		
		' The nurse's notes dated		,		
		evealed that "swelling noted		On 6/13/17, the corporate consultan	ts	
	to right (R) check and	R lip. Physician and RP		completed a 100% audit of residents	s while	
	notified."			in bed to ensure the resident is free	from	
				physical restraint while lying on the		
	Interview with NA #3	(assigned to Resident #80)		mattress. The corporate consultants	s also	
		7/17 at 5:40 PM. NA #3		ensured the resident was provided		
		sident was independent with		enough space while moving around		
	-	and ambulation but he		bed for repositioning and the bed wa	as not	
	needed constant rem	inder due to his confusion.		a restraining device at the mattress,		
				footboard and headboard. The audi		
		ector of Nursing (DON) was		completed by the maintenance assis		
		at 5:50 PM. The DON		and RN facility consultants resulted		
		ot aware of an incident with		resident beds being removed from s		
		17. The DON was asked to		to eliminate the unintended restraini	-	
		urse's notes dated 5/1/17.		devices. The 3 residents identified in		
		rse's notes loudly with the rporate staff member in the		audit were provided a bariatric bed of 6/13/17 for their comfort and safety.		
		the Administrator stated that		resident was provided a new mattre		
	they were not aware			the resident request by the RVP and		
	they were not aware t	or the of 17 17 incident.		corporate consultant on 06/13/17.	'	
	On 6/8/17 at 7:55 AM	l, Nurse #2 was interviewed.		oorporate consultant on corror in		
		ed to Resident #80 on		On 6/16/17, the corporate consultan	ts I	
	_	Nurse #2 stated that she		completed a 100% review of nursing		
	was checking the roo			progress notes and risk managemen		
	_	stuck under the base board		reports from 3/1/17 through 6/16/17.		
		fied that she meant the base		review covered injuries of unknown		
		The resident was facing the		entrapment, restraints and residents		
		s under the base of the foot		had fallen. The review ensured prov	ision	
	board and his head w	as hanging out. The		of appropriate interventions and		
	resident's body was in	n bed in downward facing		notification of the physician and resi	dent	
		talking but he was alert.		representative via voice to voice		
	Four staff members h	elped to get the resident's		conversation. All identified areas of		
		t board by lifting his body up		concern were addressed by the corp		
	and pulling the mattre	ess out under him. Nurse #2		consultant and/or Director of Nursing	9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			l	C 09/2017	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011	
				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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From page	e 120	F:	323				
F 323	stated that she called Resident #80 and no message on his voice that she was told to a attending physician a access line. Nurse #2 aware that the attende #80 was on vacation. Interview with the Ph 6/8/17 at 9:58 AM. Hinformed of the incide happened on 5/1/17. vacation the last wee work the morning of expected the nurse to or the on call physician indicated the showing that the facil 4:15 AM and left a m He stated that he was message on his voice. On 6/8/17 at 8:08 AM where Resident #80 observed to measure mattress and the food already removed from identified the same be during the 5/1/17 incismall for the bed and	I the attending physician of the on-call and left a email. She further stated always call the resident's and not the after-hours of further stated she was not ing physician of Resident at that time. I ysician was conducted on the stated that he was not ent with Resident #80 which the stated that he was on k of April and was back to 5/1/17. He stated that he of call the Nurse Practitioner and At 4:40 PM, the enath is work phone was ity had called on 5/1/17 at essage on his voice mail. I, room 413 B (the room resided on 5/1/17) was the gap between the email. I, room 413 B (the room resided on 5/1/17) was the gap between the email. In the proof of the proof of the gap between the email of the proof of the gap between the email of the gap between the gap	F:	323	(DON) with appropriate investigation are interventions implemented to decrease the number of falls and eliminate entrapment and deter elopement. The resident care plan and resident care gupdates were completed by the minimulata set (MDS) nurses and corporate consultants by 07/01/17. On 06/15/17, the corporate consultants DON, and quality improvement (QI) nuinitiated an in-service for 100% of registered nurses (RN), licensed practinurses (LPN), and nursing assistants (on restraints. This in-service included the resident assessment instrument (RAI) regulatory definition of a restraint and examples of restraints to include: 1) broken equipment that restricts freedor of movement, 2) side rails that keep residents from getting out of bed, 3) tucking in or using Velcro to hold a sheet, 4) tightly restraining fabric or clothing so that a resident "□s movement is restricted, 5) using trays, tables, bars belts that the resident cannot remove easily, and 6) any item that could preve the resident from rising, 7) placing a chor bed so close to a wall that the wall prevents the resident from rising out of chair or getting out of the bed. The	uide um s, rse cal NA) he and m		
	the foot board. The n found the resident in Interview with the Ma conducted on 6/8/17 he didn't know the inc	ne (under the mattress) and urse demonstrated how she bed. intenance director was at 8:15 AM. He stated that cident with Resident #80 until e indicate that he didn't know			in-service was completed on 7/1/17. A RN, LPN, or NA not completing the in-service by 7/1/17, was required the complete the in-service prior to returnir to a work assignment. All newly hired LPN, or NA is required to complete the training from the DON or QI nurse prior completing new employee orientation.	ng RN,		

PRINTED: 07/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		riple NG _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			l	09/2017
NAME OF PI	ROVIDER OR SUPPLIER	l	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	HAI		AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 323	Continued From page	e 121	F;	323			
F 323	what kind of bed he was on a hospice bed claimed that he didn't from room 413 B. He that he had to check foot board, head board not told to check then On 6/8/17 at 8:25 AM unit were observed w In room 418 A, the for screws were missing bed had a gap of 5 in the foot board. In room a gap of 4 inches bet foot board. The distar (under the mattress) and ¼ inches. A follow up interview conducted on 6/8/17 stated she was not in Resident #80 that occ indicated that she had report dated 5/1/17 be bad but when she rea yesterday (6/7/17), sh DON further indicated had been done after the stated that she didn't resident was on. The resident was moved the family request but she DON stated that nobe between the mattress.	was on but he thought he d. The Maintenance director know who removed the bed added that he didn't know the gaps between mattress, and and side rails and he was in. If, the beds in the secured ith the Maintenance director. On the board was loose, two in room 421 A, the hospice ches from the mattress to im 423 B, a regular bed had ween the mattress and the ince between the bed frame and the foot board was 7 with the DON was at 9:27 AM. The DON formed of the incident with curred on 5/1/17. She disgned off the incident with the board off the incident was the said "oh my God." The disa far as she knew nothing the incident. She further know what kind of bed the e DON revealed that the or another room per the e was not sure of this. The body was checking the gaps and the foot board.		323	A 100% all staff in-service was initiated 6/15/17 and completed on 7/1/17 by the corporate consultant on: Entrapment/Gaps Bed entrapment-are occurrence involving a resident who is caught, trapped, or entangled in the besystem to include the spaces in or arouthe bed rail, bed mattress, or bed frame to include the foot board. 100% of all staff responded to questionnaires given by the Administra in Training (AIT), Facility Consultants, a Director of Nursing initiated on 06/12/1 and completed by 6/22/17 for validation understanding regarding entrapment to include: 1. What do you do if you find broken or faulty equipment? 2. What is entrapment? 3. Can a bed cause entrapment? 4. What do you do if you suspect or observe entrapment? 5. Whis at risk for entrapment? 6. What are some things that can contribute to entrapment? 7. If entrapment occurs, what can you do to ensure the resident safety? 8. Who needs to be notified immediately if a resident is unsafe in bodue to space between that mattress and bed? All staff have successfully completed the entrapment questionnair. By 6/16/17, the licensed nurses were tested on their knowledge of what a restraint is and examples of restraints. Any nurse, unable to pass the test, will retrained and retested. If upon the second attempt, if the nurse is unable to	e n d und e, ator and 7 n of o d d t' s ed d d res.	
	on 6/8/17 at 9:37 AM	ministrator was conducted The Administrator stated in incident report dated			_ ·	ond	

Facility ID: 923021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/09/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCAR	E AND REHABILITATION CENTE		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page	ge 122	F 32	23			
F 323	5/1/17 because the Assurance) nurse hindicated that she exidirector to check the and the foot board a know if the maintenanot. The facility's wandedated 1/16/16 was rin part "the purpose implement guideline for inappropriate was facility and to ensurate regards to the identification of the war should occur as indicated apply to all residents this residents who in dementia units." The were "to prevent the and to plan for the rincluded "implement to or including the abracelet, monitoring (etc.)." 2 a. Resident # 3 war 7/7/16 with multiple fracture. The quarter assessment dated 3 Resident #3 had morand was independed.	DON and the QA (Quality ad already signed it off. She expected the maintenance agaps between the mattress at least monthly but she didn't ance director was doing it or displayed. The protocol read of this protocol is to see to identify a resident's risk andering within or outside the ear esident's safety in fied behavior. To identify this sure a resident's safety, adering risk potential protocol cated. These guidelines is within the facility including any reside on secured appropriate on secured appropriate on secured appropriate on secured appropriate on the protocol are identify. The procedure are plan, etcetera as admitted to the facility on diagnoses including pelvice and maintain the composition on and off	F 32	nurse will be removed from the until remediation is provided. By 6/16/17, the RN facility con completed 100% retraining of assistants on restraints and ex restraints. The nursing assistatested on their knowledge of the matter of restraints. Any nursing that is unable to pass the test retrained and retested. If upon attempt the nursing assistant is successfully pass the restraint nursing assistant will be remove schedule until remediation is pof 7/14/17, all nurses and nurse assistants have successfully prestraint testing. On 3/4/17, Nurse #1 assessed #3 for signs of injury, related unsupervised exit. Nurse #1 in placed Resident #3 on 1:1 consupervision (to prevent any fur attempts to exit the facility), by Assistant until resident #3 was bed at approximately 8:30 pm. determined Resident #3, while no longer at risk of exiting the unsupervised during the shift of the resident #3 inability to amb from the bed without extensive The resident representative was at 7:35 pm on 03/04/2017 of the occurrence and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties was at 7:35 pm. On 3/4/17, Nurse #1 in placed Resident #3 inability to amb from the bed without extensive The resident properties and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties and the licensed in documented per the time stam 7:45pm. On 3/4/17, Nurse #1 in placed Resident properties and the licensed in documented per the time stam 7:45pm.	asultant the nursing camples of ints will be the subject the gassistant will be the second so unable to test, the wed from the provided. As sing the second the resident ther ther ther ther ther ther ther the		
	utilization of the war should occur as indiapply to all residents this residents who n dementia units." The were "to prevent the and to plan for the rewell-being within the included "implement to or including the abracelet, monitoring (etc.)." 2 a. Resident # 3 war 7/7/16 with multiple fracture. The quarter assessment dated 3 Resident #3 had more and was independent. The assessment resident needed extremediates when the same and was independent.	ndering risk potential protocol cated. These guidelines is within the facility including may reside on secured in purpose of the protocol in resident's unsupervised exit esident's safety and in a facility." The procedure its preventative interventions up publication of an alarm in the care plan, etcetera in as admitted to the facility on diagnoses including pelvice orly Minimum Data Set (MDS) in 1/26/17 indicated that inderate cognitive impairment		On 3/4/17, Nurse #1 assessed #3 for signs of injury, related unsupervised exit. Nurse #1 in placed Resident #3 on 1:1 cor supervision (to prevent any fur attempts to exit the facility), by Assistant until resident #3 was bed at approximately 8:30 pm. determined Resident #3, while no longer at risk of exiting the unsupervised during the shift r the resident #3 inability to amb from the bed without extensive The resident representative wat 7:35 pm on 03/04/2017 of the occurrence and the licensed in documented per the time stars.	nmediately instant rther v a Nursing s placed in . Nurse #1 e in bed, was facility related to coulate or rise e assistants. as notified ne iurse no at notified esident message		

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 P	ROVIDER OR SUPPLIER	040200	1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	06	/09/2017	
NAME OF T	TOVIDEN ON 301 1 EIEN				HWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCA	RE AND REHABILITATION CENTE						
				ПАІ	MLET, 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	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Continued From p	page 123	F3	323				
	The assessment f	urther indicated that the			was drug tested and suspended per			
		exhibited a wandering behavior			facility policy on 6/10/17 related to ne	alect.		
	during the assess				A 24 hour report was completed by the	-		
		•			Administrator and faxed to the Health	1		
	Resident #3's war	ndering risk evaluations were			Care Personnel related to Neglect or	1		
		k evaluation form indicated that		- 1	6/10/17. On 6/10/17, an investigation			
		score of greater than 5 was at		- 1	initiated by the Regional Vice Preside	ent,		
risk for wandering.			- 1	Corporate Clinical Directors,				
	The wondering rig	de evaluation form dated 10/7/17			Administrator, and Director of Nursing			
	_	k evaluation form dated 10/7/17 ident #3 was at risk for			related to resident #3 Neglect and ex the facility.	iung		
		score of 16. The form indicated			the facility.			
		as had one or more attempts to			On 4/9/17, an unidentified staff perso	n of		
		y and or wander in the past 3		- 1	which the DON does not remember,			
	months. The form	also indicated that the resident			reported to the DON that Resident #3	3 had		
		statement of desire or intent to			an unsupervised exit through the fror	nt		
	leave the facility.				door. The previous employee (DON			
					unable to remember the employee)			
	_	k evaluation form dated 3/23/17 aled that Resident #3 was at risk			witnessed Resident #3 heading towa	rds		
		n a score of 19. The form		- 1	the facility⊡'s front door. The local Emergency Services was entering th	0		
		resident has had one or more			facility and while coming through the			
		home/facility and or wander in			door, the resident exited out with the	ii Oiit		
		. The form also indicated that			assistance of the EMT. The unidentif	ied		
		nade verbal statement of desire			staff member immediately redirected			
	or intent to leave t	he facility.			Resident #3 back into the facility. The	9		
				- 1	wander guard did enunciate, but the			
		e plan for wandering was			was already open by the EMT□s thu	5		
		andering care plan was initiated			allowing the resident to cross the	4 1		
		s reviewed on 3/28/17. One of			threshold, but was immediately redire			
		olems was wandering and or at seed exits from facility related to:			by a staff member back into the facili upon identification. On 4/10/17, the I			
		unit/had building. The goal was			spoke in person with Resident #3□s	J () (1		
		ave no episode of unsupervised			residents representative and request	ed		
		through next review. The			the resident representative to attend			
		ded to "allow resident to wander			4/11/17, 11am care plan meeting. The			
		daily to ensure resident has an			resident representative declined to at			
		and it is functioning properly,			the care plan meeting.			
	documents episod	des of wandering per facility						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245202	D MING			С	
		345293	B. WING			6/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε		
RICHMON	D PINES HEAI THCARI	E AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
T. C. IIII C. I	DI INCOTICACITICAN	TAND REHABILITATION SERVE		HAMLET, NC 28345			
(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)	N SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page	ge 124	F 32	23			
	protocol, ensure ide	ntification (ID) bracelet is in		On 5/14/17, at approximately	4:00pm. the		
		ent's picture and name are on		assigned hall Nurse #1 was a	•		
	-	ent board, ensure that alarm		station and observed residen			
		provide 1:1 staff monitoring		front door. Nurse #1 overhear			
		de supervision during		#3 stating let me out to a visit	or. Nurse #1		
		ns, and provide resident with		yelled at the visitor not to let r	esident #1		
	opportunities to atte	nd group activities of choice".		out but the visitor held the fro	nt door open		
	All of these care pla	n approaches were		for resident #3 and resident #	3 wheeled		
initiated/started on 8/9/16. There were no			out of the facility. The alarm v	vas sounding			
	revisions to the appr	oaches as of 6/9/17.		when resident #3 exited the fa	•		
				#1 immediately went outside			
The nurse's notes dated 3/4/17 at 7:45 PM			Resident #3 and observed re				
		nding at front door. Upon		the front porch. Nurse #1, CN			
		said that he had let resident		CNA #2 hear the alarm and c			
		door because resident asked	to assist Nurse #1 with brining resident #3				
		outside, this nurse noted 3) in his chair within a few		back into the facility. Residen			
		is nurse could not get		combative with the staff wher to assist back in the facility.			
	_	ilding. He was yelling "I'm		was brought back into the fac			
		e building, I'm going home."		#1, Nurse #2, CNA #1, and C			
		d to hold chair to prevent		approximately 10 minutes late			
		ng roadway and turned on her		resident being combative. On			
		ned facility. Advised staff of		upon returning resident #3 to			
		members came and assisted		Nurse #1 assessed Resident			
	writer to get residen	t back into building." The		injuries observed. On 5/14/1	7, Nurse #1		
	notes indicated that	the resident had no injuries		notified the physician and Re	sident		
	from the incident.			Representative (RR) of reside	ent #3 exiting		
				out of the facility. On 5/15/17,			
		ated 4/11/17 at 4:47 PM		worker (SW) requested Resid			
	•	for 4/10/17 at 5:30 PM,		RR/family for a care plan mee	-		
		DON) and Social Worker		held 5/17/17 to discuss. The	•		
		e to inform her that the		agreed, but did not attend the			
		upervised exit and that the		care plan meeting. On 5/18/1			
		et with her and the family to		Minimum Data Set (MDS) Nu	•		
		sparks unit. She stated that		the care guide for resident #3	-		
		and plan a meeting and she		Resident #3 is at risk for wan	•		
	would make sure the	e family was present."		written in all capital letters for recognition. On 5/18/17, Resi			
	The nurse's notes d	ated 4/14/17 at 1:59 PM		RR stated to the Director of N			
	The hurses holes u	atou mitmin at 1.00 mm	1	The stated to the Director of Iv	iai on ig	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			С	
		345293	B. WING _		0.6	5/09/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	103/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345			
						1	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From p	page 125	F3	23			
	revealed resident get out. Redirecting to ut. Redirecting to ut. Redirecting to the second of the second of the second of the second of the porch and the second of the se	"at front door yelling trying to ed to lunch with good results. loudly yelling for his wife and so dated 4/14/17 at 3:02 PM:05 PM, Resident #3 was still the facility. So dated 5/15/17 at 4:26 PM:0N was notified that resident was the building by a family member resident. The nurse asked the resident out but they did it dent made it out the door but and supervised by the nurse the so dated 5/16/17 at 4:40 PM the propelling self-up and down in yelling and screaming for him and that he needs a ride		(DON) that she would seek a placement due to RR/family of avoid secured dementia place is recommended by facility and residents attending physicians the Social Worker (SW) follows Resident #3 is RR/family about placement of Resident #3 to facility. On 6/7/17, the family made in regarding alternate facility placement about the resident to be moved to the resident to be moved to the resident to be moved to the place Resident #3 on 1:1 composervation while the resident bed. The residents RR agree the resident to the designated dementia care unit on 06/14/2 prevent further elopement oc	decision to ement which and the . On 6/7/17, wed-up with out another o decision acement for refuse for the secured tely 2:00pm, DON to the stant at is out of ed to move d locked 2017 to currences		
	him out so he car The nurse's notes revealed "wife no	repeatedly asking visitors to let in find a ride home." s dated 5/23/17 at 3:37 PM tifled that the resident has been		from the front door. The resignation on 1:1 supervision un adjusted to the room change provide for his psychosocial v	til he has and to vellbeing.		
		ing all day. The wife stated that e will not come back if he is cility."		Resident #3 last fall was 06/2 time, the resident was assess Director of Nursing and new after a medication review and	sed by the nterventions		
	revealed that the facility to vacate t	s dated 5/24/17 at 1:53 PM resident "attempts to leave he premises. Is cognitively not make good decision to om danger."		made by physician. The resic plan and care guide was upd 07/08/17 to include the fall pr interventions by the MDS nur	ated on evention se.		
		s dated 6/4/17 at 10:20 PM t sitting in wheelchair propelling		On 6/9/17, notification was see of alert and oriented resident of resident representatives vi	s and 100%		

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 _		0.0	C 5/09/2017	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	703/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCA	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From p	age 126	F3	23			
F 323	self about facility. didn't sleep last nig wandering about from the incident report occurred on 3/4/17. The daily staffing staffing sheets revassigned on the had on 3/4/17 and 5/14. A family member on 6/5/17 at 4:15 findicated that the times but the family remember the exastated that the factor other resident and services (EMS) had resident #3 was croom on 6/5/17 at observed attached. Interview with the conducted on 6/6/stated that she had wanderer and had	Third shift reports that resident ght, he has been up all night acility in his wheelchair." ts were reviewed. There was completed for the incidents that	F3	regarding Do not assist and the facility, if you are unsured is a resident please ask and by the business office made Monthly newsletter for Jurnarevised by the Activity Directivity and increased in font sometimes stress the importance of the aresident out of the build with a staff member. Also that doors close complete upon your exit so a reside follow you outside. Also the newsletter was revised to important message first. It will be mailed to all the aller residents and 100% of residents with exit seeking include wandering in and resident six months to resident with exit seeking include wandering in and resident of the facility to ensure interventions were put into prevention of actual elope	are if the person staff member mager. The me/July was ector on 6/11/17 size (26 font) to before assisting mg, you check a please be sure ly behind you ent is not able to be order of the address this the newsletter ent and oriented sident tivities Director se #1, MDS coordinator, and d 100% audit of otes and de resident #3 identify g behaviors to out of ering around the ments about the appropriate or place for the		
	refused to move h scheduled a meeti rescheduling or ca claimed that most occurred during th	im to the secured unit. She had ng with the family but they kept nceling the meeting. The SW of his wandering incidents		Interventions will be put in include 1:1 constant supe necessary immediately duthe Maintenance Director nurse #1, MDS nurse #2, Coordinator, and treatmen identified areas of concern	to place to rvision as uring the audit by and/or the MDS Admission□s nt nurse for any		

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 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			<i>y</i> 0, 2 0	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 323	NA #1 stated that Rewith locomotion using that the resident was in the morning and haround facility talking revealed that the resishe heard that he has the second shift but the incident. NA #1 NA on the hall. An interview with Nu 6/6/17 at 2:10 PM. Noworked second shift, heard and responder (didn't remember the family member had long the lock. She had to us facility to get help be return back to facility didn't know how long and how long the ala answered it. Nurse #1 had responded also and found the reside that a family member Nurse #1 stated that resident was outside indicated that she didn't remember she she didn't remember she	e 127 at 12:05 PM was conducted. esident #3 was independent g a wheelchair. She stated a always out of bed around 10 e propelled his wheelchair g to other residents. NA #1 ident was a wanderer and d wandered outside during she didn't know the date of stated that she was the only arse #1 was conducted on lurse #1 stated that she d to a front door alarm twice d dates). She indicated that a et Resident #3 out the door. Ember the exact time but it ling. She found the resident the highway (highway 177) in resident refused to come le her cell phone to call the cause the resident would not the nurse stated that she the resident was outside the resident was outside the resident was outside the resident was outside the resident would not the nurse stated that she the to another front door alarm to not he porch. She stated thad let the resident out. she didn't know how long the on the porch. She also dn't remember the dates and s. Nurse #1 also stated that if she was assigned to the Resident #3 was found	F3	Facility Consultants will complete audit of all residents to include progress notes and incident reg 3/1/17 to present for residents supervised and unsupervised ensure any resident that had efacility was not neglected (the enot have been prevented by stawas appropriately handled and appropriate interventions were place) and that an investigation completed to determine the root the supervised or unsupervised. There were 2 identified unsupe and appropriate interventions with place by DON. 100% of all residents were by the MDS nurses by 6/9/17 for accuracy. All inaccurate wands assessments were revised on the MDS nurses. A second auditory wandering assessments was con 6/11/17 and compared to the progress notes and behavior staccuracy and revised on secon 6/11/17 by the MDS nurses. The one wandering assessment was by the MDS nurses updated the recare plans, and care guides as appropriate for all residents ideat risk for wandering and to ensappropriate interventions were on the resident care plan and recare guide with oversight by the Consultant. A total of twenty-sizesidents were identified as at wandering.	resident ports from with actu- exits to exited the exit could aff, the exit could aff the exit could aff the exit completed are resident and time there was as updated by 6/12/esidents as updated as updated aff the exit could aff the exit could be address as updated as updated as updated aff the exit could be address as updated aff the exit could be address as updated as upda	t #3 m ual ed dexits in d x y d nt seed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C		
NAME OF D	ROVIDER OR SUPPLIER	343233		STREET ADDRESS, CITY, STATE, ZIP CODE	0	6/09/2017		
NAME OF PI	ROVIDER OR SUPPLIER							
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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 323	Continued From pag	ne 128	F 32	23				
	An interview with the was conducted on 6 stated that Resident times (didn't remember to move him family member to move him family member had relectronic nurse's no resident had exited the 3 wandering exident report dated there was no incident incidents on 3/4/17 a know how the reside She stated that she reminding visitors no	e Director of Nursing (DON) /6/17 at 2:50 PM. The DON #3 had went out the door 4 per the exact dates). She ad asked the resident's family in to the secured unit but the refused. She reviewed the otes and indicated that the he front door on 3/4/17, The DON indicated that out repisodes, she had only one 1 5/14/17. She indicated that hat report for the wandering and 4/10/17 and she didn't ent had exited the front door. Posted a sign on the door of to let any resident out, but e also stated that the resident		As of 06/15/2017, the MDS Nu RN facility consultant notified the care staff (nurses, nursing assist activity staff, social worker, dietadministrator and DON) A staff member was placed at the door 24 hours a day and 7 day monitor prevent unsupervised the facility. Beginning on 6/12/approximately 12 noon. An in-service was initiated by the RN-nurse consultants with all sinclude licensed nurses, nursing assistants, housekeeping staff, staff, dietary staff, activity staff, care aides, social worker, book payroll, maintenance staff, receand supply clerk on 6/12/17 regifront door will have a person to 24 hours a day. The monitor will	the front sa week to exits from 17 at the staff to g therapy geriatric exceptionist, garding the monitor it			
	3:40 PM. NA #2 was 3/4/17 and 4/10/17 of stated that she had I wanderer. She state his wheelchair arour she observed the result wheelchair to the frostated that she had I twice but she had no NA #2 stated that on last at the nurse's staremember the time. The only NA on the had no 6/6/17 at 4:46 PM that this was the time	nt door all the time. She neard him out of the facility ever witnessed him going out. 3/4/17, she saw the resident ation but she could not NA #2 revealed that she was		that no resident exits the facility unsupervised. At no time will the turn their back away from the fire The front door monitor must be view at all times. The front door cannot leave the monitoring stathere is relief. If the monitor is for violation of appropriately monitoring the front door at any time, retraining disciplinary action will be taken be a notebook kept at the monistation to identify residents that to exit the facility without super root cause analysis identified the lack of safety awareness with the supervision of impaired wander residents. Visitors and resident limited to entering and exiting the front door. As a precautionary in the facility without supervision of impaired wander residents.	ne monitor ront door. ront door. rin eyes r monitor ration until round in roring the g and ritoring t are unable vision. The ne visitor he ring s are hrough the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _				C 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE		н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489 AMLET, NC 28345	, 00,	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	family who gave her resident to the seculout she felt that the staff were monitorin door alarm immedia further stated that the (receptionist) in the who could monitor the Administrator stated complete an incident happened so the incomplete and immediate jeopardy Resident #3 and on Resident #3 and on Resident #3 was 7/7/16 with multiple fracture. The quarter assessment dated 3 Resident #3 had more and was independe unit. The assessme resident needed extransfer and was us	that she had met with the repermission to move the red unit if it was necessary resident was safe if only the g him and responding to the tely. The Administrator here was a staff member lobby until 9 PM every day	F3	323	other exit door alarms are being audite daily since they remain secured to validate they remain secured. An in-service was initiated by the RN-nurse consultant on 6/12/17 and who be completed by 6/16/17 with 100% of staff to include license nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatricare aides, social worker, bookkeeping payroll, maintenance staff, receptionist and supply clerk by the Administrator in Training (AIT), Facility Consultants, RN Nurse, and Director of Nursing regarding elopement supervision is a critical component to a safe nursing home facilt is every staff□ person's responsibility ensure that nursing home residents doenter into situations which may put themselves or others at risk of bodily harm. Residents who have full mobility but impaired mental function may be prime candidates for elopement, and the need to be carefully monitored by nursing home staff. ELOPMENT PREVENTION. The single greatest factor which can prevent elopement is proper training ar vigilance on the part of nursing home staff. Residents who suffer from mental.	ill all cc, , , , , , , , , , , , , , , , , ,	
	Resident #3's care part The falls care plan was reviewed on 3/2 was "risk for falls chrelated to: weakness"	nce admission or prior injury. plan for falls was reviewed. vas initiated on 8/9/16 and 28/17. The care plan problem aracterized by history of falls s, back surgery." The goal e free of falls through next			issues that increase their likelihood of elopement need to be more closely watched. Also a resident may wander more a certain time of the day and nee to be watched more closely at that particular time of the day. When elopement does take place, it is often a result of too little supervision. Exits whi are not intended to be operated by	1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
			A. BOILDI			، ا	
		345293	B. WING			1	09/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICHMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		н	IGHWAY 177 S BOX 1489		
KICHWICH	D FINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	transfer and mobility, encourage resident to promote exercise, promote exercise, promote exercise, promote exercise, promote exercise, promote exercise, promote easy reach, keep asson (wheelchair) within recall light within reach these approaches were 8/9/2016 and there were 6/9/17. Resident #3's incident The resident had 10. The report dated 10/resident was found to be and wheelchair. Slid off the bed. Immoresident was assessing to back to be and preach and be alarm. The report dated 11/that the resident was bathroom. There was immediate action take injuries and none not off floor and placed of the report dated 11/that resident was observed.	ched included "assist during bed in lowest position, or participate in activities that sysical activity for aproved mobility, fall risk conly used articles within sistive ambulation devise each of the resident and keep and answer timely." All of ere initiated/started on were no revisions as of a reports were reviewed. Falls in the last 6 months. 17/16 revealed that the nother floor on the side of his. The resident stated that he rediate action taken the red with no injuries and was placed the call bell within was attached. 11/16 at 2:17 PM revealed found on the floor in his is no injury noted. The en the resident was lifted.	F	323	nursing home residents should be either locked securely or equipped with alarm. In addition to keeping a close eye on residents, it is important for nursing hor staff to make sure that the alarms on exwork correctly. It is also the responsibil of nursing home staff to respond promp in the event that a door alarm goes off. Wandering can also trigger a series of injuries such as falls, bruises, and brok bones. Elopement could even be fatal is some cases, thus the importance of prevention. Facility staff needs to ensurt that all cases of elopement or potential elopement are reported immediately to the nurse. CODE ORANGE/PREVENTION OF ELOPMENT: Provide diversional activition residents with behaviors to include residents who attempt to exit the facility prevent actual unsupervised exits. If a resident is constantly exit seeking and/commenting on leaving the facility, diversional activities are to be provided such as snacks, activities of resident' to interest, family involvement, past life experience activities and/or socially appropriate interactions in a group setting the exit seeking behavior must be reported to the nurse immediately. It is nurse' resident to find out the cause of the exit seeking behavior and ensure appropriate seeking behavior and ensure appropriate.	ne exits sity of the core of t	
	action taken the resident injuries notes and resident wheelchair. Wheelch The report dated 12/	dent was assessed and no sident was placed back into air alarm in wheelchair. 7/116 at 9:01 PM revealed found on floor in front of			interventions are provided and docume in the medical records. It is also the responsibility of ALL nursing home staff respond promptly in the event that a doalarm goes off. If you observe a resider exiting the facility but cannot respond in	nt f to oor nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		00/03/2017	
				HIGHWAY 177 S BOX 1489	-,		
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page	ge 131	F 3	23			
	chair with small skir	tear to front of head.		timely manner then a	code orange must		
	Immediate action ta	ken was to "clean area on		be called. A code ora	_		
	forehead and apply dry dressing and did neuro check."			situation that indicate resident/resident elop summons medical aid	ement and		
	The report dated 12	2/19/16 at 10:07 PM revealed		using a room number			
	•	und lying on the floor in front		code orange is used t	•		
		dent stated that he slid out		summons help. The u			
the wheelchair. Immediate action taken resident			must be reported to the				
	was assessed with	no injuries noted.		immediately.			
	•	4/17 at 8:16 PM revealed that		An in-service was init	iated with 100% of		
		und on the floor beside the		license nurses on 6/1			
		hair. Immediate action taken		completed by 6/16/17			
	the resident was as	sessed with no injuries noted.		Consultants, RN Nurs			
	T	7/47 - 1 4 47 ANA		Nursing regarding NU			
		7/17 at 1:17 AM revealed that		RESPONSIBILITIES			
		on the floor beside the bed		OR UNSUPERVISED	EXIIS.		
		heelchair. The resident stated wheelchair. Immediate		Questionnaires were	initiated on 6/12/17		
		sident was assessment with		and will be completed			
		resident was assessment with		100% of all staff by th	•		
	no injunes and the i	coldent was put back to bed.		Training (AIT), Facility			
	The report dated 4/2	23/17 at 10:27 PM revealed		Nurse, and Director o			
	-	ly 10:20 PM, the alarm		validation of understa	_		
		sident was found sitting on the		elopement to include			
		stated that he slid off the bed.		Elopement? 2. If a res			
	Immediate action ta	ken the resident was		over the threshold wh			
	assessed and no in	juries noted.		a resident is trying to			
				constantly commenting	ng on leaving the		
	The report dated 4/2	29/17 at 8:06 PM revealed the		facility, what are some	e things that you can		
		on floor between his		do? 4. What code is ι			
		ionary chair. Immediate		and summons help fo			
		ident was assessed and no		resident/elopement. 5			
	injuries noted.			there be a monitor at			
				When should you rep			
		30/17 at 8:00 PM revealed		a resident has exit se	_		
	that the resident wa his wheelchair.	s found on the floor in front of		commenting on leavir actually exited the fac			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _	B. WING		C 06/09/2017		
NAME OF PROVIDER OR SUPPL	ER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				Н	IGHWAY 177 S BOX 1489			
RICHMOND PINES HEALTH	ICARE AND RE	HABILITATION CENTE		Н	AMLET, NC 28345			
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323 Continued Froi	n page 132		F 3	323				
room on 6/5/17 observed attack member was in Interview with the on 6/6/17 at 3:4 that she started She stated that the past and she the corporate of MDS training. They discussed morning meeting of Resident #3 had reviewed the for falls and state on the care play and the care play interview with the was conducted Nurse indicated March 2017. Siguidance or trailearning. She tool to monitor indicated that the incident reposhe didn't remember 1 the incident reposhe didn't remember 1 the member 1 the incident at 3:10 the member 2017 at	at 4:20 PM. A hed to his when the room with the MDS Nurse 40 PM. The M d as MDS Nurse the had receive consultant and The MDS Nurse the incident reng. She stated in approaches the Quality Assigned that there in approaches the Stated that there in approaches the Stated that ining regarding added that she stated that ining regarding added that she worts on their member what had the Administration of PM. The Arse and the Dorse	e #1 was conducted IDS Nurse stated se in March 2017. IDS experience in ad MDS training from not from the state se indicated that eports on their d that she was aware ls. The MDS Nurse electronic care plan were no revisions since 8/2016. Surance (QA) Nurse 2:40 PM. The QA ted as QA Nurse in a she had no g QA but she was a had no monitoring falls. She also ent heads) reviewed morning meeting but appened after that.			A 100% of the licensed nurses, nursing assistants and non-licensed staff will have their questionnaires reviewed by the RN-nurse consultant. The subject matter that is reviewed on the questionnaire was be reviewed by the RN-nurse consultant. Any identified licensed nurses, nursing assistants and non-licensed staff mem that are unable to pass the test will be retrained and retested. If upon the secondattempt the licensed nurses, nursing assistants and non-licensed staff mem is unable to successfully pass the significant change test will be removed from the schedule until remediation is provided. A 100% of the Nursing Assistants and non-nursing staff will be in serviced by RN Facility Consultant by 06/16/2017 of Observing and Reporting Change in Residents Condition. The nursing assistants and non-nursing staff will be tested on their knowledge of the subject matter of observing and reporting changes in resident is condition. Any nursing assistant or non-licensed staff is unable to pass the test will be retrain and retested. If upon the second attem the nursing assistant or non-licensed s is unable to successfully pass the significant change test will be removed from the schedule until remediation is provide. On 6/7/17, the regional vice president completed a 100% re-training for all department Managers (administrator,	ave er er er er ill nt. ber ond ber the on the ct that ned pt ttaff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER ID PINES HEALTHCARE	AND REHABILITATION CENTE	•	STREET ADDRESS, CIT HIGHWAY 177 S BOX HAMLET, NC 2834	1489	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFI TAG	(EACH CO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X COMPL DA DA		
F 323	Continued From pag	e 133	F	nurse, SW, marecords, accoureceivable, adidirector, dietar services direct regarding the Aunsupervised for all unsuper complete the Aunsupervised ensure supervexiting the built when the alarm thorough search the staff find the door. An in-service vertical and the staff find the door. An in-service vertical and the staff find the door. An in-service vertical and the staff find the door. An in-service vertical and the staff find the door. An in-service vertical and the staff find the door. Consultants are 6/16/17 regard Unsupervised ensure licenses responsibilities exit. On 6/13/1 checklist for licentary in the staff find the nurse of the staff find the door.	aintenance director, medunts payable, accounts missions director, activity manager, environment for, and therapy manage Action Check list for exits. Beginning on 6/7/1 vised exits, the facility watchion Checklist for Exit for Nursing Staff to rising the resident at risk lding and also what to do a sounds to make sure ach is done, to make sure ach is done, to make sure ach is done, to make sure resident if they exited was initiated with all licer 3/17 by the Facility and will be completed by ding the Action Checklist Exit for Nursing Staff to a nurses are aware of a during an unsupervised exit censes nurses was posted to a guide and quick reference a resident exits the station by the Facility and guide and quick reference a resident exits the station of the centered Resident #80 facing the matter of the station of the st	/ ral r) 7, ill of of the ase for l ad nce oom oom on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	(.	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017	
NAME OF D	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE		06/09/2017	
NAME OF FI	NOVIDER OR SUFFLIER						
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 PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE		
F 323	Continued From page	e 134	F3	wedged between the foot board mattress by lifting Resident #80 pulling the mattress out from un resident to make room to slide I #80 head out from the foot boar Resident # 80 was assessed by nurse with observation of a brui back of the neck, resident #80 or pain and discomfort. Vital signs obtained for resident #80 on 5/1 hall nurse with a blood pressure 126/68, pulse of 72, respirations temperature of 98.2. No change noted during the assessment by nurse in resident #80 level of consciousness, Pupils Equal Ro Reactive to light and Accommod able to move all extremities with baseline. The Medical Director notified by phone and message 5/1/17 at 4:50am by the hall nur Resident Representative (RR) vnotified by phone and informed by the hall nurse on 5/1/17 at 4:50am by the hall nurse on 5/1/17 at 4:50am by the hall nur Resident Representative (RR) vnotified by phone and informed by the hall nurse on 5/1/17 at 4:50am by the hall nurse	o body an oder the Resident rd. y the hall ise to the denied were 1/17 by the of s of 18 ares were y the hall ound and dation, hin was eleft on rse, was of incide 150am. A on reside 17, and e with no ded to cursing ector on of resider en the esident #8 perly fitting e. Resider ON on	ne nd dent dent dent dent dent dent dent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	06/09/2017	
(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)		
F 323	Continued From page	e 135	F3	Beginning on 6/10/17, the Registered Nurse Facility Consultants and Regional Vice President began to provide daily oversight to the facility to ensure that the facility used its resources effectively an efficiently to attain and maintain the highest practicable physical, mental, an psychosocial wellbeing of each resident and reviewed systems to include monitoring restraints and entrapment to ensure policies and procedures were being followed. On 6/13/17, the Regional Vice Presider reviewed the policy for restraints per the Nursing Policy Manual with the Administrator, Director of Nursing, and Quality Improvement Nurse (QI Nurse) include it is the policy of the facility that order to prevent possible injury or entrapment, the facility will provide an organized and systemic method for both positioning and bed measurements per FDA guidelines for hospital beds for the residents. By 6/16/17, the Regional Vice President reviewed the Quality Improvement System for restraints per Quality Improvement Manual with the Administrator, Director of Nursing and on urse to include the purpose in monitor residents with high potential for entrapment, to ensure that physical restraints are used only as prescribed to the Nursing Policy, that the resident has medical symptom which may require the use of a physical restraints are applied only with a physician of emergency), and that physical	ne dd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u></u> DE	1 00/03/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCAR	E AND REHABILITATION CENTE		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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		
F 323	Continued From page	ge 136	F3	restraints are reviewed on a restraints are reviewed on a restraints. The Administrator, Direst Nursing and Quality Improver are to ensure systems are initiational and maintained to it compliance with equipment of assessments of residents that risk for entrapment and docur initiation and updates to the replans, and to ensure that high entrapment residents are reviregular basis through the care process. The DON, Administr nurse will review the incident and ensure there is proper in and follow up to include have interventions been initiated, we documentation completed in records, was it necessary to recare plan, review of the chart the resident, collect witness as from employees, residents, on education and documentation related investigation document as copies of nursing or social notes, care plan revisions, refimalintenance work orders. 100% of all residents beds, to resident #80 was audited by the maintenance assistants on 6/2 ensure that there were no idea for entrapment zones, to incluent and the mattress end, entrapment between the rail supports or resingle support, entrapment between the rail and the mattress, entrapment and the mattress.	ector of ment Nurs itiated, include checks, at are high mentation, resident catherisk for riewed on a report form exestigation exappropria was require the medicarevise the t, review of statements or family, and other ntation such progress ferrals, or o include: the //13/17 to entified risk ude, foot board within example.	a QI m n ate ed al f s er ch	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2017	
DICUMON	D DINEC HEALTHOADE	AND DELIABILITATION CENTE		HIGHW	AY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLE	ET, NC 28345		
(X4) ID PREFIX TAG			ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	Continued From pag	e 137	F3	the bett ent and book madis ma	e rail, at the end of the rail, entrapment between the splint bed rails, and trapment between the end of the rail of the side edge of the head or foot ard. There were 2 mattress that the attress flaps were adjusted to correct tance between headboard and attress by the maintenance assistance 6/13/17. 20% of all resident were observed for dy positioning in bed by the Facility insultant on 6/13/17, for any potentials of or entrapment. There were no entified negative findings for body sitioning in bed during the audit. 20% of all residents, to include reside to a nurse progress notes and risk inagement reports from 3/1/17 to esent were reviewed by the corporate idents. The review was completed to 6/17, to ensure all identified resident h bruises and/or entrapment incident re assessed and provided appropriate decreations and the physician and esident representative were notified view, with voice to voice conversation message left for the physician, and propriate documentation is in the edical records. By 6/16/17, all identifications of concern will be addressed by the prorate consultant or DON with the edical records. The notifications will be comented in the electronic medical cord. The notifications will be comented in the electronic medical cord.	ne t ces al ent by sts sts ste ia n,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			06/) 09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, C HIGHWAY 177 S BO HAMLET, NC 283		1 00/	5572511	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 323	Continued From pag	e 138	F	each nurse visual guidelin nurse, for voi physician for entrapment a condition. On 6/13/17, a with all licens Consultants a Completion on Reporting Form event or incide consistent with treatment of a entrapment of damage, or with the nurse is form, the nurse	e corporate consultant at station on 6/13/17, as a ne for responsibility of the ce to voice notification to incidents, to include and changes in resident an in-service was initiated se nurses by the Facility and RN Nurse regarding of resident Incident/Event arm which is to occur where the expected care and a resident to include or that may cause loss, riolation of a residents incident and/or Director of Nursing incident requiring medical ary of unknown origin, abuse, neglect, or tion of property and is to occur. was initiated by the Facility of and/or Director of Nursing incident requiring medical ary of unknown origin, abuse, neglect, or tion of property and is to occur. was initiated by the Facility of all staff on Bed entrapment-an involving a resident who is the ded, or entangled in the beat includes the spaces in content of the property and in the property and includes the spaces in content of the property and includes the spaces in content of the property and includes the spaces in content of the property and includes the spaces in content of the property and includes the spaces in content of the property and includes the pade of the pade of the property and includes the pade of the property and includes the pade of the pade of the property and includes the pade of the property and includes the pade of the pade of the property and includes the pade of the pade of the property and includes the pade of the pade of the property and includes the pade of the pa	the n an ght. g ity d by ed or ed risk k,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			С	
NAME OF B	20,4252.02.0122.152	343293	D. WING_			06/09/2017	
NAME OF P	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 BY 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 323	Continued From page	e 139	F3	Residents who are frail or elderly who have conditions such as ag delirium, confusion, pain, uncombody movement, hypoxia, fecal and acute urinary retention that them to move about the bed or the from the bed. The absence of: ti toileting, position change, and frindividualized care are factors the also contribute to the risk of entromage of the risk may also increase due technical issues to include, improving sized mattresses or broken equing these technical issues must be to the nurse and maintenance downward immediately and work order must completed per policy. Intervention to do to ensure that the mattree bed if unsure notify the Maintena Director and nurse immediately the mattress. If a resident is not have a body part, to include the head/neck, entrapped in any past bed system, to include the foot to immediately call for assistance at the entangled body part out of a Assess the resident for injuries, speak with the attending physici on-call physician, to notify of who occurred and your assessment. any orders if given. Call the Resemptive (RR) and notify the what occurred and that the atterphysician was notified and any or recommendation that was given Document ALL in the residents of Make sure that an incident report completed along with witness stafform all staff involved. Administ	itation, trolled impaction, cause try to exit imely requent nat may rapment. to roperly ipment. reported irector st be cons/What ease to assess ted to rt of the coard, and ease rea. CALL and ian, or the lat Initiate sidents them of ending orders or chart. rt is atements		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION S	. ,	TE SURVEY MPLETED
		345293	B. WING			C 6/09/2017
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 140	F 32	need to be notified. Prevention president' so body position is unsubed at any time due to space be mattress and bed or any other rourse must be notified immedianurse must find out the root cause of the change) of why the is in that position and provide apinterventions to ensure the resident to the bathroom, maintowork slips, wedges, new bed an mattress, transfer out of the bed resident' schoice. Take the beservice if broken or unrepairable Questionnaires were initiated or and will be completed by 6/16/1 100% of all staff to include licen nursing assistants, housekeepin therapy staff, dietary staff, activity geriatric care aides, social work keeping, pay roll, maintenance receptionist, and supply clerk by Administrator in Training (AIT), Consultants, RN Nurse, and Dir Nursing for validation of understregarding entrapment to include do you do if you find broken or fequipment? 2. What is entrapmed Can a bed cause entrapment? 4 you do if you suspect or observe entrapment? 5. Who is at risk for entrapment? 6. What are some can contribute to entrapment? 7 entrapment? 7 entrapment occurs, what can you ensure the resident' safety? 8 needs to be notified immediately resident is unsafe in bed due to	safe in the etween the reason, the stely. The use (the etween the propriate dent propriate dent that is a considered out of etween the stellar of the staff, stern that is a considered out of the staff, stern that is a considered out of the staff, stern that is a considered out of the staff, stern that is a considered out of the staff, stern that is a considered out of the staff, stern that is a considered out of the staff that is a considered out	

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		0,	C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0-10200	1	STREET ADDRESS, CITY, STATE, ZIP CODE	00	6/09/2017	
TO WILL OF T	NOVIDER OR COLL FIELD			HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345			
	CLIMANA DV C	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	0/5)	
PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	Continued From pag	ne 141	F 32	3			
		,		between that mattress and bed?			
				In-servicing of 100% of all licensed was initiated on 6/12/17 by the DON completed by 6/16/17 regarding: Notification of Physician for Change Resident' S Condition. Notify Physi (speak with the physician) by teleph Acute Change in Resident Condition occur, Changes in Cognitive Status Changes in Behavior occur, Change Oral Intake to include fluids occur, Changes in Immune System occur, Changes in Normal Body Functionin occur, PANIC laboratory values occur, PANIC laboratory values occur, Panic Include, bruises of unknown origin, entrapment, elopement, and initiation restraints. If you are unable to reach Attending Physician, you may call the On-call for physician. If you are unareach attending or on-call physician may call the facility' S Medical Dire Notification of the physician of these of changes in a resident' condition fax or leaving a message is not acceptable! Documentation of the	I and Is in cian cian cian cone: on coccur, es in Ing ur, seed ents to on of n ne ble to n, you ctor. e types n by		
				notification of the attending physicia be documented in the residents cha license nurse will be allowed to wor	rt. No		
				receiving the in-service on Notificati	on of		
				Physician for Changes in Resident'			
				Condition and Documentation of the			
				notification of the attending physicia			
				be documented in the residents cha	rt. If		
				unable to reach, voice to voice, the			
				attending physician, the on-call or the			
	1		1	medical director, the DON MUST be	<u>.</u>	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			06/) 09/2017
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			30/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE
F 323	Continued From page	ge 142	F	notified for further into The licensed nurse is assess, document, printerventions and not Physician and Resid any acute changes in bruises of unknown and/or any other signiformation, noted. It is unable to reach the on-call Medical Examples and the Medical reach, voice to voice physician, the on-call director, the DON Milicensed nurse will in interventions based a resident and notify A and RR. On 6/10/17, the region corporate clinical directors and the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility has systems in an environment as from the facility and monit facility and monit facility has systems in an environment as from the facility and monit facility	s responsible to provide appropriate tify Attending ent Representative in condition, to incluorigin, entrapment, nificant clinical of the licensed nurse attending physici Director must be contact the attending all Director, the nurse of Director of the attending Physician on the needs of the attending Physician on the needs of the attending oversight toring to ensure the providing oversight to provide the adequate reside attending bed de adequate reside attending to prevent unsupervised exits or the progress notes or progress notes or progress notes.	e of ude e an, g se to ne e to e de ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	343233	I B. Wille	STREET ADDRESS, CITY, STATE, ZIP CODE	06/09/2017	
				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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 323	Continued From page	e 143	F3	electronic medical record for injuries of unknown origin, fall, entrapment and elopement. These audits revealed two elopements by resident #3 that have to investigated, reported and revised intervention implemented by the Administrator, DON, RVP, licensed nurses, nursing assistants. The audit ensure all interventions are in place to prevent cognitively impaired, wandering residents from unsupervised exit/elopement, to protect residents with fall, and bed entrapment. Any concertare immediately addressed by the audit is documented on the Accident Hazards/Supervision Audit Tool, which covers: 1) if the progress notes were reviewed for incidents/accidents, 2) if risk management/incident reports were reviewed for appropriate interventions if the 24 hour reports were reviewed in daily clinical meeting, 4) if the maintenance work orders were completed. The audit tool will be completed weekly x 3 months, then monthly x 3 months. The maintenance director will complete monthly preventative maintenance checklist and safety audit checklist to audit the beds for entrapment hazards wheel chairs, Geri chairs and other medical equipment for deficit or non-working issues. All identified area safety or non-working equipment will the safety audit ment will the safety or non-working equipment will the safe	is to ig no ns litor or ne the e a the e s s s s s s	

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		
		345293	B. WING _				09/ 2017
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017
			HIGHWAY 177 S BOX 1489				
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 144	F3	rem rep On vice director as i four sup The ass According revi 6 m cau rector the Ass The Confaction rector will as i	noved from service until repaired or laced. 6/26/17, the administrator, regional expresident, and/or corporate clinical extor will begin a weekly review of the inpleted Accident Hazards/Supervision to to ensure the systems for a experiment, proper application of vices, and supervision for resident ety remain in place and are function perly. The review will be completed indicated by initialing the audit tool, in weeks to ensure adequate pervision and oversight. Experiment Quality provement the findings of the cident Hazards/Supervision Audit Towentative maintenance, and safety dit tool at the monthly Quality provement Committee meeting. The ality Improvement Committee will liew the results of the audits monthly inonths, identify trends, use 5 Whysis and make commendation for follow-up as need a QI nurse and/or maintenance will sent the findings of the Care Planniticipation and Revision Audit Tool at quarterly Quality Assessment and surance (QAA) Committee meeting. The QAA Committee will review the QI mmittee recommendations and lity' sollow-up to the ommendations. The QAA Committee meeting. The QAA Committee meeting and the perform additional root cause analymeeded, make additional ommendations, and provide oversigneeded, make additional ommendations, and provide oversigneeded.	I ne oon fing I, for e ool, e x root ed. ng t	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		2.45202	B. WING			l	0
		345293	B. WING_			06/	09/2017
	OVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		н	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 323	Continued From page	: 145	F	323	The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed throu further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of Free of Accid Hazards/Supervision/Devices.	d gh o	
F 329 SS=E			F:	329			7/25/17
	483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used						
	(1) In excessive dose therapy); or	(including duplicate drug					
	(2) For excessive dura	ation; or					
	(3) Without adequate	monitoring; or					
	(4) Without adequate	indications for its use; or					
		adverse consequences se should be reduced or					
		of the reasons stated in bugh (5) of this section.					
	resident, the facility m	ensive assessment of a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	00/03/2017		
(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)			
F 329	medication is necess condition as diagnose clinical record; (2) Residents who us gradual dose reduction interventions, unless	nese drugs unless the ary to treat a specific ed and documented in the e psychotropic drugs receive ons, and behavioral clinically contraindicated, in	F 329				
	interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, Nurse Practitioner interview, pharmacist interivew, physician interview and record review the facility failed to administer a diuretic medication as prescribed and to obtain weights for the purpose of diuretic dose titration for 1 of 6 residents (Resident #135), failed to administer antidepressants as ordered for 1 of 6 residents (Resident #74) and to complete the Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 6 Residents (Resident #76), and failed to obtain a blood pressure as ordered for medication monitoring for 1 of 6 residents reviewed for unnecessary medications (Resident #91). The findings included: Resident #135 was admitted on 4/3/17 and readmitted on 4/13/17 with diagnoses including chronic kidney disease, pneumonia, atrial fibrillation and heart failure. Review of the Physician 's Orders dated 4/13/17 revealed an order for Lasix/Furosemide (a			F 329 Free from Unnecessary drugs On 5/13/17, Resident #135 was discharged from the facility. On 5/17/17, the director of nursing (DC obtained a clarification order for Reside #74□s Cymbalta. The clarification orde was to discontinue previous Cymbalta orders and to decrease Cymbalta to 60 daily. On 6/7/17, the DON completed a Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment for Resident #76. The results of the DISCUS assessment indicated Resident #76 has no involunt movements for a person on antipsycho medication. Resident #76 has had no changes in the antipsychotic medicatio Risperdal 2mg since 4/20/17. On 6/7/17, 6/13/17, 7/5/17, and 7/6/17.	ent er erg ary tic		
	excreted from the boo	ases the amount of fluid dy) 20 mg (milligrams) by ninistration time of day er was 8:00 AM.		On 6/7/17, 6/13/17, 7/5/17, and 7/6/17, the nurse and/or the nursing assistant obtained Resident #91□s blood pressureading. On 6/13/17, the nurse			

` '		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION FUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E. ZIP CODE	1 00/0	J/2011	
				HIGHWAY 177 S BOX 1489	,			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRI FICIENCY)		(X5) COMPLETION DATE	
F 329	Review of the Medic (MAR) from 4/13/17 Lasix 20 mg was sig 15th through the 24th medication was not swas not determined. A 4/24/17 order writter revealed "daily weigh (every) 3 days & (an Further review of the 4/24/17 through 4/30 order to clarify the titter Review of the MAR for revealed a hand writer 7 days starting on 4/0f 203 pounds writter 4/25/7 but there were 4/26/17 through 4/30 Medical Record revealed a hand writer 4/26/17 through 4/30 Medical Record revealed a hand writer 4/26/17 through 4/30 Medical Record revealed a hand writer 4/30/17 and was signer and wa		F 3	DEI	Resident #91, not in a consult audit niatric consult audit niatric consults had on 6/29/17, the tof residents for a con the provider on the provider at 100 lers to ensure weights are noted cation administrative physician order noted correctly and blood taken, and DISCUS ording to DISCUS The audit revealed essures were not the physician and	ottor d is ON), ones		
	dosage titrated based on the resident 's weight. Further review of the Physician 's Orders from 4/30/17 through the resident 's discharge on 5/13/17 revealed that an original order to clarify the titration dosage was not present. Review of the Physician 's Orders summary from 5/1/17 through 5/31/17 revealed the following typewritten order "Lasix 20 mg Furosemide Tab (tablet) 20 mg 1 by mouth daily for wt (weight) gain of more than 2 lbs (pounds) in a day; or more than 5 lbs in a week, double dose for 2			completed according assessment policy fo As of 6/30/17, the DC improvement (QI) nur were no residents who dosage adjusted bas weight. Beginning 6/29/17, the consultant in-serviced registered nurses (RI practical nurses (LPN antipsychotic drug the	r several resident DN and quality rse determined the no have medicationed on the resident me corporate facility of the DON, Ns), and licensed Ns) on: 1)	ere n t□'s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			(
NAME OF B	201/1050 00 01/1001/150	343233	B: Willo _			06/	09/2017	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 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 PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 329	from 5/1/17 through 8 "Lasix 20 mg Furoser daily for wt gain of momore than 5 lbs in a vidays". Further review of the a hand written entry for Weights for the reside allotted space for 5/2. Were no weights after pounds showed a weight showed a weight showed as weight showed as follows: 5/4/17. No other weight more was documented recorded as follows: 5/2 - 200 5/3 - 198 5/4 - 200 5/5 - 199 5/6 - 199 5/7 - 200 5/8 - 200 On 6/8/17 at 3:15 PM (DON) was interviewed noted orders and MA stated that the original Lasix should have be dosage instructions. order appeared to ha point before 5/1/17 be instructions were in that this time. She did	of MAR revealed the off as given daily at 8:00 AM 6/12/17: mide Tab 20 mg 1 by mouth ore than 2 lbs in a day; or week, double dose for 2 MAR for May 2017 revealed or daily weights for 7 days. ent were documented in the /17 through 5/8/17. There is 5/8/17. The weights in light gain of 2 pounds on ght gain of two pounds or ed. The weights were If the Director of Nursing ed and reviewed the above R documentation. She all order for titration of the en clarified for specific She acknowledged that the we been clarified at some ecause specific dosage ne order summary and MAR not know why that	F3	329	(Dyskinesia Identification System Condensed User Scale) assessment, 2 physician orders requiring appointment 3) pneumococcal vaccination. On 6/30/17, the DON, corporate clinical director, and regional vice president (RVP) met with the clinical director of pharmacy services to review the outcor of the pharmacy consultants 6/29/17-6/30/17 audit findings, discuss recommendations, and identify a root cause. It was determined communicat is a root cause of several issues related drug regimen being free from unnecessary drugs. On 6/30/17, the corporate clinical direct worked with the DON, quality improvement (QI) nurse, and minimum data set (MDS) nurses to perform a root cause analysis (RCA) of why the physician orders were not clarified, why weights were not recorded on the MAR and why medication was not administe as ordered. The RCS determined communication was the root cause of the problem. On 6/30/17, the DON re-established the weekly weight meeting to ensure weigh are being obtained as ordered by the physician and documented in the electronic health record. On 7/13/14 the weekly weight committee reviewed residents no longer met the criteria for weekly weights and identified those resident requiring continued weekly	s, I me fon d to tor red he e al		
	at this time. She did					a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
			D MINIO					
		345293	B. WING _			06/	09/2017	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DICHMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		Н	IGHWAY 177 S BOX 1489			
KICHIVION	D FINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
F 329	Continued From page	e 149	F:	329				
	medical record. How	ever she indicated that the			physician order for weekly weights are			
	way the order was written in the MAR was like a				being weighed weekly as ordered by th	е		
	"whole protocol" used	d in the hospital. She			physician. On 7/17/17 through 7/21/17	,		
	indicated the 2 pound	d weight gain administration			the DON, pharmacy consultant, MDS			
		veight gain should have had			nurses, admissions nurse, and quality			
	- ·	cumenting administration if			improvement nurse will complete a			
	given. She acknowle	edged it was confusing			DISCUS audit to ensure all resident			
	looking and in additio	n appeared that the			DISCUS are updated according to the			
	medication had been	given without weights and/			DISCUS assessment policy. Any resid	ent		
	or without weight gair	n. The DON also			requiring an updated DISCUS			
	acknowledged that th	ere was no discontinuation			assessment will be assessed by the D0	ON,		
	order for the Lasix 20	mg daily order written			MDS nurse, admissions nurse, or quali	ty		
	4/13/17, although it w	as no longer on the MAR			improvement nurse no later than 7/21/1	17		
	after 4/30/17. She inc	dicated that although the	and the physician notified of any changes			es		
	resident received the	Lasix that was for weight	in a resident□'s DISCUS assessment.					
	gain, even when she	did not have weight gain,						
	the outcome was a co	ontinued dose as if she was			On 7/14/17, the DON, QI nurse, and			
	on the Lasix 20mg for	r her entire stay and			corporate consultants initiated an			
	therefore there was n	no negative outcome for the			in-service for all nurses and medication	IS		
	resident.				aides. The in-service is a communicati	on		
					focused in-service, interactive using the	9		
	On 6/8/17 at 4:28 PM	1 a telephone interview was			MARs and pharmacy recommendations	S,		
		urse Practitioner. She			to further educate and explain the			
	recalled Resident #13	35 and recalled writing a			importance of documenting weights,			
		24/17 Lasix titration order.			documenting blood pressures, and			
		sed the titration specifying			performing DISCUS assessments in ar			
		on what the resident had			effort to maintain drug regimens free fro			
		hospital. The NP thought			unnecessary drugs. By 7/25/17, the Do			
		duled order for Lasix 20 mg			QI nurse, and/or corporate consultants			
	•	going and that the additional			present this in-service to all facility and			
		given for weight gain. Since			agency nurses and medication aides,			
	the resident 's weight remained stable she did				including all newly hired nurses and			
		nad a negative outcome			medication aides. After 7/25/17, no nu			
	however she acknowledged daily weights should				or medication aide will be allowed to we	ork		
		omply with an order based			until completing the in-service.			
	on daily weight.							
					The DON and/or QI nurse will use the			
		I a telephone interview was			Unnecessary Drugs Audit tool to compl			
	conducted with Nurse	e #6. She indicated that she			a 100% review of pink slips in the clinic	al		

	F DEFICIENCIES CORRECTION	IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING	_			0	
NAME OF DE	ROVIDER OR SUPPLIER	345293	B. WING _		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	09/2017	
		AND REHABILITATION CENTE		Н	IGHWAY 177 S BOX 1489 AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 329	Resident #135 's hal She acknowledged so resident her morning recall the dates. She giving any medication based on weights. We titrate Lasix based on that an order like that because were not ab without specifications read to her: "Lasix 2011 by mouth daily for wear a day; or more than 50 for 2 days" she indicated she did not know the said the resident done every morning the medication should be informed that the wei were listed on a separathe Lasix was on she under the Lasix would and work better. Last there should have be whether the original of supposed to be discott. 2. Resident #74 was 5/10/16 with multiple depressive disorder. The plan of care for Focus area of psychological.	hift (7:00 AM - 3:00 PM) on I and did recall the resident. he would have given the Lasix but she could not a stated she did not recall in that was supposed to be When the 4/24/17 order to a weights Nurse #6 indicated a would require clarification le to decide on dosage at When the following was a mg Furosemide Tab 20 mg wit gain of more than 2 lbs in a blbs in a week, double dose ated that she thought it was II required clarification. She low why she had not noticed a sweights should have been before determining if the a given. When she was ghts that were completed urate page of the MAR than said having the weights did draw more attention to it thy she acknowledged that en a clarification regarding daily scheduled Lasix was	F	329	meetings 5 times weekly on an ongoing basis. Also, the DON and/or QI nurse audit for any missing weights that should be recorded on the MAR at the weekly weight meeting for 8 weeks then every-other-week for 4 weeks to ensure residents are not given unnecessary drugs. The DON and/or QI nurse will complete the pharmacy recommendation and DISCUS assessment audits month on an ongoing basis to ensure resident have drug regimens free from unnecessary drugs. The results of the audits will be present by the DON and/or QI nurse at the monthly QI Committee meeting x 3 months for further review and recommendations. The results of the audits will be presented by the DON and/or QI nurse at the quarterly quality assessment and assurance (QAA) Committee meeting for 1 quarter for review of trends, root cause analysis, a any additional recommendations to sustain compliance in the area of maintaining a drug regimen free of unnecessary drugs.	will Id e ons nly s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	E	33/33/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 329	Cymbalta (antidepre milligrams (mg) once #74. A physician's order of Cymbalta 60mg once Resident #74. The April 2017 physi #74 indicated Cymbalta 30mg of The annual Minimum assessment dated 4 #74's cognition was received antidepress MDS review period. A review of the April Administration Recoindicated he receive in the morning and of night and as ordered.	dated 2/28/17 indicated ssant medication) 30 e daily at night for Resident dated 3/28/17 indicated e daily in the morning for dician's orders for Resident alta 60mg once daily in the once daily at night. In Data Set (MDS) //24/17 indicated Resident intact. Resident #74 sant medication during the 2017 Medication rd (MAR) for Resident #74 d Cymbalta 60mg once daily cymbalta 30mg once daily at 100 ce daily at 100	F3	329				
	indicated he receive in the morning as or MAR revealed Resid Cymbalta 60mg onc administrations rathe ordered. A physician's order of decrease in Cymbalta Resident #74.	d Cymbalta 60mg once daily dered by the physician. This lent #74 had also received e daily in the evening on 13 er than the 30mg that was dated 5/17/17 indicated a ta to 60mg once daily for higher with the Director of /8/17 at 2:35 PM. The						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 06/09/2017		
	ROVIDER OR SUPPLIER D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00/03/2017		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 329	with the May 2017 reviewed with the Da handwritten trans MAR for the night til Resident #74. She have received 30m than 60mg once daily the night physician's order the 60mg once daily. Set determine who had The DON revealed one evening in May when she reviewed reported she had coobtained a clarificat DON confirmed Regreater dose of Cyr 13 administrations. expectation for medordered. A phone interview with the May 2017 reviewed with the padministrations of Codose was given that #74 was reviewed with the was uninformed. He indicated the set of the control	MAR for Resident #74 were MAR for Resident #74 should gonce daily at night (rather ily at night) along with the 60 norning until the 5/17/17 at decreased the Cymbalta to She stated she was unable to made the transcription error. she was working on the floor and she identified the error Resident #74's MAR. She matched the physician and cion order on 5/17/17. The sident #74 had received a mbalta than he was ordered on She indicated it was her dications to be administered as was conducted with Resident 6/8/17 at 2:56 PM. The for Cymbalta that coincided MAR for Resident #74 were	F 32	9			
		s admitted to the facility on diagnoses that included					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 329	with psychotic feature behavioral disturbantal A physician's order of Risperdal (antipsychology) once daily at nit An Abnormal Involutional Involuti	corder, single episode, severe les and dementia with ce. Idated 8/10/16 indicated otic medication) 3 milligrams ght for Resident #76. Intary Movement Scale an assessment utilized to movements for persons on ation) was completed on #76 with a score of 0 (no ints identified). Inum Data Set (MDS) I/17/16 indicated Resident organitive impairment. He was a level II for Serious Mental ent #76 received ation during the MDS review Assessment (CAA) related to tions for the 8/16/16 MDS d antipsychotic medication Idated 4/6/17 indicated a all to 2.5mg (from 3mg) once	F3	329	JENCY)		
	decrease in Risperd daily at night for Res The quarterly MDS a	assessment dated 5/4/17					
		76's cognition was intact. ed antipsychotic medication					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		345293	B. WING				C 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGH	EET ADDRESS, CITY, STATE, ZIP CODE HWAY 177 S BOX 1489 MLET, NC 28345	1 00/	03/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	during the MDS reviee The plan of care for F Resident #76 had a previewed on 5/5/17, varea of psychotropic A review of the medican AIMS assessment Resident #76 since 8 An observation was con 6/5/17 at 12:25 Ph movements noted. An interview was con Nursing (DON) on 6/5 indicated her expectant assessment to be continuously and with an antipsychotic medicant quarterly, and with an antipsychotic medicant Admissions Nurse was completing the AIMS the charge nurse was the AIMS assessment physician's order chant antipsychotic medicant completed that order completing the AIMS revealed she was aw problem with the time assessments. She in of this problem since reported she had a min February 2017 and that was discussed.	Resident #76 was reviewed. Dan of care, most recently which indicated the focus drugs. Dal record on 6/6/17 revealed thad not been conducted for //11/16. Conducted of Resident #76 which in involuntary ducted with the Director of 7/17 at 8:58 AM. She atton was for an AIMS inducted for all residents on tions upon admission, my dosage change of the tion. She stated the as responsible for assessment on admission, is responsible for completing the quarterly, and if a inged the dosage of an tion the nurse who was responsible for assessment. The DON are the facility had a ely completion of AIMS indicated she had been aware February 2017. The DON intention was one of the areas She revealed the timeliness is had not improved since the	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09	9/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 329	at 9:03 AM. The AIM for Resident #76 was The medical record was The medical record was assessments or Resident #76 was resisted this was not a indicated Resident #76 assessment complete revealed the pharmacian assessment for Resident #76 pharmacian this pharmacy request A phone interview was pharmacist on 6/7/17 expectation was for a completed for all resimedications on administervals thereafter. Hexpected an AIMS as an antipsychotic medicated he reviews. The AIMS and Resident #76 was reviews. The AIMS and Resident #76 was reviews. The medical record was AIMS assessments or Resident #76 was reviews. The revealed he had resident #76 was reviews. The reviews. He in the request following his 2/24/17 4/28/17 review. He in the request following his May 2017 review. assessment had not followed the second place of the reviews.	e DON continued on 6/7/17 S assessment dated 8/11/16 reviewed with the DON. rhich contained no additional completed after 8/11/16 for riewed with the DON. She surprise to her. She 6 should have had an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16. She resist had requested an AIMS red since 8/11/16 for resist had not been completed. The sessment to be red since 10 miles had been sessment to be red since 10 miles had been sessment to be red since 10 miles had been sessments red since 10 miles had been sessments red since 10 miles had been sessments red since 10 miles had been sessment to be conducted if red since 10 miles had been sessments red since 10 miles had been sessments red since 10 miles had been sessments red since 10 miles had been sessment red since 10 miles had been sessme	F3	329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING_			C 6/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/03/2017	
(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)	I SHOULD BE	(X5) COMPLETION DATE	
F 329	An interview was con Practitioner on 6/8/17 she expected the AIN completed for all resi	ducted with the Nurse ' at 7:54 AM. She stated	F3	329			
	12/1/16. Cumulative hypertension. A Quarterly Minimum indicated Resident #8 in cognition. Diagnos A physician order dat blood pressure (BP) (hypertensive medical physician order for an mouth daily. A review of the March 2017 Medication Adn revealed no documen recorded. A review of vital signs medical record reveal documented on 4/9/1 A review of the nursing documentation of blo March 2017 through. On 6/8/17 at 7:54 AM	Data Set dated 3/4/17 21 was moderately impaired ses included hypertension. ed 3/9/17 stated to monitor weekly for amlodipine use ation). Resident #91 had a mlodipine 10 milligrams by a 2017, April 2017 and May ministration Record (MAR) matation of blood pressures a recorded in the computer led one blood pressure 7 of 102/84. and notes revealed no od pressures recorded from June 9, 2017. It, an interview was urse Practitioner. She					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE	H	TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 177 S BOX 1489 IAMLET, NC 28345	1 00/03/2017	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 329			F 329			
F 332 SS=D	orders, obtain the blo	ood pressure as ordered and on the MAR. F MEDICATION ERROR	F 332		7/25/17	
	that its- (1) Medication error greater; This REQUIREMEN' by: Based on record revinterview, the facility medication error rate following doctor's orgastrostomy (G) tube medications. There opportunities for error rate. This was evide observed during the #74 & Resident # 49 Findings including: 1a. Resident #74 has 5/30/17 for Lasix (a composite by mouth daily for Hy On 6/7/17 at 8:00 AM during the medication	were 4 errors of 25 r resulting in a 16% error nt for 2 of 4 residents medication pass (Resident). d a doctor's order dated diuretic) 20 milligrams (mgs)		F 332 Free of Medication Error Rates 5% or More On 6/7/17, Resident #74'□s Lasix 20 r was discontinued by the physician ord On 6/7/17, Resident #74'□s potassium chloride 20 meq by mouth on Monday, Wednesday, and Friday was discontin On 6/7/17, the physician gave a new of for Resident #74 to continue on potass chloride 40 meq by mouth every day. 6/7/17, the director of nursing (DON) updated Resident #74□'s medication administration record (MAR) to reflect new orders. On 6/24/17, Resident #49 physician order noted to flush gastrost tube with 15 ml of water between each medication. The order for Resident #44 was transcribed and placed on the MA On 6/24/17, Resident #49 □'s MAR wa	ng er. ued. urder sium On the '□s omy I	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			l	C 5/ 09/2017
NAME OF P	ROVIDER OR SUPPLIER		I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	70372017
5101111011				н	IGHWAY 177 S BOX 1489		
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			H	AMLET, NC 28345			
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 332	Continued From page	e 158	E 4	332			
. 002	Continued From page	2 100	1	552	grams, mix in 9 ounges of liquid		
	On 6/7/17 at 8:30 AM	1, Nurse #7 was interviewed.			grams, mix in 8 ounces of liquid.		
		nat she had administered			On 6/28/17 through 6/29/17, the corpo	rate	
) mgs to Resident #74. She			consultants completed a 100% audit o		
		know that the order for the			comparison of resident MARs compare		
	Lasix was changed to	o 20 mgs.			to current physician orders. The audit		
					was to ensure physician orders are be		
		1, the Director of Nursing		transcribed correctly regarding medica	tion		
	(DON) was interviewed. The DON stated that she expected the nurses to administer				administration and medication specific		
					instructions (mixing with correct amoun	nts	
	medications as order	ea.			of water and flushing the gastrostomy tube with 15 ml of water after each		
	h Pesident #74 had	a doctor's order dated			medication is administered). The audi		
		n Chloride (Potassium			identified transcription errors and	.5	
		equivalents (meq) by mouth			variances from the physician orders ar	d	
	daily and 20 meg by	· · · · · · · · · · · · · · · · · · ·			MAR□s. By 7/11/17, the quality		
	Wednesday and Frid	•			improvement (QI) nurse, DON, and		
	-				corporate consultants obtained any		
		17 at 8:00 AM, Nurse #7 was			needed clarification orders, corrected		
	_	medication pass. She was			inaccurate MARs with the appropriate		
		and to administer Resident			medication and dosage, and complete	b	
	#74's medications inc Potassium Chloride 2				medication error reports.		
		·			On 6/29/17 through 7/17/17, the QI nu	rse,	
		1, Nurse #7 was interviewed.			DON, and corporate consultants will		
		nat she had administered			in-service 100% of all registered nurse		
		um Chloride 20 meq to			(RNs), licensed practical nurses (LPNs	5)	
		dded that she didn't know			and medication aides regarding the 6		
		er order to give Potassium			rights of medication administration,		
	Monday, Wednesday	ddition to the 20 meq on			reading the MAR, accurately administering the medication per the		
	ivioriuay, vveuriesuay	and Filday.			physician order, medications with spec	ific	
	On 6/8/17 at 2:15 PM	1, the Director of Nursing			instructions, mixing medications with the		
		ed. The DON stated that			correct amount of water and flushing the		
	she expected the nur				gastrostomy tube with 15 ml of water a		
	medications as order				each medication is administered.		
					On 6/16/17, the RN pharmacy consulta	ant	
	2 a. Resident #49 wa	as readmitted to the facility			in-serviced the DON and QI Nurse on		

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 09/2017
NAME OF PE	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	09/2017
TO THE OT THE	TO VIDER OR OUT FEEL				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HAMLET, NC 28345		
()(1) ID	QUIMMADV CT	FATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	Continued From page	e 159	F3	332			
	3/8/17 with a diagnos	sis of cerebrovascular			correctly performing a medication pass	j.	
	accident and aphasia	a. An Annual Minimum Data			The DON and QI nurse were able to pa	ass	
	Set dated 5/16/17 inc	dicated Resident #49 was			a medication pass audit with less than	а	
		decision-making. He			5% medication pass error rate.		
		ssistance with eating.					
	Cumulative diagnose				On 6/29/17 through 7/25/17, a 100 %		
	· ·	cident) with hemiplegia			observation of RNs, LPNs, and		
		d gastrostomy (GT-a feeding			medication aides for medication		
	tube inserted into the	abdominai area).			administration will be conducted by the	i.	
	A review of physician	orders revealed the			DON, QI nurse, facility consultant, or pharmacy consultant utilizing the		
		s were to be administered at			Medication Pass Audit Tool to ensure a	ıll	
	_	wable 81 milligrams via GT,			medications are being administered pe		
	•	tive) 17 grams and mix in 8			the physician orders and medication	•	
		give via GT, Plavix (blood			specific instructions, mixing with correct	:t	
	-	s via GT, Carvedilol (for			amount of water and flushing the		
		art failure) 6.25 milligrams			gastrostomy tube with 15 ml of water a	fter	
		syrup (for seizures) 250 s-give 12 milliliters (600			each medication is administered.		
		There was also a physician			Starting 7/25/17, the DON, QI nurse,		
	order to administer Z	antac (for heartburn relief)			pharmacy consultant, and/or corporate		
	150 milligrams via G	T to be administered at 9:00			consultants will complete a Medication		
		order to restrict fluids for			Pass Audit Tool on 10% of RNs, LPNs,		
	Resident #49.				and medication aides weekly for 8 week		
					then monthly for 1 month, to include all		
	On 6/7/17 at 8:00 AM				shifts and weekends. The administrato		
	_	dication pass. Nurse #8			will review the results of the medication		
	10 milliliters of water	ation separately and added			pass audits weekly to ensure RNs, LPI and medication aides have medication	-	
		8 administered 30 milliliters			error rates less than 5%.		
	of water in the GT, a				The QI nurse or DON will review with the	he	
		time and flushed the GT			monthly Quality Improvement Committee		
		vater at the end of the			the Medication Pass Audit Tool		
		ration. Nurse #8 did not			discrepancies and medication error rat	е	
	flush with water betw	veen each medication.			audit results monthly x 3 months for		
					trending, root cause analysis and		
	On 6/7/17 at 9:04 AM	1, an interview was			recommendations.		
	conducted with Nurse	e #8. She stated she flushed					
	the GT before and af	ter medication administration			The QI nurse or DON will review with the	ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/09/2017
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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 332	knew Resident #49 w fluid. She stated he w more fluid. Nurse #8 have a physician 's composed of the conducted with the D she expected nursing ordered by the physic staff to follow the polimedications through a included flushing the water between each included flushing the water between each included with the physician of the conducted with a diagnose accident and aphasia Set dated 5/16/17 indiseverely impaired in conducted extensive as Cumulative diagnose (cerebrovascular accident acc	extra water because she could not tolerate any more would vomit if she gave any acknowledged she did not order to restrict the fluid. , an interview was irector of Nursing who stated staff to give medications as sian. She said she expected by for administration of oral a gastrostomy tube which GT with at least 15 ml of medication. , a phone interview was mysician who stated he orders to be followed. readmitted to the facility is of cerebrovascular . An Annual Minimum Data icated Resident #49 was decision-making. He sistance with eating. It is included: CVA dent) with hemiplegia gastrostomy (GT-a feeding	F 332		ts, QI acility 1 lysis, The ring ire
	Miralax powder (laxat	orders revealed an order for ive) 17 grams. Mix in 8 give via GT. There was no for Resident #49.			
		, Resident #49 was ication pass. Nurse #8 ns of Miralax and mixed the			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION	COMPLETED	
		345293	B. WING		C 06/09/2017	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00/03/2011	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOEFICIENCY)	BE COMPLETION	
F 334 SS=E	medication with 10 ounces of water). Sand did not add an Miralax. On 6/7/17 at 9:04 / conducted with Nu mix the Miralax wit she knew Residen more fluid. She stany more fluid. She stany more fluid. Nu not have a physicial On 6/7/17 at 9:56 / conducted with the she expected nurs ordered by the phy On 6/7/17 at 2:56 / conducted with the expected physiciar 483.80(d)(1)(2) INI PNEUMOCOCCAI (d) Influenza and potential side effectives education potential side effectives immunization Octo	milliliters of water (0.33 She administered the Miralax y additional water to the AM, an interview was rse #8. She stated she did not h 8 ounces of water because t #49 would not tolerate any ated he would vomit if she gave urse #8 acknowledged she did an 's order to restrict the fluid. AM, an interview was Director of Nursing who stated ing staff to give medications as rsician. PM, a phone interview was physician who stated he n orders to be followed. FLUENZA AND LIMMUNIZATIONS Inneumococcal immunizations facility must develop policies	F 33		7/25/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 6/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/00/2011	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 334	Continued From pag	e 162	F 3	34			
	immunized during thi	s time period;					
		ne resident's representative o refuse immunization; and					
	` '	edical record includes ndicates, at a minimum, the					
	` '	or resident's representative ion regarding the benefits ects of influenza					
	immunization or did r	either received the influenza not receive the influenza medical contraindications or					
	1	sease. The facility must procedures to ensure that-					
	representative receiv	e pneumococcal resident's resident or the resident's res education regarding the resident side effects of the					
	immunization, unless	ated or the resident has					
		ne resident's representative o refuse immunization; and					
	1	edical record includes ndicates, at a minimum, the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	00/03/2017	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 334	was provided education and potential side efficient immunization; and (B) That the resident pneumococcal immunithe pneumonia accine pneumonia vaccine pneumonia vaccine pneumonia vaccine pneumococcal immunitation evidence the vaccine pneumococcal immunitation evidence the vaccine pneumococcal plant previous providence pneumococcal plant pneumococcal plant pneumonia vaccine pneumococcal plant pneumococcal plant pneumococcal plant pneumococcal pneumococcal pneumococcal immunitation pneumococcal immunitati	or resident's representative for regarding the benefits ects of pneumococcal either received the nization or did not receive imunization due to medical fusal. T is not met as evidenced fiews and record review, the nister pneumonia vaccine on don admission for 3 ent #3 and Resident #9) 5 or immunizations. Findings Y "Consent/Release Form" ead the pneumonia vaccine limission unless medically consent form offered an I option to be reviewed and at of or the responsible party admitted 6/16/16. Her 16/17 indicated moderate in the Her RP signed the consent gothe facility to administer the incomplete the records revealed no	F 334	F 334 Influenza and Pneumococcal Immunizations On 6/6/17, Resident #98 was offered the pneumonia vaccination and provided the Centers for Disease Control required education prior to administering vaccinations. The licensed nurse administered the pneumonia vaccination to Resident #98 and documented on the Medication Administration Record (MA) and electronic medical record (EMR). On 7/1/17, Resident #9 was offered the pneumonia vaccination and provided the Centers for Disease Control required education prior to administering vaccinations. The licensed nurse administered the pneumonia vaccination to Resident #9 and documented on the MAR and EMR. On 7/10/17, the director of nursing (DC) obtained a declination from Resident #3 serident representative (RR) after being provided the Centers for Disease.	on ee R) ee ene	

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 _				09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		HI	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 177 S BOX 1489 AMLET, NC 28345	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	s immunization reconvaccine was given. 3. Resident #9 was a quarterly MDS dated cognitive impairment on 2/28/17 authorizing the pneumonia vacci #9 's immunization in the vaccine was give. In an interview on 6/6 Assurance (QA) Nurse position on 1/26/17 a ensure residents recondered. In another interview on 6/8 Nurse stated Resident #3 and Residen	y to administer the A review of the Resident #3 'ds revealed no evidence the dimitted 2/28/17. Her 3/21/17 indicated moderate. Her RP signed the consent g the facility to administer ne. A review of the Resident ecords revealed no evidence n. 6/17 at 4:55 PM, the Quality se stated she started her nd it was her responsibility to eived the immunizations as on 6/7/17 at 1:30 PM, the QA nt #15, Resident #98, sident #9 received their on 6/7/17.	F	334	Control required education prior to administering vaccinations. On 6/29/17, the quality improvement (Conurse completed a 100% audit of all resident medical records to determine in the pneumonia vaccination had been administered or declined. 30 residents have received the pneumonia vaccination at residents/RRs have refused the pneumonia vaccination. The QI nurse interviewed the 34 residents/RRs and provided the education. After receiving the pneumococcal immunization education, the QI nurse received consents, administered, and document pneumococcal vaccinations. On 6/29/17, the DON and corporate consultant initiated a 100% in-service from all registered nurses (RNs) and license practical nurses (LPNs): 1) each reside is offered a pneumococcal vaccination upon admission, 2) the nurse must revithe Consent to Treat form in the health record to determine if consent was given 3) It is the responsibility of the quality improvement (QI) nurse/infection controller to the consent of the consent was given and ensure all pneumococcal vaccines are given if the is consent. On 7/12/17, the corporate consultant competed a second 100% pneumococci immunization audit to ensure timely and appropriate administration of pneumococcal immunizations. The audetermined there were 40 residents	ed or dent ew en, ol	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER ID PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, 2 HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 334	Continued From pag	e 165	F3	without documentation pneumococcal immuniz given. By 7/25/17, the admissions nurse will p pneumococcal immuniz residents or provide sup documentation in the he supporting why the immigiven. The QI nurse/infection of admissions coordinator review all admissions withen monthly for 1 monimesidents with authorizar pneumococcal vaccinate administered a pneumococcal vaccinate administered and pneumococcal vaccinate administered on a Pneumococcal vaccinate o	ration was not DON, QI nurse, rovide ration for all poorting ealth record nunization was not control nurse and (a LPN) will reekly for 8 weeks th to ensure all ration to receive the tion are record and review all audit will present the review all audit will present the record vaccine I committee for 3 rendations, take and monitor for will present the record vaccine executive quality and monitor for will present the record vaccine executive quality and present the record vaccine the record vaccine record vaccine executive quality and present the record vaccine recor		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 06/09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00/03/2017
(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)	JLD BE COMPLETION
F 334	Continued From page	± 166	F 33	implemented and newly implement processes are sustained to mainta regulatory compliance in the area of influenza and pneumococcal immunizations.	in
F 353 SS=D		FICIENT 24-HR NURSING LANS	F 35	53	7/25/17
	483.35 Nursing Service	ces			
	the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res- resident assessments and considering the ne diagnoses of the facili- accordance with the fat §483.70(e). [As linked to Facility Assessments of the facility	e sufficient nursing staff with etencies and skills sets to elated services to assure stain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and sity's resident population in acility assessment required assessment, §483.70(e), will mining November 28, 2017			
	of personnel on a 24-	each of the following types			
	(i) Except when waive this section, licensed	ed under paragraph (e) of nurses; and			
	(ii) Other nursing pers limited to nurse aides	sonnel, including but not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		00	C
	ROVIDER OR SUPPLIER D PINES HEALTHCAI	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	 06/09/2017 DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR 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 353	this section, the facility in nurse to serve as a duty. (a)(3) The facility in nurses have the spects necessary to didentified through in described in the plant resident care plant needs. This REQUIREME by: Based on observation interviews and recorprovide sufficients scheduled for residents reviewed (ADLs). Findings in This citation is crossistance with barresident should be resident sho	a waived under paragraph (e) of cility must designate a licensed a charge nurse on each tour of a charge nurse on each tour of the cility must designate a licensed a charge nurse on each tour of the charge nurse of the charge nu	F3		nursing t Resident uled on udit was be president st 14 days of fficient de resident esident care eated from the Index. No	
	problem with resident staff shortages and the problem. The E budgeted for 9 aids	ents getting their shower due to management was aware of DON stated the facility was es on first shift, 8 aides on aides on third shift. She stated		completed a 100% audit of the 14 days of shower/bathing residents to ensure residents provided a shower/bath according preference. The audit reveals	ne previous ecords for all s were rding to their	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
						С	
		345293	B. WING _			06/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
DICHMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		HI	GHWAY 177 S BOX 1489		
Monitor	DI INCO HEALIHOAKE	AND REHADIEHATION SERVIC		H	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 353	Continued From page	e 168	F3	353			
	when she started tool 12/26/16, there was 4 showers and 2 more doing the showers. O were terminated or reproblems with staffing the shower teams be stated she interviewed ay and they worked orientation and then the stated the facility receives (GCAs). She sticuttered night stands push residents to actipassing trays. The DO	k the position of DON on aides assigned to do aides in the secured unit nee she started, a lot of staff signed. She stated g due to call outs resulted in ing pulled to the floor. She d nursing assistants every along enough to go through hey would quit. The DON ently hired 4 geriatric care ated they can clean s, make unoccupied beds,			residents had not been assisted with tw showers per week for the previous 14 days. Any resident that did not receive shower or bath was provided one upon review. On 6/29/17, the DON ensured each resident not receiving two shower weekly in the previous 14 days was offered a shower/bath. The DON documented the audit on the electronic health record look-back report. On 7/10/17 through 7/11/17, the corporate consultant and DON updated the show schedule to ensure adequate staffing is scheduled to assist residents with bathing/showers.	a er	
	Assistant (NA) #4 sta years on second shift was the only person in urse was passing maide was in a room property of the state of the st	trefused a shower. 26/17 at 3:46 PM, Nursing ted she worked almost 3 and the secured unit when the edications and the other roviding care. She stated owers until she knew that the other aide was present. 2/17 at 10:39 AM, NA #12 and at the facility for about 2 at there had been times when complete the showers that due to time limitations. She made her resident assignment as residents which made it showers as scheduled. NA as an ongoing problem, but at she could to complete her			On 7/10/17, the administrator and DON continued discussing staffing related business at the morning department he meetings and/or clinical meetings to ensure the scheduler was providing the administrator and/or DON the opportunt to review staffing schedules three days advance. On 7/11/17 through 7/14/17, the quality improvement (QI) nurse facilitated new employee orientation. On 7/13/17, nursing staff reported they were please to see the new employees coming onboard and showers were given according to the resident preferences. On 7/12/17, the corporate human resources representative continued assisting the facility with nursing staff recruitment during an in-site visit, meet new employees, reviewing applications	ead e ity in d	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
						С	
		345293	B. WING _			06/	09/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEAT THCARE	AND REHABILITATION CENTE		H	IGHWAY 177 S BOX 1489		
KIOIIMOK	DI INCO HEALIHOARE	AND REHADIEHATION SERVE		H	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 353	53 Continued From page 169		F 3	53			
		7/17 at 12:10 PM, NA #7			On 7/47/47 the endowinished BON		
		3/30/17. She stated, when			On 7/17/17, the administrator, DON,		
		she had trouble completing #7 stated sometimes the			scheduler, corporate consultants, and RVP continued weekly review of the da	ilv	
	_	led to the floor so she was			census, 24 hour documentation,	iiiy	
		vn showers and she could			incident/accident reports, resident		
	not complete her assi				grievances, resident council concerns,		
	-	are of the staffing problems			daily nursing staffing sheets, and nursi	ng	
	and hired GCAs but they cannot assist with direct				staff assignment sheets, to determine		
	resident care.				trends and ensure appropriate staffing	is	
					provided to meet resident needs. The		
	In an interview on 6/7/17 at 12:30 PM, NA #8				DON will immediately address all		
		ted in January, there was a			identified areas of concern with staffing		
		sisted with resident showers.	levels and make staffing level adjustment			ent	
	NA #8 stated due to d	ot always able to complete			or staffing assignment changes as needed upon consideration of facility		
	_	stated she would let her			census, resident needs. The		
	_	nd the DON was aware.			administrator and/or RVP will review D	ailv	
					Nursing Staffing audit reviews and	<i>y</i>	
	In an interview on 6/8	/17 at 8:17 AM, shower aide			follow-up with the DON to ensure		
	(SA) #1 stated she sta	arted on the shower team			adequate staffing and follow up for any		
	10/1/16. She stated the	nere were two separate			identified concerns.		
		ue to staffing shortages, the					
		mantled in February 2017.			The QI nurse or DON will review with the	_	
		wer team was restarted			monthly QI Committee the results of the		
	5/1/17 when SA #2 w	as hired in April.			Dignity/Staffing Audit Tool and the resu		
	In an intension, an 6/9	1/17 at 9:20 AM tha			of the Daily Nursing Staffing audit revie		
	In an interview on 6/8	started her position on			for 6 months for identification of trends, actions taken, and to determine the new		
		ed at the facility for seven			for and/or frequency of continued	Ju	
		She confirmed the shower			monitoring, and make recommendation	ıs	
	-	7 and prior to that, the aides			for monitoring for continued compliance		
		oonsible for giving showers.			The QI nurse or DON will present the		
		as a big problem and she			Dignity/Staffing Audit Tool findings, Dai	ly	
		ng shortages this bad. She			Nursing Staffing audit review findings,		
		aides weekly. They would			the QI Committee recommendations to		
	•	pass the drug test, then only			the quarterly quality assessment and		
	stay a few weeks.				assurance (QAA) Committee for further		
					recommendations and oversight regard	ling	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _				C 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		н	IREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 354 SS=D	In an interview on 6/8 of Nursing (DON) stathe residents receive twice per week or model 483.35(b)(1)-(3) WANDAYS/WK, FULL-TIME (1) Except when waive (f) of this section, the services of a register consecutive hours a consecutive hours and (2) Except when waive (f) of this section, the registered nurse to see nursing on a full time (3) The director of nunurse only when the foccupancy of 60 or fee This REQUIREMENT by: Based on staff intervial facility failed to staff a seight consecutive hour of 40 days reviewed for included:	ted it was her expectation a shower a minimum of re often if requested. VER-RN 8 HRS 7 IE DON red under paragraph (e) or facility must use the ed nurse for at least 8 day, 7 days a week. red under paragraph (e) or facility must designate a erve as the director of basis. rsing may serve as a charge facility has an average daily ever residents. ris not met as evidenced iews and record review, the a Registered Nurse (RN) for urs, seven days a week for 4 for RN coverage. Finding g sheets from 5/1/17 to following: RN coverage RN coverage RN coverage		353	appropriate staffing to meet the needs the residents. F 354 Waiver RN 8 Hrs 7 Days per Week, Full Time DON On 6/30/17, the director of nursing (DC administrator, and regional vice preside (RVP) began aggressively recruiting, interviewing, and hiring additional registered nurses (RNs). The newly hir registered nurses will work to assist residents with care and medications the	DN), ent red	7/25/17
	through 6/9/17 reveal	y's census from 5/1/17 ed the census never sident with the daily average			allowing the director of nursing (DON) perform the duties of the director of nursing on a fulltime basis. The RVP, administrator, DON, schedul		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _	B. WING		C 06/09/2017	
	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 NCY 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 354	scheduler stated sh needed to be staffe not have a RN avai of Nursing (DON) w coverage. In an interview on 6 stated she had bee coverage and was Data Set (MDS) Nu requirement. In an interview on 6 Administrator stated	ge 171 6/8/17 at 8:20 AM, the he was aware that a RN was d on weekends but she did lable. She stated the Director has aware of the lack of RN 6/8/17 at 5:00 PM, the DON hin serving as the required RN hot aware she or the Minimum harse did not meet that 6/8/17 at 5:05 PM, the d it was her expectation there has secutive hours daily.	F	and/or corporate consultants will the Nurse Schedules, Daily Staf Sheets, and/or Daily Nurse Staff sheets by 7/25/17 to determine appropriate RN coverage is assi include providing a registered numinimum of 8 hours per day 7 diweek. The RN coverage will be provide RN Minimum date set (MDS) Nuquality improvement (QI)/staff development nurse, RN treatme and/or RN supervisor to ensure coverage 7 days a week until mare hired. While at the facility peroversight, the RN MDS nurse, Cand/or RN supervisor will assist supervision of the other nurses a perform their regular duties until RN hours by RN staff nurses can achieved. On 6/30/17, the administrator be aggressively recruiting, interview hiring additional nurses, nursing assistants, and geriatric assistant nursing department. The newly will work to assist residents with medications thus allowing a fullt registered nurse function as a fundirector of nursing or a RN as as By 6/30/17, the administrator inthe administrative nurses (direct nursing, quality improvement nutreatment nurse, MDS nurses) a nursing staff scheduler that a RN assigned on the daily assignment assignment.	ifing fing fing fing fing fing fing fing	ed e e e e e e e e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017	
NAME OF P	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			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 354	Continued From page	e 172	F3	ensure there is a RN supervising facility per the Medicare guideline hours RN onsite RN coverage 7 c week. After 6/30/17, no administr nurse or the scheduler will be allowork until this in-service is complenew administrative nurses and so will receive this in-service during employee orientation. On 6/29/17 RVP in-serviced the administrator DON on ensuring RN coverage 8 per day, 7 days per week. The administrator, director of nurs (DON), quality improvement (QI) and/or scheduling coordinator will a registered nurse provides onsite supervision and coverage 8 hours days a week through appropriate scheduling and staff assignments The RVP will review the Sufficient Audit Tool weekly for 12 weeks an up with the administrator and DOI ensure daily 8 hour RN coverage days per week. The administrator or DON will pre results of the Sufficient Staffing A to the monthly QI committee, mor 3 months. The QI committee will recommendations, take action as appropriate, and monitor for contic compliance. The administrator or DON will pre results of the Sufficient Staffing A to the quarterly executive quality assessment and assurance (QAA)	of 8 lays a lative wed to leted. All hedulers new hedulers hew hours sing hurse ensure letes a day 7 Staffing hd follow N to seven sent the ludit Tool lithly for offer hued sent the ludit Tool lithly for		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
	2.45002		D. WING		С	
	345293	B. WING_			06/	09/2017
	AND REHABILITATION CENTE		HIG	GHWAY 177 S BOX 1489		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	•		(X5) COMPLETION DATE
				will review the QI committee recommendations and facility's follow-uto the recommendations. The administrator is accountable for ensuring QAA Committee recommendations are implemented and newly implemented processes are sustained to maintain	ng	
INFORMATION 483.35 (g) Nurse Staffing Info (1) Data requirementhe following information (i) Facility name. (ii) The current date. (iii) The total number by the following categoral unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census.	and the actual hours worked fories of licensed and aff directly responsible for the control of t	F;	3356			7/25/17
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page 483.35(g)(1)-(4) POS INFORMATION 483.35 (g) Nurse Staffing Informat (i) Data requirementhe following informat (ii) Facility name. (ii) The current date. (iii) The total number by the following category unlicensed nursing staresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census.	ROVIDER OR SUPPLIER ID PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 173 Continued From page 173 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides.	ROVIDER OR SUPPLIER ID PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 173 F: 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	ROVIDER OR SUPPLIER ID PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 173 F 354 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	ROWIDER OR SUPPLIER 345293 ROWIDER OR SUPPLIER D PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF PERCENCIES (EACH DEPOSITE VALUE REPOSITION NUMBER PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 173 F 354 Committee meeting. The QAA committee recommendations and facility's follow-up to the recommendations and	A BUILDING 345293 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY OR LSC IDENTIFYING INFORMATION) Continued From page 173 Continued From page 173 F 354 Committee meeting, The QAA committee will review the QI committee recommendations and facility's follow-up to the recommendations and facility's follow-up to the recommendations are implemented and newly implemented processes are sustained to maintain regulatory compliance in the area of daily 8 hour RN coverage, seven days per week. 483.35 (g) (1)-(4) POSTED NURSE STAFFING INFORMATION 1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _		C 06/09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00.00.2011
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 356	F 356 Continued From page 174		F3	56	
		ost the nurse staffing data h (g)(1) of this section on a inning of each shift.			
	(ii) Data must be post	ted as follows:			
	(A) Clear and readab	le format.			
	(B) In a prominent pla residents and visitors	ace readily accessible to			
	The facility must, upo make nurse staffing d	nosted nurse staffing data. In oral or written request, Itata available to the public It to exceed the community			
	facility must maintain staffing data for a mir required by State law	tion requirements. The the posted daily nurse nimum of 18 months, or as whichever is greater.			
	Based on observation record review, the fact staff hours by including calculated into the direct for 5 of the 8 days reviposting. Findings including	uded:		F 356 Posted Nurse Staffing The Federal Posting was corrected the Geriatric Care Aides hours were removed from the Daily Nursing Stasheet during the annual/complaint son 6/8/17 by the receptionist.	e affing
	recently hired 4 gerial stated they can clean make unoccupied bed activities and assist w	OON) stated the facility tric care aides (GCAs). She cluttered night stands, ds, push residents to		On 6/29/17, the regional vice presic (RVP) in-serviced the administrator director of nursing (DON), and sche regarding not including non-license non-certified staff (non-resident car on the required Daily Nursing Staffi sheet, according to the regulatory	duler d and e staff)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		0.45000	D WING			С	
		345293	B. WING _			06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
RICHMON	ID PINES HEAT THCA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
KICIIWICI	ID FINES HEALTHCA	INC 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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 356	Continued From p	age 175	F 3	56			
	indicated the follow	wina:		guidelines.			
		CAs working 8 hours each were		3			
		hours into the direct resident		On 6/30/16, the director of nu	rsing (DON)		
	care hours.			in-serviced the receptionist ar			
	-On 6/4/17, one G	CA working 8 hours each were		nurses regarding: 1) the Daily	/ Nursing		
	calculated with 8 h	nours into the direct resident		Staffing sheets are to be com	pleted in		
	care hours.			pencil, 2) when staff hours ch			
		GCAs working 8 hours each		corrections are made to the D	, ,		
		ith 16 hours into the direct		Staffing sheet to reflect actual			
	resident care hour			3) Non-licensed and non-certi			
	 On 6/6/17, four GCAs working 8 hours each were calculated with 32 hours into the direct resident care hours. On 6/8/17, three GCAs working 7.5 hours each 			(non-resident care staff) are n			
				on the nursing staffing sheet,	according to		
				the regulatory guidelines.			
		ith 22.5 hours into the direct		On 7/10/17, the corporate cor	nsultant		
	resident care hour			re-educated the receptionist (
				and nursing staffing schedule			
	In an interview on	6/8/17 at 12:00 PM, GCA #1		completion of the federal post			
	stated she recentl	y started but she was not		regarding maintaining the Dai			
	allowed to do any	resident care. She stated she		Staffing sheets, including the	proper		
	could take resider	nts to activities, pass trays,		calculation of hours and to no	t include		
	make beds and ru	in errands.		non-licensed and non-certified			
				(non-resident care staff), acco	ording to the		
		6/8/17 at 12:10 PM, the		regulatory guidelines.			
		she completed the Daily					
		heets. She stated she added		The administrator, DON, qual			
		ours but was never told to do it.		improvement (QI) nurse and/o	•		
	hours.	sumed they counted as staffing		consultant will audit and initial Nursing Staffing sheets to ens	,		
	nours.			accurate completion of staffing			
	In an interview on	6/8/17 at 2:22 PM, the		and to ensure non-nursing an	-		
		ed it was her expectation that		non-certified staff (non-reside			
		calculated in with the Daily		are not included in the calcula	•		
		ours since they had no direct		according to the regulatory gu			
	resident care resp	<u>-</u>		The audit will be completed, 5			
				weekly for 4 weeks (to include	e Saturday		
				and Sunday), then 3 times a v			
				weeks, then 1 time weekly for			
				The receptionist or scheduler	will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 06/09/2017	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
F 356	DENTAL SERVICES (b) Nursing Facilities The facility- (b)(1) Must provide or resource, in accordance	OUTINE/EMERGENCY IN NFS Tobtain from an outside ce with §483.70(g) of this atal services to meet the	F 4	immediately re-educated by the administrator, DON, QI Nurse and corporate consultant for any noted incorrect Daily Nursing Staffing sh. The QI nurse or DON will review was monthly Quality Improvement Conthe results of the Daily Nursing State audit reviews monthly for 3 monthstrending, root cause analysis and recommendations. The QI nurse or DON will review was quarterly Quality Assessment and Assurance (QAA) Committee the rof the Daily Nursing Staffing audit QI Committee recommendations, a facility progress with the QI Committee recommendations for 1 quarter for additional root cause analysis, recommendations, and additional monitoring requirements as needed administrator is responsible for enguAA Committee recommendations implemented and for reporting back QAA Committee.	eets. vith the nmittee affing s for vith the results reviews, and nittee d. The suring s are	7/25/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	, 30.05.20.1.
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 412	(ii) Emergency dent (b)(2) Must, if neces the resident- (i) In making appoir (ii) By arranging for dental services loca (b)(5) Must assist re wish to participate to dental services as a under the State plar This REQUIREMEN by: Based on observati interviews and recor provide routine dent #71) of 3 residents in Findings included: Resident #71 was a cumulative diagnose accident (CVA), hen His significant chang 5/17/17 indicated m	ervices (to the extent covered n); and all services; sary or if requested, assist attents; and apply for reimbursement of n incurred medical expense n. IT is not met as evidenced ons, staff and resident are review, the facility failed to all services for 1 (Resident reviewed for dental services. It is not met as evidenced ons, staff and resident review, the facility failed to all services for 1 (Resident reviewed for dental services. It is not met as evidenced on the facility failed to all services for 1 (Resident reviewed for dental services. It is of cerebral vascular niplegia and contractures. It is of cerebral vascular niplegia and contractures are ge MDS assessment dated orderate cognitive impairment le required extensive	F 4	F 412 Routine /Emergency Dental Services On 7/6/17, the dental services provious was scheduled to provide dental serfor Resident #71. On 6/29/17, the RN Corporate Conscompleted a 100% audit to ensure a residents have a dental consultation a year. Twenty-one residents did not receive a dental consult. For resident requiring a dental consultation within	vices ultant II within t outs not
	read he required as daily. Staff were to a hygiene and groomi	t care plan revised on 5/23/17 sistance with mouth care assist Resident #71 with his ng as needed. Resident #71 d on 5/23/17 included his of daily living with		year, the social worker and/or admis coordinator will interview residents of contact the resident'□s representative (RR) by 7/10/17 and offer the service dental consult. Any resident/RR requesting dental services consult we scheduled at that time for a consult.	or ve e of a vill be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	09/2017	
NAME OF T	TO VIDER OR OUT FEET				IGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE						
				П	AMLET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 412	Continued From pag	ue 178	F 4	12				
	interventions to inclu	ide flexibility and return and			resident that requires dental services w	/ill		
	offer assistance in 5-				have services provided by 7/26/17.			
		d interview on 6/5/17 at 1:13			On 6/29/17, the regional vice president			
		ated he was experiencing no			(RVP) in-serviced the social worker,			
		eeth or gums. He stated he			admissions coordinator, administrator,			
		t time he saw a dentist and			and director of nursing (DON) that the			
	_	ver told him they offered observation, his teeth were			facility must, according to regulations,			
		n multiple missing teeth. He			provide or obtain from an outside resource: 1) emergency dental service	ac.		
		h his own teeth if staff set up			2) assist in making appointments, and			
	the toothbrush.	ii iiis owii teetii ii staii set up			assist to apply for reimbursement of	3)		
	the toothordon.				dental services as an incurred medical			
	In an interview on 6/	8/17 at 11:55 AM, the Social			expense under the State plan. The			
		she was not responsible for			Dental Services in-service also include	d		
		vices but rather the medical			the expectation that the social worker			
		did it. The SW stated the			and/or admissions coordinator will mor	itor		
		ouse dental provider in April			dental services to ensure all residents	are		
	-	residents had to go out to			offered services yearly and as needed			
					Beginning on 7/17/17, the social worke	r		
	In an interview on 6/8	8/17 at 2:13 PM, the MR			and/or admissions coordinator will use			
	person stated she wa	as filling in and she was not			Dental Services audit tool to monitor			
	told she needed to s	et up a dental assessment			residents: 1) with a request for dental			
		ouse dentist. She stated she			services, 2) with a physician' □s order f			
		nat Resident #71 had been			dental services, and 3) that have not have	ad		
	evaluated by a denti-	st since he was admitted			a dental consult within the past 12			
	9/4/14.				months. Upon identification of a denta	l		
					consult need, the social worker and/or			
	In an interview on 6/8	· ·			admissions coordinator will assist the			
		it was her expectation			resident in making appointments, assis	it		
		have received dental			with arranging for transportation if			
	services annually un	iess refused.			needed. The Dental Services Audit too	OI .		
	In an interview on 0"	9/17 of 2:52 DM number			will be completed once weekly for 4			
		8/17 at 2:53 PM, nursing			weeks, then once every 2 weeks for 4			
		ated Resident #71 refused to			weeks, then once monthly x 2 months.			
		eth. She stated she had not and she had not been asked			The social worker and/or admissions			
	if he refused.	and one had not been asked			coordinator will present the findings of	the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0200	 	STREET ADDRESS, CITY, STATE, ZIP CODE	06/09/2017	
TO THE OT THE	TO VIBER OIL OUT I EIER			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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	483.45(c)(1)(3)-(5) DI REPORT IRREGULA c) Drug Regimen Rev (1) The drug regimen	RUG REGIMEN REVIEW, R, ACT ON	F 4:	Dental Services audits, monthly for 3 months, to the monthly QI Committee review, root cause analysis, and recommendations. The social worker and/or admissions coordinator will pre the finding of the Dental Services aud the root cause analysis, and the follow to the QI Committee recommendation the quarterly Quality Assessment and Assurance (QAA) Committee meeting The QAA Committee will review the Committee recommendations and facility is follow-up to the recommendations for one quarter. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and pro oversight. The administrator will be responsible for ensuring QAA Commiconcerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of dental services.	esent lits, v-up es at d. d. d. d. d. d. d. d. d. d. d. d. d.	
	brain activities associ and behavior. These	ug is any drug that affects ated with mental processes drugs include, but are not e following categories:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 6/09/2017	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/00/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	to the attending physical director and these reports m (i) Irregularities including that meets the (d) of this section for (ii) Any irregularities during this review m separate, written regulated and the irregularity to (iii) The attending physician and the irregularity to (iii) The attending physician should door the resident's medical resident's medi	must report any irregularities sician and the ector and director of nursing, ust be acted upon. de, but are not limited to, any criteria set forth in paragraph an unnecessary drug. noted by the pharmacist ust be documented on a port that is sent to the and the facility's medical of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. Anysician must document in the ecord that the identified a reviewed and what, if any, ten to address it. If there is to medication, the attending cument his or her rationale in al record. develop and maintain policies	F 42				
	review that include, frames for the difference steps the pharmacis	he monthly drug regimen but are not limited to, time ent steps in the process and t must take when he or she rity that requires urgent action nt.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040200	1 2:	STREET ADDRESS, CITY, STATE, ZIP COL	•	6/09/2017	
NAME OF F	ROVIDER OR SUFFLIER				<i></i>		
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
				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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From p	page 181	F 42	28			
	This REQUIREME	ENT is not met as evidenced					
	by:						
	Based on observation, record review, pharmacis interview, Nurse Practitioner interview, and staff interview, the facility failed to complete the			F 428 Drug Regimen Revi Irregular, Act On	ew, Report		
		est to conduct an Abnormal		On 6/29/17, the director of nu	ırsina (DON)		
		ment Scale assessment (an		completed an antipsychotic of	O (,		
		ed to monitor involuntary		therapy/DISCUS (Dyskinesia	-		
		ersons on antipsychotic		System Condensed User Sca			
		of 6 residents reviewed for		assessment on Resident #76	•		
		ications (Resident #76). The					
	findings included:	,		On 6/29/17, the corporate clin	nical director		
				completed a psychiatric cons	ult audit		
	Resident #76 was	admitted to the facility on		which revealed psychiatric co	onsults had		
	8/9/16 with multip	le diagnoses that included		not been completed on sever			
		disorder, severe with psychotic		On 6/29/17, the DON develop			
	features, and dem	nentia with behavioral		residents for a psychiatric co			
	disturbance.			these residents to be seen up			
				health care provider'□s next	visit on		
		der dated 8/10/16 indicated		7/12/17.			
		vchotic medication) 3 milligrams		0.00047.4.4.6	. (501)		
	(mg) once daily at	t night for Resident #76.		On 6/29/17, the director of nu			
	A A	Lunton, Movement Coale (AIMC)		and corporate consultants co			
		luntary Movement Scale (AIMS)		100% audit of physician orde			
		completed on 8/11/16 for a score of 0 (no involuntary		residents on antipsychotic me have a DISCUS completed a			
	movements identi	· · · · · · · · · · · · · · · · · · ·		the facility pharmacy policy.	-		
	movements identi	nea).		revealed additional DISCUS			
	The admission Mi	nimum Data Set (MDS)		were required for four (4) res			
		d 8/17/16 indicated Resident		6/30/17, the DON, registered			
		e cognitive impairment.		licensed practical nurses con			
		eived antipsychotic medication		required DISCUS assessmer	•		
	during the MDS re						
				Beginning 6/29/17, the corpo	rate facility		
	An MDS Care Are	a Assessment (CAA) related to		consultant in-serviced the DC	ON,		
	psychotropic med	ications for the 8/17/16 MDS		registered nurses (RNs), and			
	indicated he recei	ved antipsychotic medication		practical nurses (LPNs) on: 1	•		
	daily.			antipsychotic drug therapy/D	ISCUS		
				(Dyskinesia Identification Sys	stem		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			1	C 09/2017	
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017	
					IGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAF	RE AND REHABILITATION CENTE			AMLET, NC 28345			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 428	Continued From pa	age 182	F4	128				
	A physician 's orde	er dated 4/6/17 indicated a			Condensed User Scale) assessment, a	and		
		dal to 2.5mg from (3mg) once			processing physician orders requiring			
	daily at night for Re				further appointments.			
		er dated 4/20/17 indicated a			On 6/30/17, the DON, corporate clinica	ıl		
		dal to 2mg from (2.5 mg) once			director, and regional vice president			
	daily at night for Re	esident #70.			(RVP) met with the clinical director of pharmacy services to review the outco	mo		
	The quarterly MDS	assessment dated 5/4/17			of the pharmacy consultants 6/29/17-			
		#76 's cognition was intact.			6/30/17 audit findings and discuss and			
		ved antipsychotic medication			follow the recommendations if approve			
	during the MDS rev				by the attending physician. All pharma			
	daming and mibe re-	nen penea.			recommendations will be reviewed by t	-		
	The plan of care fo	r Resident #76 was reviewed.			attending physician by 7/17/17. The			
		a plan of care, most recently			approved, revised or denied			
		, which indicated the focus			recommendation will be transcribed an	d		
	area of psychotrop				entered into the medical record and	.		
		dical record on 6/6/17 revealed			medication administration record as			
	an AIMS assessme Resident #76 since	ent had not been conducted for e 8/11/16.			needed.			
					The DON and/or QI nurse will use the			
	An observation was	s conducted of Resident #76			Unnecessary Drugs/DISCUS Audit too	l to		
	on 6/5/17 at 12:25	PM with no involuntary			complete a 100% review of pink slips in			
	movements noted.	•			the clinical meetings 5 times weekly or			
					ongoing basis. Also, the DON and/or (
	An interview was o	onducted with the Director of			nurse will audit the electronic health			
	Nursing (DON) on	6/7/17 at 8:58 AM. She			record and pharmacy recommendation	S		
	indicated her exped	ctation was for an AIMS			for any missing DISCUS, to be done or	nce		
	assessment to be	conducted for all residents on			weekly for 8 weeks then every-other-w	eek		
	antipsychotic medic	cations upon admission,			for 4 weeks to ensure residents are be	ing		
		any dosage change of the			assessed for abnormal involuntary			
		cation. She stated the			movement using the DISCUS.			
		was responsible for						
		S assessment on admission,			The results of the audits will be presen	ted		
		as responsible for completing			by the DON at the monthly Quality			
		ent quarterly, and if a physician			Improvement Committee meeting for 3			
		he dosage of an antipsychotic			months for further review and			
		se who completed that order			recommendations. The DON will prese			
	was responsible fo	r completing the AIMS			the audit results to the quality assessm	ent		

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	09/ 2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2017
					IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE					
				П	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page	e 183	F 4	128			
F 428	assessment. The DC the facility had a prob completion of AIMS a she had been aware. February 2017. The meeting with the pharand this was one of the She revealed the time assessments had not February 2017 meeting. The interview with the at 9:03 AM. The AIM for Resident #76 was The medical record we AIMS assessments or Resident #76 was resisted this was not a indicated Resident #76 assessment complete.	ON revealed she was aware blem with the timely ssessments. She indicated of this problem since DON reported she had a rmacist in February 2017 he areas that was discussed. Eliness of AIMS improved since the hig. DON continued on 6/7/17 S assessment dated 8/11/16 reviewed with the DON. Which contained no additional completed after 8/11/16 for viewed with the DON. She surprise to her. She of should have had an AIMS and since 8/11/16. She cist had requested an AIMS	F	1428	and assurance (QAA) Committee for 1 quarter for additional review and recommendations to ensure new syste remain in place to sustain regulatory compliance.	ms	
		nacy review. She verified st had not been completed.					
	expectation was for a completed for all residual medications on admissintervals thereafter. Hexpected an AIMS as an antipsychotic med He indicated he reviewhen he conducted hereviews. The AIMS a Resident #76 was reviews the medical record was recorded.	at 9:47 AM. He stated his n AIMS assessment to be dents on antipsychotic ssion and at 6 month He reported he also sessment to be conducted if ication was newly initiated. wed the AIMS assessments					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 06/09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	00/00/2011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 431 SS=E	He revealed he had rassessment to be confollowing his 2/24/17 4/28/17 review. He in the request following his May 2017 review. assessment had not 1 #76 prior to his June 6/26/17) he planned to An interview was con Practitioner on 6/8/17 she expected the AIM completed for all resimedication as per the protocol. 483.45(b)(2)(3)(g)(h) LABEL/STORE DRUGUES and biologicals them under an agree §483.70(g) of this part unlicensed personnel law permits, but only supervision of a licen (a) Procedures. A far pharmaceutical service that assure the accurdispensing, and admit biologicals) to meet the conformation of the conformation	viewed with the pharmacist. equested an AIMS nducted for Resident #76 pharmacy review and his ndicated he had not repeated his March 2017 review or He revealed if the AIMS been completed for Resident 2017 review (scheduled for to repeat his request. ducted with the Nurse of at 7:54 AM. She stated AS assessment to be dents on antipsychotic er facility and pharmacy DRUG RECORDS, GS & BIOLOGICALS ride routine and emergency to its residents, or obtain ment described in rt. The facility may permit I to administer drugs if State under the general sed nurse.	F 42		7/25/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	<u> </u>	00/03/2017
(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 CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	431 Continued From page 185		F 4	.31		
	(2) Establishes a syst disposition of all cont detail to enable an ac	em of records of receipt and rolled drugs in sufficient curate reconciliation; and				
	that an account of all maintained and perio					
		s used in the facility must be e with currently accepted s, and include the y and cautionary				
	the facility must store locked compartments	n State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to				
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected.	orovide separately locked, ompartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can				
	Based on observation and staff interview, the expired medications of carts (dementia unit r	n, manufacturer's instruction e facility failed to discard on one of four medication nedication cart). The facility d date opened medications		F431 Drug Records Label Stor Biologicals On 6/8/17, the nurse removed of medications from the medications	expired	

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 _			06/	09/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	1 00/	03/2017
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 431	Continued From page	e 186	F 4	31			
F 431	on three of four media 400 hall and 200 hall of one medication roomedication according instructions on 1 of 4. The findings included 1. An observation of medication cart was PM with Nurse #6 and one bottle of Uti-Stat health) liquid with apliquid in the bottle. The an expiration date of revealed instructions medication should be opening. There was (used to treat diarrhed 2/17. There was a be drop medication opening the eye drop medication expired 6. On 6/8/17 at 2:00 PM medications should help the drop medication when it was opened. On 6/8/17 at 2:16 PM conducted with the Design that the expected if expired, dated where the expected if expired, dated where the expected if expired, dated where the expected in the expected if expired, dated where the expected in the expected in the expected if expired, dated where the expected in the ex	cation carts (dementia unit, medication carts) and in one oms and failed to store a g to manufacturer 's medication carts (400 hall). d: I the dementia unit conducted on 6/8/17 at 2:00 id revealed the following: (medication for urinary tract proximately 120 milliliters of the bottle was undated with 5/17. The Uti-Stat bottle that specified the ediscarded 3 months after one bottle of loperamide in with an expiration date of cottle of Xalatan 0.005% eye ned and undated. If ye medication stated the exweeks after opening. I, Nurse #6 stated the expired nave been discarded and the should have been dated If, an interview was birector of Nursing. She said PM-7:00 AM) was supposed ion carts and the medication or expired medications and edated when opened. She medications to be discarded in opened and the	F 4	upon discovery. On 6/8 nursing (DON) discarded medications per pharm. On 6/22/17, the corporations and medication ensure medications we were dated upon openicated audit determined there expired/unlabeled medication rooms and refrigerators. For the exunlabeled medications the audit, the corporate immediately removed, or reordered the medication pharmacy. On 6/28/17, the corporate immediately removed from the medication include UTI stat, Prostational Xalatan eye drops, Duction Tuberculin solution. On corporate consultants a expired medications per protocol. Starting on 6/28/17, the consultants, DON, and improvement (QI) nurse in-serviced 100% of reg (RNs), licensed practical and medication discard date	ed the expired acy protocol. ate consultant lit of all medicative refrigerators to be re not expired and if required. To were multiple ications in the medication expired and identified during the consultants discarded, and ons from the late consultants discarded, and ons from the late consultants discarded, and ons from the late consultants ication carts all medications, to late, Loperamide, lone of solution are 16/28/17, the late of discarded the pharmacy leteror quality existered nurses all nurses (LPNs egarding leteror and which	on nd he nd	
	manufacturer 's instr regarding dating.	ructions were followed		medications must be da to include UTI stat, Pro Xalatan eye drops, Duc	stat, Loperamid	e,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING_		_	C 06/09/2017	
NAME OF P	ROVIDER OR SUPPLIER	1 1 11		STREET ADDRESS, CITY, ST	TATE ZIP CODE	00/03/2017	
	101.02.1 01.1 00.1 2.2.1			HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345	,		
(V4) ID	SLIMMADA	STATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
F 431	Continued From pa	ge 187	F4	31			
F 431	2. An observation of conducted on 6/8/1 and revealed an op Tuberculin Purified a vaccine used to infection. Manufacturer's inst Protein Derivative is be discarded 30 da On 6/8/17 at 2:16 F Tuberculin Purified have been dated wif she had opened in the third shift (11:00 to check the medical rooms every night if that medications we stated she expected if expired, dated who manufacturer 's incregarding dating. 3. An observation of was conducted on 6/8/17 and revealed the of Uti-Stat (medicat that was not dated to	of the medication room was 7 at 2:16 PM with Nurse #7 ened undated vial of Protein Derivative (Mantoux) of aid diagnosis of tuberculosis ructions for Tuberculin Purified stated the medication should ys after opening. PM, Nurse #7 said the Protein Derivative should then it was opened. She said, then it was opened. She said, then it was opened. She said of PM-7:00 AM) was supposed ation carts and the medication or expired medications and the direct dated when opened. She direct dated when opened.	F 4	Tuberculin solution be completed by 7 nurse will train all r and medication aic regarding medicati which medications opening, to include Loperamide, Xalat solution and Tuber The DON, QI nurse admissions nurse, and/or corporate comedication carts a for dating of medic required and expirinclude UTI Stat, F Xalatan eye drops. Tuberculin solution be documented on Undated Medication weeks and monthly licensed nurses with QI Nurse, DON, proconsultant for any concern during the review and initial the Medication audit to then monthly x 1 mrse.	an eye drops, DuoNel culin solution. e, treatment nurse, pharmacy consultants onsultants will monitor and medication rooms ations upon opening it medications to prostat, Loperamide, DuoNeb solution and the QI Expired the QI Expired on audit tool weekly x y x 1 month. The lil be re-educated by the transport of the properties of the pr	QI ss,	
	supplement) that woopened-on date and Duoneb (an inhaled breathing easier) or came in without a dobeen removed from	as not dated with the d approximately 10 vials of I medication to make utside the foil packaging that it ate indicating when it had the foil pouch. Further i-Stat bottle revealed		findings of the aud committee. The co QI Expired\Undate results for 3 month issues, concerns a	ON will present the its to monthly QI committee will review the Medication Audit To us and address any and\or trends and maked, to include continued	ol e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _		00	C 5/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		5/05/2017	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED I DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From page	age 188	F 4	31			
	instructions that sp be discarded 3 mc Prostat bottle also after 3 months and had instructions to being outside the f On 6/8/17 at 1:45 and stated that if s Prostat she would was good practice opened. She also the Uti-Stat and Pr being opened and they were opened them. Nurse #7 al aware that there we cart that was not in She stated she wa after a period of be since it was not da	pecified the medication should on the after opening. The had instructions to discard it it the Duoneb foil packaging discard the medication after foil pouch for 2 weeks. PM Nurse #7 was interviewed the had opened the Uti-Stat or have dated it and that she felt it to date all medications when indicated that she was aware costat expired after a period of since she did not know when she would need to discard so said she had not been that as Duoneb in the medication inside the foil pouch it came in the saware the medication expired being outside the foil pouch and ted and she did not know when curred she would need to		frequency of monitoring. The QI nurse or DON wifindings of the audits to assessment and assura committee. The QAA coreview the QI Expired\U Audit Tool results for 1 caddress any issues, contrends and make change include continued freque to sustain regulatory core	ill present the quarterly quality nce (QAA) ommittee will ndated Medication quarter and ncerns and\or es as needed, to ency of monitoring		
	conducted with the the third shift (11:0 to check the medic rooms every night that medications we stated she expected if expired, dated we manufacturer 's in storage were followed. An observation was conducted on #2 and revealed the storage with the storage were followed.	PM, an interview was Director of Nursing. She said to PM-7:00 AM) was supposed cation carts and the medication for expired medications and were dated when opened. She and medications to be discarded then opened and the structions regarding dating and wed. of the 200 hall medication cart 6/8/17 at 1:49 PM with Nurse the following: one opened bottle is not dated with the opened-on					

AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 06/09/201	7
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
				HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(XI COMPL	ETION
F 431	Continued From page	e 189	F 4	31			
F 431	date and one Advair I treatment medication; packaging and that wopened-on date. The doses left counter ind left in the inhaler. Furt Uti-Stat bottle revealed the medication should after opening. The Ads instructions (Highlig Information, Revised "ADVAIR DISKUS shounded from the polinitial use. Discard AD after opening the foil preads "0" (after all blis whichever comes first information also reveal inhaler counter would linterview with Nurse prevealed she was not needed to be dated wonted the pharmacy hole clear plastic storage prinformation that indicate discarded 30 days acknowledged the Adbeen opened and indicated and order another one Uti-Stat should be dated wasn't and said that	Discus (a breathing) that was not in its foil as not dated with the Advair Discus inhaler icated there were 58 doses ther inspection of the ad instructions that specified a be discarded 3 months dvair Discus manufacturer 'hts of Prescribing February 2017) indicated ould be stored inside the rotective foil pouch and only uch immediately before DVAIR DISKUS 1 month pouch or when the counter sters have been used), t." The prescribing aled that when unused - the show 60 doses left. #2 on 6/8/17 at 1:55 PM aware the Advair Discus when opened but she then had placed a sticker on the pouch with the prescription ated the medication was to after opening. She vair Discus had already icated she would discard it e. Nurse #2 was aware the ted. She was not sure why it she was not typically the in that cart. Nurse #2 stated onsible to check the	F 4	31			
	medications when pass On 6/8/17 at 2:16 PM	-					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		345293	B. WING _		06/) 09/2017
	ROVIDER OR SUPPLIER	AND 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 BY 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 456 SS=D	the third shift (11:00 to check the medical rooms every night for that medications were stated she expected if expired, dated when manufacturer 's inst storage were followed 483.90(d)(2)(e) ESS OPERATING COND (d)(2) Maintain all me patient care equipmed condition. (e) Resident Rooms Resident rooms must for adequate nursing residents. This REQUIREMENT by: Based on observation interviews and recomensure the safe function of (Resident #37) are reviewed to safe resincluded: Resident #37 was accumulative diagnose posture and muscle. A review of an Occuptreatment note dated order was completed maintenance to fix Resident maintenance to fix	Director of Nursing. She said PM-7:00 AM) was supposed ion carts and the medication of expired medications and received when opened. She medications to be discarded in opened and the ructions regarding dating and d. ENTIAL EQUIPMENT, SAFE ITION The designed and equipped care, comfort, and privacy of the sampled residents for the sampled residents dent equipment. Findings	F 4		pervisor elchair elerk theelchairs nctional, the and 4) the t. This ent #37□s ses were in	7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345293	B. WING _		06	6/09/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
				DEI IOIEITO	,		
F 456	Continued From p	page 191	F 4	56			
	s OT notes reveal	ed the following:		good repair, and 3) the arm intact. Several other wheeld			
		treatment note dated 2/10/17 wheelchair brake was still		geriatric chairs required repaidentified from the audit com 6/10/17. Any chair needing identified in the 6/10/17 aud	npleted on work		
		treatment note dated 2/14/17 wheelchair brake was still		repaired, parts were ordered chairs were cleaned. By 7/2 wheelchairs, geriatric chairs	s were d, and some 25/17, all		
		treatment note dated 2/15/17 wheelchair brake was still		repair work orders will be co	empleted.		
	A review of an OT	treatment note dated 2/16/17 wheelchair brake was still		the maintenance worker: 1) safe function of wheelchairs completion of work orders, 3 maintenance schedules, and preventative maintenance sc	ensuring the , 2) 3) preventative d 4)		
		treatment note dated 2/23/17 wheelchair brake was still		to be adhered to and weekly maintenance rounds are to l to ensure equipment is in prorder.	preventative be completed		
		treatment note dated 2/27/17 wheelchair brake was still		Starting 7/13/17, all staff we by the quality improvement nurse/staff facilitator and/or	nurse (QI)		
	Resident #37 's quarterly Minimum Data Set (MDS) dated 5/22/17 indicated severe cognitive impairment. She was coded for extensive assistance of 2 staff for transfers, non-ambulatory and coded for the use of a wheelchair for mobility.			regarding: 1) examples of ed issues that need a work ordelished blank work orders are located fill out a work orders, and 4) place work order requests. orders in-service will be com	quipment er, 2) where ed, 3) how to where to This work		
	for two staff assis and mobility assis scoot chair is a w increased mobility	s last care planned on 5/23/17 tance using a mechanical lift stance using a "scoot" chair. (A heelchair designed to promote while reducing fall risk). 6/4/17 at 5:00 PM, a family		The maintenance director we the Wheelchair Audit tool to wheelchairs each day for 5 of for 4 weeks, 5 wheelchairs each days a week for 4 weeks, the	include 5 days a week each day 3		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE COMF	SURVEY PLETED
		345293	B. WING _			C / 09/2017
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO	•	00/2017
DICHMON	ID DINES HEALTHO	ADE AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 456	Continued From p	page 192	F 4	56		
	brakes had been not lock. Observation on 6. s wheelchair reversappeared loose a right wheel, the bright wheel of the side of the wheelch ln an interview on Assistant (NA) #7 the facility 3/30/1 worked with Resident #37 was lift so one of the steady while putting she personally had but knew the Main aware. She stated	esident #37 's wheelchair broken for almost 6 months did /4/17 at 5:05 PM, Resident #37 'saled the right side brakes and when pushed to lock the rake lever did not prevent the wheelchair from rolling. The left chair brake functioned properly. 16/7/17 at 12:10 PM, Nursing stated she began working at rand as long as she had dent #37, her ride side did not lock. She stated is transferred using a mechanical staff had to hold the wheelchair ang her in the chair. NA #7 stated and not reported the broken brake intenance Supervisor (MS) was did the family had complained right side wheelchair brake		wheelchairs weekly for 4 wee administrator, DON, regional president, and/or nurse consign off the audits weekly for The administrator, DON, reg president, and/or nurse consinitial completed work orders review was completed. The administrator or mainter will present the findings from Wheelchair Audit tool at the committee meetings for three further recommendations. A administrator or maintenance present findings at the quarte assessment and assurance committee meeting for further recommendations, follow up or continued compliance in to determine the need for an frequency of the continued Compliance on the continued Compliance in the conti	I vice sultant will 3 months. iional vice sultant will s to signify the mance worker the monthly QI e months for also, the e worker will erly quality (QAA) er as needed, his area and id/or	
	In an interview or stated she started January 2017. She Resident #37 's r locking. She state work order becau about it. In an interview or Rehabilitation Ma Resident #37 's treported to the M stated at the time	a 6/7/17 at 12:30 PM, NA #8 d working at the facility in he stated she knew about hight wheelchair brake not hed she had not completed a hise she thought the MS knew hight of 6/7/17 at 3:20 PM, the hager, who was an OT, stated horoken wheelchair brake was higher of Resident #37 's discharge high/17, she did not recall if the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 06/09/2017
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00/03/2017
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 490 SS=J	stated he tightened in wheelchair brake too provide evidence of a by the staff or rehabing possible he tightened brake and it came look did not do a monthly check off list of items routinely. In an interview on 6/8 Administrator provide Maintenance Depart stated it was her expright side wheelchair monthly rounds be consure proper and see equipment. 483.70 EFFECTIVE ADMINISTRATION/F 483.70 Administration A facility must be adrenables it to use its refficiently to attain or practicable physical, well-being of each restricted the seed on record reversident, staff, Nurse interview, the facility provide the leadersh	Resident #37 's ride side ay and was unable to any work orders completed litation. He stated it was different her right side wheelchair ose again. The MS stated he rounds and he did not have the should be evaluating. B/17 at 3:05 PM, the ed a blank copy of ment Rounds Checklist and ectation that Resident #37 's brake be fixed timely and completed by the MS to afe function of resident. RESIDENT WELL-BEING n. ministered in a manner that resources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced riew, observation and administration failed to	F 48		ector ctor of

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′				E SURVEY IPLETED	
				_				
		345293	B. WING _			06/	09/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DIG. 114.01	D DIVISO 115 41 5110 4 D			Н	IGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		Н	AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From 10	TO 104		100				
F 490	Continued From pa	=	F4	190				
	Immediate jeopardy began on 3/4/17 when				of immediate jeopardy and expedited			
		nitively impaired resident and			protection of the residents.			
		wanderer, had exited the			0 0/0/47 // 50/50 // // // //			
	facility unsupervised	d.			On 6/9/17, the RVP and corporate clini	cal		
					director addressed communication	_		
		began on 5/1/17 when			breakdown during an in-service with the	е		
		caught between the bed's			administrator and DON on the significance of conducting the			
	the back of his neck	ot board causing a bruise to			, ,			
	the back of his neck	Λ.			standup/daily clinical meeting with administrative nurses to review the			
	The immediate icon	pardy is present and ongoing.			incidents and accidents or significant			
	Findings included:	datay is present and origoning.			occurrences identified in the resident			
	i manigo moladea.				electronic medical records. The			
					administrator and DON were further			
	This tag is cross ref	ferred to:			in-serviced on performing root cause			
					analysis to determine potential systema	atic		
	1. F157 - Based on	record review and staff,			failure and implement an immediate pla			
		and Physician interview, the			to protect the residents through effective			
		fy the physician when a			communication. Corporate, (RVP, clinic			
	_	I resident was entrapped			director, policy director, and/or facility			
	between the mattre	ss and the foot board causing			consultants) is providing daily off-site a	ınd		
	a bruise to the back	of the resident's neck. This			on-site review of the electronic health			
	was evident for 1 of	3 sampled residents			record for nursing progress notes and			
	reviewed for accide	nts (Resident #80).			incident and accident reports.			
	Immediate jeopardy	began on 5/1/17 when			On 6/9/17, the RVP in-serviced the			
	Resident #80 was fe	ound entrapped between the			administrator and DON related to			
	mattress and the fo	ot board and the facility did			ensuring the resident environment			
	not notify the physic	cian.			remains free of hazards, ensuring staff			
					are trained on entrapment, restraints,			
	The immediate Jeopardy is present and ongoing.				critical thinking, and unsupervised exits			
					Communication was determined to be			
					key problem and was address with the			
		record review, observation			administrator and DON. Communication	n		
		the facility utilized a device			is improving through the use of: 1) a			
		without considering it to be a			newly added structured daily standup			
		it a medical symptom.			meeting, 2) newly structured daily clini	cal		
		d was caught between the			meeting with end of day follow-up, 3)			
	bed's mattress and	the foot board causing a			review of the 24 hour report sheets, 4)	ļ		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
						С
		345293	B. WING _			06/09/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE .	
				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCA	RE AND REHABILITATION CENTE		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 490	Continued From p	age 195	F 4	90		
		of the resident's neck. This		use of accident and incident		
	was evident for 1 of 3 sampled residents			maintenance work order prod		
	reviewed for accid	ents (Resident #80).		follow through, 6) care plan r		
				attendance, 7) care plan invi		
		dy began on 5/1/17 when		new informative signage on e		
		found with his head entrapped		notification to family member		
		ess and the foot board causing		to facility security for elopem	•	
	a bruise to the bac	ck of the resident's neck.		visitor postcard on safety for	•	
The immediate leen		anardy is present and angeing		provided upon entrance, 11)		
	The ininediate Je	opardy is present and ongoing.		notification procedures, and implementation of wandering		
	3 F224 Based o	n record review, observation		binders (with resident information		
	3. F224- Based on record review, observation and staff interview, the facility neglected to			biliders (with resident informa-	auon).	
		ively impaired resident who		On 6/9/17, Corporate began	nrovidina	
		wanderer which resulted in an		daily onsite (including weeke		
		from the facility for 1 of 3		holidays) support of the facili		
		reviewed for accidents		administrative staff to ensure		
		esident #3 was found a few feet		administered in a manner tha	-	
	'	g towards a busy highway.		to use its resources effective	ly and	
		o go through a parking lot to get		efficiently to attain and maint	•	
	to the road.			highest practicable physical,	mental and	
				psychosocial wellbeing of the	e residents.	
	Immediate jeopard	dy began on 3/4/17 when		Corporate is supporting the f	acility by	
	Resident #3 exited	d the building unsupervised.		directing and providing the ed		
				staff and testing their recall a		
	Immediate jeopard	dy is present and ongoing.		demonstration through quest interviews.	ionnaires and	
	4. F280 - Based o	on record review and staff				
	interview, the facil	ity failed to revise the care plan		On 6/9/17, the RVP, adminis	trator, DON,	
	for wandering for a	a cognitively impaired resident		and corporate clinical directo	r discussed	
		l at risk for elopement, which		the deficient practices regard	ling Resident	
		upervised exit from the facility's		#3'□s unsupervised exits and		
		3 sampled residents reviewed		#80□'s entrapment by a bed'		
		ident #3.) The facility also		board. Discussions and review		
		care plan of a cognitively		investigative files, nurse prog	ress notes,	
	l •	who had repeated falls for 1 of		resident medical records,		
		nts (Resident #3) at a scope		incident/accident reports, and		
		The facility failed to involve		with staff determined the faci	•	
	alert and oriented	residents in the care planning		administration was not follow	ing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			1	C / 09/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	09/2017	
TO UNIC OF T	TO VIDER OR GOLF EIER				GHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAI	RE AND REHABILITATION CENTE			AMLET, NC 28345			
				- ''	·		1	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From pa	age 196	F 4	190				
	process for 2 (Res	idents #82 & #74) of 3 sampled			policies/procedures. It was also			
	·	is at a scope and severity of D.			determined the facility systems were n	ot		
		•			functioning as designed, as evidenced			
	Immediate jeopard	y began on 3/4/17 when			failure to complete and record			
	Resident #3 exited	the facility unsupervised and			preventative maintenance rounds (bed	S		
		update the care plan. Resident			and wheel chairs, room temperatures,			
	#3 had an unsuper	vised exit on 3/4/17 and had			security on windows), and failure of the)		
several attempts of leaving the facility 3/4/17 incident and the care plan for w					nursing staff to follow through with the			
					unsupervised exit checklists.			
	was not revised sir	nce 8/9/2016.						
					On 6/9/17, the RVP and administrator			
	The immediate jeopardy is present and ongoing.				directed the initiation of door audits,			
					resident bed audits to include head bo			
		n record review, observation			and foot boards, room temperature aud	JIIS,		
		, the facility failed to prevent a dresident from exiting the			wheelchair/Geri chair audits, door and window security audits to see if other			
		ed (Resident #3) and also failed			residents had been affected. The resul	lte		
		ively impaired resident from			of the audits demonstrated the facility	.13		
		etween the mattress and the			found three beds that were identified a	9		
	•	nt #80). The facility also failed			restraints. The maintenance assistants	_		
		intervene to prevent repeated			immediately removed the beds from th			
		at a scope and severity of D.			resident care area.			
	, ,	nt for 2 (Residents #3 and #80)						
		ents reviewed for accidents.			On 6/10/17, the quality improvement (0	QI)		
					committee members (administrator, Do	ON,		
		y began on 3/4/17 when			QI nurse, MDS nurses, social worker,			
	Resident #3 exited	the facility unsupervised.			maintenance assistants) discussed:			
					Abuse/Neglect policy and procedure,			
		y began on 5/1/17, when			elopement prevention interventions,			
		caught between the foot board			wandering risk assessments, audit and			
		ausing a bruise to the back of			safety of equipment, and effectiveness	of		
	his neck.				the quality improvement program.			
	Immediate jeopard	y is present and ongoing.			On 6/12/17, the RVP and clinical direct	tor		
					assisted the administrator and DON in			
					daily clinical meeting. The daily corpora			
					onsite provided it to ensure a systematic			
					approach and effective communication			
					the review of the accident/incident repo	orts		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′				LETED
		345293	B. WING _				C 09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE	1	HI	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 177 S BOX 1489 AMLET, NC 28345	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 490	Continued From pag	e 197	F	490	and occurrences from the electronic health record. For the support and supervision of the facility, the corporate nurse consultant has attended the daily clinical meeting to ensure the administrator and DON are identifying a systematic approach in the review and root cause analysis of incidents/accide. On 6/12/17, the quality assurance assessment (QAA) Committee membe (medical director, administrator, DON, Q/Infection Control Nurse, MDS nurses social worker, maintenance assistants) met and discussed what went wrong, wand performed a 5 Whys root cause analysis (RCA) and determined communication as the root cause of system breakdown. The Committee recommended continued in servicing a implementation of the following to ensuthe safety of the residents: 1) a newly added structured daily standup meeting 2) newly structured daily standup meeting 2) newly structured daily clinical meeting with end of day follow-up, 3) review of 24 hour report sheets, 4) use of accide and incident reports, 5) maintenance worder process and follow through, 6) caplan meeting attendance, 7) care plan invitations, 8) new informative signage elopement, 9) notification to family members in regards to facility security elopement, 10) visitor postcard on safe for elopement provided upon entrance, 11) physician notification procedures, a 12) implementation of wandering board and binders (with resident information).	nts. rs s, why, nd ire g, ng the ent ork are on for ty ind i	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY MPLETED
		345293	B. WING _			C 6/09/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE		
F 490	Continued From page	e 198	F 4	corporate clinical director, and corconsultants, began providing overs the facility and monitoring to ensur facility has systems in place to proleadership and management nece meet resident needs by 1) providir adequate resident supervision to punsupervised exits and entrapment providing an environment as free faccident hazards as is possible, in safe beds, 3) notifying the physicial a resident is involved in an incident/accident, including entrapelopement, 4) removing restraints there is a physician order with measymptom, including bed foot board revising care plans to promote safincluding inviting residents/resident representatives to care plan meeti. On 6/23/17, DON, QI nurse, staff facilitator, hall nurse, MDS nurse, sworker, and/or corporate consultant began auditing nurses progress and risk management reports in the electronic medical record. The autensure all interventions are in place prevent cognitively impaired, wand residents from unsupervised exit/elopement, to protect resident fall, and bed entrapment. Any confare immediately addressed by the to include reporting to the administ and/or DON. Beginning on 6/26/1 audit is documented on the Accide Hazards/Supervision Audit Tool, we covers: 1) if the progress notes we reviewed for incidents/accidents, 2 risk management/incident reports	ite to e the vide the ssary to g revent t, 2) rom cluding n when ment or unless ical s, 5) ety, t notes e dit is to e ring s who cerns auditor rator r, the nich ere) if the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	' '	TE SURVEY MPLETED
		345293	B. WING _			C 6/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/03/2017
DICUMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
KICHWON	D PINES REALI ROAKE	AND REPABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE			(X5) COMPLETION DATE
F 490	Continued From page	a 199	F 4	reviewed for appropriate interven if the 24 hour reports were review daily clinical meeting, 4) if the maintenance work orders were comply the maintenance assistant, 5) preventative maintenance logs are complete. The audit tool will be completed weekly x 3 months, the monthly x 3 months. On 6/23/17, the administrator, DO nurse, MDS registered nurse, and corporate facility consultants confirm onitoring the facility in-services, questionnaires, wandering boards books, resident beds, facility exit work orders, and audit tools to vacompletion/updates/proper function. The administrator and DON also to verbally quiz staff (nurses, nursessistants, dietary, environmental services, therapy, maintenance, services, bookkeeping, reception confirm understanding of expectarelated to: resident safety, preventaccidents, code orange for unsupexit, reporting of incidents to DON/administrator, notification of physicians and resident representant documentation. On 6/26/17, the corporate regional president, corporate consultant, a corporate clinical director (Corporate dinical director (Corporate	ompleted if the completed if the completed if the completed if the completed if the complete in the complete i	

	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	345293	B. WING			C 06/09/2017
NAME OF PROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u> E	06/09/2017
			HIGHWAY 177 S BOX 1489	_	
RICHMOND PINES HEALTHCARE AND I	REHABILITATION CENTE		HAMLET, NC 28345		
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
F 490 Continued From page 200		F 4	attendance at the facility mee occur five times weekly for two three times weekly for two we weekly for four weeks, and at weekly for 16 weeks. On 6/26/17, the administrator vice president, and/or corpora director will begin a weekly re completed audit tools (Accide Hazards/Supervision Audit To Note Audit Tool, Unsupervised Tool, Planning Participation at Audit Tool) to ensure the syste safe environment, proper app devices, staff supervision for safety, care planning invitation plan revisions remain in place functioning properly. The revicompleted, as indicated by initiational audit tools, for four weeks to eadequate supervision and over the DON, QI nurse, MDS nur worker, and/or the maintenan will present the findings of the (Accident Hazards/Supervision Progress Note Audit Tool, Unsexit Audit Tool, Planning Participation Audit Tool) at the modulative Improvement Committee mee Quality Improvement Committee Mee	ro weeks, twice a least once a	essit on are state of the state

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	ľ	(X3) DATE SURVEY COMPLETED
		345293	B. WING _			C 06/09/2017
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		00/03/2017
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 498 SS=E	DEMONSTRATE CO 483.35 (c) Proficiency of Nurrous to demonstrate computechniques necessary needs, as identified the assessments, and de 483.95	1)(2)(4) NURSE AIDE MPETENCY/CARE NEEDS se Aides are that nurse aides are able etency in skills and a to care for residents' hrough resident scribed in the plan of care. se training for nurse aides.	F 4	the findings of the audit tools (A Hazards/Supervision Audit Tool Note Audit Tool, Unsupervised Tool, Planning Participation an Audit Tool) at the quarterly Quarterly and Assessment and Assurance (C Committee meeting. The QAA will review the QI Committee recommendations and facility to the recommendations and facility to the recommendations. The Committee will perform additionals and additional recommendations, a oversight. The administrator wiresponsible for ensuring QAA concerns and recommendation addressed through further train other interventions so that new implemented process are sustamaintain regulatory compliance area of effective administration well-being.	ol, Progress Exit Audit d Revision ality QAA) A Committe S follow-t QAA anal root ke and provid ill be Committee as are aning or vly ained to e in the	t n ee up de e

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING _			1	09/2017
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	03/2017
				н	GHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCAR	RE AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 498	Continued From pa	nge 202	F 4	198			
	(a)(1) Be sufficient	to ensure the continuing					
		se aides, but must be no less					
	than 12 hours per y						
		, 64.					
	(a)(2) Include deme	entia management training and					
	resident abuse pre						
	(g)(4) For nurse aid						
		gnitive impairments, also					
		f the cognitively impaired.					
		NT is not met as evidenced					
	by:						
	,	erviews and record review, the			F 498 Proficiency of Nurse Aides		
		vide evidence of dementia			, , , , , , , , , , , , , , , , , , ,		
	training for 4 of 4 a			On 6/29/17, the director of nursing (DO	N)		
	_	(NA). The findings included:			began ensuring nurse aides are able to		
		. ,			demonstrate competency in skills and		
	The business office	e manager (BOM) provided a			techniques necessary to care for reside	ent	
	list of all current em	nployees on 6/6/17 at 3:00 PM			needs, as identified through resident		
	indicating the follow	ving:			assessments, and described in the plan	n of	
	-NA #2 hire date-11	/4/11			care.		
	-NA #4 hire date- 8	/12/14					
	-NA #9 hire date- 2	/19/13			On 6/29/17, the consultants initiated Ha		
	-NA #12 hire date-	6/23/15			in Hand dementia training to nurse aide	3 S.	
					This is to be completed for all current		
		6/6/17 at 3:40 PM, NA #2			nurse aides by 7/25/17 and upon hire for		
		recall any recent in-service or			new nurse aides, including agency aide		
	training on the care	e of residents with dementia.			instructed by the quality improvement (nurse/staff facilitator.	QI)	
	In an interview on 6	6/6/17 at 3:46 PM, NA #4					
	stated she normally	worked in the secured			The corporate consultants, regional vic	е	
	dementia unit and	did not recall any recent			President (RVP) and payroll/bookkeep	er	
	in-service or trainin	g on the care of residents with			completed a 100% audit of nurse aide		
	dementia.				training records to identify who had		
					received the Hand in Hand dementia		
		view on 6/8/17 at 11:35 AM,			training. None were found.		
		id not recall any recent					
		g on the care of residents with			Beginning 7/3/17, the DON,		
	dementia.				payroll/bookkeeper, and/or corporate		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING _				09/ 2017
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	,	
DICHMON	D DINES HEAT THOADE	AND REHABILITATION CENTE		HIG	HWAY 177 S BOX 1489		
KICHWON	D FINES HEALTHCARE	AND REPABLITATION CENTE		HA	MLET, NC 28345		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 498	stated she normally we dementia unit and did in-service or training dementia. In an interview on 6/8 Administrator stated had not received mandementia and her extrained upon hire and dementia. In an interview on 6/8 Assurance (QA) Nursposition January of 2 responsibilities includin-services for the NA stated the facility use working dementia restated she was still less that the services for the stated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working dementia restated she was still less that the facility use working demential she was still less that the facility use working demential she was still less that the facility use working demential she was still less that the facility use working demential she was still less that the facility use working demential she was she was still less that the facility use working demential she was sh	2/17 at 11:40 AM, NA #12 vorked in the secured d not recall any recent on the care of residents with 2/17 at 3:05 PM, the she was unaware the staff indatory in-servicing on oectation was that staff be if then annually thereafter on 2/17 at 12:30 PM, the Quality is estated she started her index of the staff of the	F 4		consultants will review the nurse aide training records. 5 nurse aide training records will be reviewed weekly for 4 weeks, 2 times monthly for 2 months to ensure that nurse aides have successficompleted the Hand in Hand dementia training resulting in the ability to demonstrate competency in skills and techniques necessary to care for residenceds. This review will be documented on the Nurse Aide Competency Audit to The results of the Nurse Aide Competency Audit tool will be reviewed the administrator weekly. The QI nurse/staff facilitator or DON will present audit findings to the monthly QI Committee for 3 months for further recommendations, take action as appropriate, and to monitor continued compliance. The QI nurse/staff facilitator or DON will present the audit findings and the progress made with the QI Committee's recommendations to the quarterly Qual Assurance and Assessment (QAA) Committee for 1 quarter. The QAA Committee will perform additional root cause analysis as needed and make recommendations for sustaining regulatory compliance in the area of nual aide competency.	ully ent d bool. d by nt	
F 516 SS=E		3.70(i)(3) RELEASE RES CLINICAL RECORDS	F 5		and compositions.		7/17/17
	483.20(f)(5) Residen	t-identifiable information.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017	
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 00/09/2017	
(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 APPROPRI DEFICIENCY)	DATE	
F 516	resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or except to the extent to do so. 483.70(i)(3) The facility record information agunauthorized use. This REQUIREMENT by: Based on observation facility failed to mainth secure location. The Con 6/8/17 at 4:35 PM that contained reside conducted with the Do observed that the mean a wooden storage buthe middle of the lawn building could be lockwithout any staff president were in cardboard bo stacked on top of the determined what year because, when the downs opened, a large subuilding. The Director expected the building	elease information that is on the public. Elease information that is on an agent only in intract under which the agent disclose the information the facility itself is permitted. It y must safeguard medical ainst loss, destruction, or is not met as evidenced in and staff interview, the ain medical records in a findings included: If a tour of the storage area and medical records was irector of Nursing. It was dical records were stored in a idding outside the facility in an in an unsecured area. The steed but was left unlocked ent. The medical records were boxes. It could not be res were being stored for of the storage building swarm of wasps exited the rof Nursing stated she to be locked.	F 516	F 516 Safeguard of Clinical Records On 06/09/17, the maintenance staff secured and locked the medical record storage building. On 6/30/17, the maintenance worker installed a new hat and lock on the medical records storage building. On 06/12/17, the administrator, maintenance worker, and regional vice president (RVP) worked with the corporate office and determined to acquire bids for repair or replacement the medical records storage building. On 06/29/17, the administrator and director of nursing were in-serviced by RVP. The in-service covered safeguarding clinical records informatic	asp ge of the	
	expected medical rec	, an interview was dministrator who stated she ords to be secured with a stated they did a tour about		against loss, destruction or unauthorize use. On 06/30/17, the facility had one estim	ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 06/09/2017
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	00/03/2017
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 516	3 weeks ago and the was supposed to get 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS (g) Quality assessme (1) A facility must ma and assurance communimum of: (i) The director of nur	maintenance supervisor bids for new buildings. (i)(ii)(h)(i) QAA ERS/MEET ant and assurance. intain a quality assessment nittee consisting at a	F 52	and was awaiting another estimate repair or replacement of the medic records storage unit. On 06/30/17, the administrator, maintenance worker, RVP, and/or corporate consultant will conduct of audit per week for 4 weeks then or monthly for 2 months to ensure the medical records storage unit is seen and locked to prevent loss, destruction unauthorized use. The audit will be documented on the Safeguard Clin Record Audit tool. The administrator or maintenance will present the findings of the Safe Clinical Record Audit tool at the medical Record Audit tool at the modulity Improvement (QI) Committed the results of the audits monthly xecond and the recommendation for follow-up as recommendation for follow-up as recommendation for follow-up as recommendation.	one ne time e cured ction, or ne nical worker eguard onthly tee eview 3 ys root

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 06/09/2017	
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	06/09/2017	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 520	staff, at least one of administrator, owne individual in a leade (g)(2) The quality as committee must: (i) Meet at least qual coordinate and evalidentifying issues where a seement and as necessary; and (ii) Develop and impaction to correct ide (h) Disclosure of information to correct ide (h) Disclosure of information to correct ide (h) Disclosure is resuch committee with section. (ii) Sanctions. Good committee to identify deficiencies will not sanctions. This REQUIREMENT by: Based on record resinterview, the facility Assurance Committee cause analysis in resentrapment. Reside unsupervised on 3/4 investigate the root action to prevent fur	her members of the facility's who must be the r, a board member or other	F 52	F 520 QAA On 6/9/17, the Quality Improvement Committee Chairperson/administrator reviewed with the regional vice presic (RVP) and corporate clinical director identified areas of concern from the complaint/annual survey that lead to it deficient practices for further	lent the	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _				09/ 2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	,	00.2011
				н	GHWAY 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 PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 520	Continued From page	e 207	F 5	520			
	foot board and the fac	ne bed's mattress and the cility failed to investigate the velop plan of action to			recommendation and immediate protection of residents.		
	prevent further bed e for 2 of 3 sampled res	ntrapment. This was evident			On 6/10/17, the RVP in-serviced the department heads (director of nursing, minimum data set nurses, treatment nurse, quality improvement/infection		
	Immediate jeopardy began on 3/4/17 when Resident #3 exited the facility unsupervised and was found by Nurse #1 few feet away from a road.				control nurse, maintenance director, dietary manager, social worker, medica records, dietary manager and contract housekeeping manager) related to the	al	
	Resident #80 was for entrapped between the	pegan on 5/1/17 when and in bed with his head he mattress and the foot ruise to the back of his neck.			appropriate functioning of the Quality Assurance Assessment Committee (Quand the purpose of the committee to include identifying issues related to quantification assessment and assurance activities a in the development and implementation	ality nd	
	The immediate Jeopa This tag is cross refe	ardy is present and ongoing.			plans of action for identified facility concerns.		
	and staff interview, the cognitively impaired in facility unsupervised to prevent a cognitive bed entrapment between foot board (Resident 2 (Resident #3 and Residents reviewed for Immediate jeopardy to Resident #3 exited the Immediate jeopardy to Resident #80's head	ecord review, observation e facility failed to prevent a esident from exiting the (Resident #3) and also failed ely impaired resident from een the mattress and the #80.) These were evident for esident #80) of 3 sampled r accidents. Degan on 3/4/17 when be building unsupervised. Degan on 5/1/17 when was found caught between e mattress causing a bruise			On 6/12/17, the Quality Improvement (Committee members (administrator, director of nursing, quality improvement nurse, minimum data set nurses, social worker, maintenance assistants) met a discussed what went wrong, why, and performed a 5 Whys root cause analyst (RCA). Using the RCA process, the QCC Committee identified communication as root cause in the deficient practice area of: 1) resident neglect, 2) revising care plans, 3) preventing entrapment, 4) preventing elopement, 5) supervision, administration, and 7) Quality Assurance and Assessment Committee. The Committee further implemented immediate in-services, observations, and monitoring tools for the protection and	t I Ind is is a as	
	TO THE DACK OF NECK.				safety of the residents.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 6/09/2017	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	•	0/09/2017	
				HIGHWAY 177 S BOX 1489	_		
RICHMON	D PINES HEALTHCAF	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 520	2. F224 - Based or and staff interview, supervise a cogniti was identified as a unsupervised exit f sampled residents (Resident #3). Resto the road heading Resident #3 had to to the road. Immediate jeopard Resident #3 exited Immediate jeopard	age 208 y is present and ongoing. n record review, observation the facility neglected to vely impaired resident who wanderer which resulted in an from the facility for 1 of 3 reviewed for accidents sident #3 was found a few feet g towards a busy highway. go through a parking lot to get y began on 3/4/17 when the building unsupervised. y is present and ongoing.	F 52		QI QAA ths. The QI us on gh tion of As identified and the fect process, acility acreal ess failures. dent s, 3)		
	and staff interview, (foot board) in bed restraint and without Resident #80's head bed's mattress and bruise to the back was evident for 1 creviewed for accide Immediate jeopard Resident #80 was between the mattre a bruise to the back The immediate Jeon Interview with the Owas conducted on that she started as She stated that she regarding QA but si	the facility utilized a device without considering it to be a ut a medical symptom. It was caught between the lithe foot board causing a portion of the resident's neck. This of 3 sampled residents ents. (Resident #80). It was and the foot board causing the found with his head entrapped ess and the foot board causing the		The monthly QI committee will results of the bed audit tools, Drug Administration Entrapme measurement tools, care plan and implementation, restraint accident reports, and exit doo These audits will be reviewed 6 months for the identification actions taken, and to determine for and/or frequency of continumonitoring. The QI committee recommendations to the administration DON will present the committee and recommendations of the committee to the quarterly Quantum Assurance Assessment (QAA for further recommendations as	Federal ent updates audits, r audits. monthly for of trends, ne the need ued will make inistrator r and/or ee findings monthly QI ality committee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER	0.10200		STREET ADDRESS, CITY, STATE, ZIP COD		06/09/2017
	10 115211 011 001 1 2.2.1			HIGHWAY 177 S BOX 1489	_	
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From pag	ge 209	F 52	20		
	added she didn't ha monitor falls or elop that they discussed morning meeting bu happened after that The administrator as immediate jeopardy	or accident hazard. She we any monitoring tools to ement. She further indicated incident report during the t she didn't remember what and the DON were notified of on 6/7/17 at 1:23 PM for 6/8/17 at 12:06 PM for		oversight. The QAA committee agenda, resulting plans of cor and audit results will be docur the meeting minutes. The ad will be responsible for ensurin committee concerns are addresommendations followed. Tadministrator or DON will report the QAA committee at the new quarterly meeting.	rrections, mented in ministrator ng QAA essed and ihe ort back to	
	procedures and more committee put into precertification surversident Assessmer Quality of Care, F31 of Nursing Services inability to sustain a Assessment and As included: This tag is cross reference.	y 6/2/16 in the area of it at F278. In the area of 2 was recited and in the area , F353 pattern of the facility 's in effective Quality surance program. Findings		On 6/18/17, the RVP contacted Quality Improvement Organiz Raleigh, NC office to request consultation to provide guidar with the QI/QAA process and identification of further areas improvement systematic failur 7/13/17, the administrator, dir nursing, and corporate consultation, reference mater discussed additional quality in measures. The administrator the QIO consultation informatinext QI and QAA Committee in the QIO consultation informatinest QI and QAA Committee.	ation (QIO), a nce and help assist in the in quality res. On rector of Itant met at eceived a ials, and improvement will present ion at the	
	interview, the facility Minimum Data Set (and diagnoses for 2 #100) 22 MDS 's re During the recertific facility was cited for code catheter use, b status, and restraint	an record review, taff interview and resident a failed to accurately code the MDS) in the areas of dental (Resident #71 and Resident viewed for accuracy. The state of the st		On 6/10/17, the regional vice (RVP), corporate clinical direct corporate consultants (Corporate consultants) of the facility of the facility of the facility systems in place for quality as and assurance (QAA) that will and implement appropriate place to correct identified quality de On 6/14/17, the QAA Commit	ctor, and rate), began lity and ity has ssessment I develop ans of action ficiencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C	
NAME OF B	20/4050 00 011001150	340293	D. WING _	0.TDEET ADDDESS OFTV 0.TATE 7/D 0.05	•	5/09/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E		
RICHMON	D PINES HEALTHCA	ARE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
				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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From p	page 210	F 5	20			
	·	ely code areas of dental care		medical director, administrato	or DON OI		
	and diagnoses on			nurse, MDS nurse, treatment			
	and diagnoses on	1 WD3 3.		facilitator, hall nurse, nursing			
	2 F312-D: Base	d on observations, staff and		maintenance director, social			
		s and record review, the facility		medical records, activities, di			
		esident showers as scheduled		manager, therapy manager, a	-		
		37) of 5 residents who required		environmental services super			
	•	rith bathing and reviewed for		attend quarterly QAA Commit			
	activities of daily I	_		on an ongoing basis and will	•		
	During the recertification survey of June 2016 the facility was cited for failure to provide nail care to			additional team members as			
				Using the 5 Whys root cause	analysis		
	a resident. On the	e current survey the facility was		process, the QAA Committee	was able to		
	recited for failure	to provide showers to a		determine communication is	a key factor		
	dependent reside	nt.		in the deficient practice areas	•		
				physician and resident repres	sentative		
		d on observations, resident		notification, 2) unnecessary			
		erviews and record review, the		restraints/entrapment, 3) resi			
		ovide sufficient staff to provide		neglect/unsupervised exits, 4			
		duled for residents who required		participation in care planning			
		rith bathing for 1 (Resident #37)		accidents/falls, 6) administrat	•		
		iewed for activities of daily living		purpose, process, and failure	· .		
	(ADLs.)			On 6/10/17, the regional vice	propident		
	During the recorti	fication survey of June 2016 the		On 6/19/17, the regional vice and administrator contacted t	•		
	_	or failure to provide sufficient		Improvement Organization (C	-		
		eet the needs of resident in the		request assistance with the C			
	_	e nursing. On the current survey		On 7/13/17 the administrator,	•		
		cited for failure to provide		nurse, and Corporate are sch			
		complete showers for a		meet with the QIO for consult			
	dependent reside						
				On 6/23/17, the administrator	, DON, QI		
	In an interview on	6/8/17 at 3:05 PM, the		nurse, MDS registered nurse			
		ed her expectation was for the		corporate facility consultants	continued		
		Nurse to have focused on the		monitoring the facility in-servi			
		n the last survey of record,		questionnaires, wandering bo			
		ctiveness if the implemented		books, resident beds, facility			
		notified her if there was		work orders, and audit tools t			
		nued noncompliance in those		completion/updates/proper fu			
	areas.			The administrator and DON a	also continue		

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 06/09/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	<u></u>)E	00/03/2017
				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	DATE
F 520	Assurance Nurse state based on needed action identify and problems her position and she	e 211 2/17 at 12:30 PM, the Quality ated the committee met tions and they had no tool to s. She stated she was new to was not aware of any focus at tags at F278, F312 and	F 5	to verbally quiz staff (nurses, assistants, dietary, environme services, therapy, maintenance services, bookkeeping, recept confirm understanding of exprelated to: resident safety, predictional accidents, code orange for unexit, reporting of incidents to DON/administrator, notification physicians and resident repredient and documentation. The more revealed the facility wander grequired additional maintenar was completed on 7/13/17, Houring needs completion by and is being provided to new QI nurse, and quizzing of staff understanding of expectations. On 6/26/17, the corporate reception of the facility delead meetings, QI meetings, meetings. The purpose of meattendance is to provide additional oversight and guidance. The president or corporate clinical aide in facilitating the QI and Committees root cause and process. Corporate attendant facility meetings will occur five weekly for two weeks, three to for two weeks, twice weekly for two weeks, three to for two weeks, twice weekly for two weeks. On 6/26/17, the regional vice in-serviced the Quality Improvements of the president or corporate clinical corporate the Quality Improvements of the quality Improvements	ental ce, social otionist) to bectations evention of nsupervised on of esentatives nitoring guard system current stat hires by the ff confirms is. gional vice ant, and/or orporate) wi epartment and QAA eeting itional e regional vi al director w QAA alysis nce at the te times times weekl for four ekly for 16	m nd iff e

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 06/09/2017
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, Z HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From pag	e 212	F	Committee (administrate MDS nurses, treatment maintenance assistants activities, medical recommanager, therapy mana environmental services related to the appropriate the QI and QAA Commingurpose of the committed identifying issues related improvement, quality as assurance activities as a developing and implement plans of action for identification concerns. As of 6/26/17, the DON, nurse, social worker, and maintenance assistant of findings of the audit tool Hazards/Supervision Au Note Audit Tool, Unsuper Tool, Planning Participar Audit Tool) at the month Improvement Committed Quality Improvement Correview the results of the 6 months, identify trends cause analysis, and maintenance analysis analysis analysis ana	nurse, , social worker, ds, dietary ager, supervisor) te functioning of ttees and the ees to include d to quality sessment and needed and enting appropriate ified facility A QI nurse, MDS id/or the will present the ls (Accident ldit Tool, Progress ervised Exit Audit tion and Revision ily Quality e meeting. The formittee will audits monthly x s, use 5 Whys root ke ow-up as needed. In the QI Committee areas of quality review process, ounds tools, eview of Point fledical Record),	

C P. WING	
345293 B. WING 06/09/20 ²	2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	1017
HIGHWAY 177 S BOX 1489	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE HAMLET, NC 28345	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) DMPLETION DATE
The quarterly Executive QAA Committee, to include the medical director, will meet at a minimum of quarterly. The quarterly Executive QAA Committee, including the medical director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The DON, QI nurse, MDS nurse, social worker, and/or maintenance will present the findings of the audit tools (Accident Hazards/Supervision Audit Tool, Progress Note Audit Tool, Unsupervised Exit Audit Tool, Planning Participation and Revision Audit Tool) at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. Findings and results of the QI tools will be reviewed by the monthly QI committee and the quarterly QAA committee meeting for 6 months. The QI and QAA committee will focus on improving resident care through developing communication processes. As recommended by QIO, utilization of the cause and effect (fishbone) diagram and 5 Whys Root Cause Analysis (RCA) will help the facility uncover the real causes for systemic breakdown including. 1) physician and resident representative notification, 2) unnecessary restraints/entrapment, 3) resident neglect/unsupervised exits, 4) participation in care planning, 5) accidents/falls, 6) administration, 7) QAA purpose, process, and failure.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 06/09/2017
NAME OF P	ROVIDER OR SUPPLIER	1 0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE		06/09/2017
RICHMON	ID 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 PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE	
F 520	Continued From page	e 214	F 5	The QAA Committee will review the Committee recommendations and facility so follow-up to the QI Committee so recommendations. QAA Committee will validate the form progress in correction of deficient practices or identify concerns. The Committee will perform additional cause analysis as needed, make additional recommendations, and oversight. The quarterly Executive Committee meeting agenda, resurplans of corrections, and audit resure be documented in the meeting ming The administrator will be responsiensuring QAA Committee concern recommendations are addressed further training or other intervention that newly implemented process a sustained to maintain regulatory compliance in the area of effective administration/resident well-being administrator will report back to the Executive QAA Committee at the scheduled quarterly meeting.	. The facility the QAA I root I provid ye QAA Ilting sults wi inutes. sible for ns and throug ons so are	le L