	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245000			с
	ROVIDER OR SUPPLIER	345293		TREET ADDRESS, CITY, STATE, ZIP CODE	04/26/2018
NAME OF PI	CONDER OR SUPPLIER			IGHWAY 177 S BOX 1489	
RICHMON	RICHMOND 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
E 000	Initial Comments		E 000		
	An unannounced rec investigation was con 04/26/18.	ertification/complaint iducted 04/22/18 through			
E 001 SS=F	Establishment of the CFR(s): 483.73	Emergency Program (EP)	E 001		5/24/18
	comply with all applic emergency prepared [facility] must establis comprehensive emer program that meets th section.* The emerge				
	comply with all applic local emergency prep hospital must develop comprehensive emer	gency preparedness he requirements of this			
	with all applicable Fee emergency prepared CAH must develop ar comprehensive emer- program, utilizing an This REQUIREMENT				
	facility failed to establ comprehensive emer plan which described	iew and staff interviews, the lish and maintain a gency preparedness. (EP) the facility's comprehensive health, safety and security		Richmond Pines Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings	D

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.

TATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONTECTION	IDENTIFICATION NUMBER.	A. BUILDING		C
		345293	B. WING	04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER	l	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 001		nd resident population	E 001	factually correct and in order to ma	
	needs for their staff and resident population during an emergency or disaster situation. The facility's EP plan failed to address to following: Resident population Process for EP collaboration Subsistence need for staff and residents Procedure for tracking of staff and residents Policies and Procedures for medical records Policies and procedures for volunteers			compliance with applicable rules ar provisions of quality of care of resid The Plan of Correction is submitted written allegation of compliance. Richmond Pines Healthcare and Rehabilitation Center⊡s response to Statement of Deficiencies does not denote agreement with the Statemen Deficiencies nor does it constitute a	to this ent of
	Arrangement wit Development of Names and cont Emergency Offic Primary/alternate Methods for shar	h other facilities a communication plan act information ials contact information e means for communication ring information ion on occupancy/needs		admission that any deficiency is ac Further, Richmond Pines Healthcar Rehabilitation Center reserves the refute any of the deficiencies on thi Statement of Deficiencies through Informal Dispute Resolution, forma appeal procedure and/or any other administrative or legal proceeding.	re and right to s
	the facility with policie conducted. The many established compreh- the federal requirement Interview on 04/26/18 Administrator stated in	at 7:28 PM AM, the t was her expectation the e EP Plan to meet the		An acceptable plan of correction m contain the following elements: "The plan of correcting the spec deficiency. The plan should addres processes that led to the deficiency "The procedure for implementin acceptable plan of correction for the specific deficiency cited; "The monitoring procedure to e that the plan of correction is effective that specific deficiency cited remain corrected and/or in compliance with regulatory requirements; "The title of the person respons implementing the acceptable plan of correction.	cific s the / cited; ng the e nsure /e and ns n the sible for

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 2 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	IG	COMPLETED
		345293	B. WING		04/26/2018
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	(EACH CORRECTIVI CROSS-REFERENCED	IN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
E 001	Continued From page	2	E 0	01	
				The plan of correcting deficiency	the specific
				The position of Richmo and Rehabilitation cem process that led to this staff failure to establish comprehensive emerg (EP) plan. On 5/18/18, the region in-serviced the adminis development of a com which described the fa comprehensive approa health, safety and secu staff and resident popu emergency or disaster On 5/18/18, the admin development of a com which described the fa comprehensive approa health, safety and secu staff and resident popu emergency or disaster facility s EP plan inclu resident population, pr collaboration, subsiste	ter regarding the a deficiency was the n and maintain a ency preparedness al vice president strator related to prehensive EP plan cility□s ach to meeting urity needs for their ulation during an r situation. istrator began prehensive EP plan cility□s ach to meeting urity needs for their ulation during an r situation. The udes addressing rocess for EP
				and residents, procedu staff and residents, po procedures for medica and procedures for vol arrangement with othe development of a com names and contact info emergency officials co primary/alternate mean	licies and I records, policies lunteers, er facilities, munication plan, ormation, ntact information,

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 3 of 171

		ND HUMAN SERVICES			FORM APPROVED			
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED			
					С			
		345293	B. WING		04/26/2018			
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	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION			
E 001	Continued From page	e 3	E 00	1 communication, methods for sharing information, sharing information on occupancy/needs, EP training and emergency power. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18 the regional vice preside review the facility EP plan to ensure facility plan included a comprehensi approach to meeting health, safety security needs for their staff and respopulation during an emergency or disaster situation. The monitoring procedure to ensure the plan of correction is effective an specific deficiency cited remains co and/or in compliance with the regular requirements The monthly quality improvement (committee will review the EP plan n and make recommendations for char for continued compliance. The administrator and/or director of nursing will present the findings and recommendations of the monthly Q committee to the quarterly executive quality assurance (QA) committee further recommendations and oversite furth	ent will e the ive and sident e that d that rrected atory QI) nonthly anges			
				The title of the person responsible f	or			
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: SX.	1711	Facility ID: 923021 If co	ntinuation sheet Page 4 of 171			

Facility ID: 923021

If continuation sheet Page 4 of 171

						TE SURVEY
		345293	B. WING		C 04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		IGHWAY 177 S BOX 1489 IAMLET, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 001	Continued From pag	e 4	E 001	implementing the acceptable pla correction. The administrator is responsible implementing the acceptable pla correction.	e for	
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)	(2)(b)(1)(2)	F 550			5/24/18
	self-determination, an access to persons ar	ght to a dignified existence, nd communication with and nd services inside and cluding those specified in				
	with respect and digr resident in a manner promotes maintenan					
	access to quality car severity of condition, must establish and m practices regarding to	cility must provide equal e regardless of diagnosis, or payment source. A facility naintain identical policies and ransfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				

Facility ID: 923021

If continuation sheet Page 5 of 171

	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	D. 0938-03 SURVEY PLETED
		345293	B. WING			C 04/26/2018	
AME OF PR	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
	D PINES HEALTHCARE	AND REHABILITATION CENTE			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 PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 550	Continued From pag	e 5	F 5	50			
1 000			F J	50			
		e his or her rights without n, discrimination, or reprisal					
	8483 10(b)(2) The re	esident has the right to be					
		coercion, discrimination, and					
		lity in exercising his or her					
	· ·	ported by the facility in the					
	exercise of his or he	r rights as required under this					
	subpart.						
		T is not met as evidenced					
	by:						
		view, observation and staff			F 550		
		failed to promote dignity by evet and soiled for 1 of 2			The plan of correcting the specific deficiency		
	-	eviewed for dignity (Resident			denciency		
	#69). Findings inclu				The position of Richmond Pines		
					Healthcare and Rehabilitation Center		
	1. Resident #69 was	admitted to the facility on			regarding the process that led to the		
	1/20/11 with multiple	diagnoses including anxiety			deficiency of failure to promote reside	nt	
	disorder.				right of dignity by assisting a resident	with	
					eating while the resident required		
	The quarterly Minimu				incontinent care was incorrect	- 1 - 57	
		/2/18 indicated that Resident			understanding of staff, including floor	staff	
		d decision making problems al staff assistance with			and administrative staff regarding		
		he assessment further			incontinent care during mealtimes.		
		sident was incontinent of			On 4/26/18 at 1:22 PM, nurse assista	nt	
	bowel and bladder.				(NA) #4 and #5 provided incontinent of		
					to Resident #69 and assisted the resid		
		plan dated 4/2/18 was			with incontinent care, including a new		
		e care plan problems was			disposable brief and clean pants.		
		uired assistance with					
		as for the resident to remain			The procedure for implementing the		
		proaches included to check or incontinent episodes.			acceptable plan of correction for the specific deficiency cited		
	On 1/26/18 at 12:06	PM, 12:33 PM, 1:01 PM and			On 5/14/18, the staff facilitator (SF), D		

Facility ID: 923021

If continuation sheet Page 6 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30 FORM APPR OMB NO. 0938	OVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 04/26/2013	8
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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	ETION
F 550	wearing a pair of pant observed to be wet of On 4/26/18 at 1:15 PI observed to enter the the lunch tray. She we tray in front of the res her. On 4/26/18 at 1:16 PI before she started fee stated that she check by looking at the colo the resident was dry. get the chance to che was kind of hectic tod at the resident's pants NA #5 and NA #6 wei #69 in bed using a me Resident #69's pants on the buttock area. H soaking wet and was thighs were observed On 4/26/18 at 1:22 PI observed to provide in	A seat belt on. She was ts and her pants were in the crotch and thigh areas. M, Nurse Aide (NA) #5 was room of Resident #69 with vas observed to set up the ident and was about to feed M, NA #5 was interviewed eding Resident #69. She ed the resident at 11:30 AM r on the disposable brief and She added that she didn't teck her again because "it lay" she said. NA #5 looked is and said "she was wet". re observed to put Resident echanical lift. When in bed, were observed soaking wet her disposable brief was soiled with feces. Her	F 55	Data Set (MDS) nurses, and tree (Tx) nurse initiated a 100% re-e of registered nurses (RNs), lice practical nurses (LPNs), NAs, a geriatric care assistants (GCAs Resident Rights - Dignity and R including part time, as needed (agency. The re-education instr on the importance of maintainin and respect of residents to inclu activities of daily living (incontin during meal times, clean clothin noted odors. The in-service is t completed by 5/24/18. Any sta in-serviced by 5/24/18 will not b to work until the in-service comp During the new employee orien process, the SF, QI nurse, DON administrator will provide reside dignity and respect training, to s including part time, prn, and age The monitoring procedure to em the plan of correction is effective specific deficiency cited remain and/or in compliance with the re- requirements	education nsed ind) titled tespect, (PRN), and ucts staff ig dignity ude ent care) ig, and to be ff not be allowed pleted. tation N or ent rights staff ency. sure that e and that is corrected egulatory	
	interviewed. She stat	M, the Administrator was ted that she expected the t frequently and before episodes.		Beginning 5/14/18, the QI nurse nurse, SF, activities director, ar worker (SW), administrator, ma duty, or corporate consultant be resident care observations durin mealtime at random meals, to o breakfast, lunch, and supper ar days per week, to ensure reside been treated with dignity and re observed for cleanliness, and n	nd social nager on egan ng sover nd seven ents have spect and	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 7 of 171

TEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE (CONSTRUCTION	(X3) DAT	O. 0938-03
d plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		COM	IPLETED
		345293	B. WING _		04	4/26/2018	
AME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	- 10/	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	K	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO
F 550	Continued From page	7	FF	550			
				500	odors. This information is being documented on a Dignity Audit Tool. T dignity audits will be completed with 10 residents weekly times 4 weeks, then once weekly for 8 weeks, then once monthly for one month.		
					The QI nurse will review with the mont QI committee the results of the audits of four months for identification of trends, actions taken, and to determine the ne for and/or frequency of continued monitoring to maintain compliance.	for	
					The QI nurse will present the dignity at tool findings and QI committee recommendations to the quarterly qual assessment and assurance (QAA) Committee for further recommendation and oversight.	lity	
					The title of the person responsible for implementing the acceptable plan of correction.		
					The director of nursing is responsible f implementing the acceptable plan of correction.	or	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-	(3)(8)	F 5	561			5/24/18
	promote and facilitate through support of res	right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f)					

Facility ID: 923021

If continuation sheet Page 8 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489 IAMLET, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 561	§483.10(f)(1) The res activities, schedules (waking times), health care services consists assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect facility that are signifie §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res participate in other activities to facility. §483.10(f)(8) The res participate in other activities to facility. This REQUIREMENT by: Based on record revis staff interviews, the far resident ' s choice to preference for showe eight sampled resider The findings included 1. Resident #11 was 2/10/17. Cumulative diabetes, rheumatoid and hemiparesis follo affecting the left domi	ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the ident has a right to ctivities, including social, inity activities that do not ts of other residents in the is not met as evidenced iew, resident interview and acility failed to honor a receive showers per rs over bed baths for two of nts (Resident #11 and #68). : admitted to the facility diagnoses included: arthritis, and hemiplegia wing cerebral infarction inant side. 2/17 and last revised on sident #11 required	F 561	F561 The plan of correcting the specific deficiency The position of Richmond Pines Nursi and Rehabilitation center regarding the process that led to the deficiency of fa to allow resident choice of shower preferences over bed bath was knowledge deficit. On 5/11/18, Resident #11 received a shower per resident preference. On 5/8/18, Resident #68 received a	e

Facility ID: 923021

If continuation sheet Page 9 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/30/201 MAPPROVE: 0.0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		345293	B. WING		04	C // 26/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD			
RICHMON	RICHMOND 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 561	Continued From page	e 9	F 56	1			
	hemiplegia and decre	eased mobility. Interventions nce for bathing. Prefers		shower per resident preferen	ce.		
	The quarterly Minimu 4/10/18 indicated Re	im Data Set (MDS) dated sident #11 was moderately . Resident #11 required		The procedure for implement acceptable plan of correction specific deficiency cited			
		with dressing, toilet use and e was totally dependent on		On 5/1/18 through 5/10/18, th worker (SW), quality improve nurse, and admissions director residents in the facility for sho	ment (QI) or reviewed		
	÷	ncil meeting held on 4/24/18 t #11 stated he was not showers.		in the last 7 days for showers resident preference using the assistant documentation in th record and resident shower p	e nursing ne medical		
		er schedule revealed leduled for showers every ay during the 7:00 AM-3:00		sheet. The Shower Preference completed through resident in and/or family/resident represe interviews by the SW, QI nurs admissions, minimum data se	ce sheet is nterviews, entative se,		
	months revealed Res following: February 2	chedule for the past three sident #11 received the 20183 showers and 13 full		(MDS), director of nursing (Dr facilitator, (SF), payroll, acco payable, activity director, and	ON), staff ounts I/or charge		
	bed baths; April 2018 3/31/18 until 4/6/18 w	18 5 showers and 20 full 3No documentation from when a partial bed bath was received three showers and		nurse. Shower preference sho completed on admission, read and as requested by resident responsible party, or as need	dmission, t, their		
	7 full bed baths durin			All registered nurses (RNs), li			
		e #3 who stated Resident perative and did not refuse		practical nurses (LPNs), and nursing assistants (CNAs), in time, as needed (PRN), and a be in-serviced by 5/24/18 by	certified cluding part agency, will		
	conducted with Resid	AM, an interview was dent #11 who stated he stead of bed baths. He		SF on resident choice includin preference which includes sh 5/24/18, no licensed nurse or work including part time, prn,	owers. After CNA can		
		d anyone he was not getting 11 stated staff come in and		until in-service is complete. T in-service will be added to the			

Facility ID: 923021

If continuation sheet Page 10 of 171

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · · ·	TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;	CON	MPLETED	
						С	
		345293	B. WING			4/26/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION DATE	
F 561	Continued From page	e 10	F 56	1			
	he did not tell them he	e wanted a shower instead		process for new license	d nurses and		
		s then do what they want but		CNAs, including part tim			
	he would prefer a sho	ower.		agency.			
	On 4/26/18 at 1:40 Pl	M, a second interview was		The monitoring procedu	re to ensure that		
		e #3 who stated residents		the plan of correction is			
		owers and looked forward to		specific deficiency cited			
		here was a shower team but		and/or in compliance wit	th the regulatory		
		wer team a few months ago eam staff working on the		requirements			
		, residents had not been		The DON, staff facilitato	r facility		
		consistently. More bed		consultant, and/or MDS			
		ne because it was quicker for		residents weekly for 12			
	-	an take them to the shower.		showers were given per			
	Nurse #3 said Reside	ent #11 would refuse a		audit includes resident in	nterviews,		
		If he refused a shower, the		observations, family inte	-		
		rse, the nurse would talk to		needed), and staff interv			
		ument in the nursing notes if		of nursing staff documer provided. This audit will			
	they continued to refu	156.		on the Resident Care Au			
		ng notes for the past three ident #11 had refused a		The monthly QI committ	oo will roviow the		
	shower on one occas			results of the resident ca			
				months for identification			
	On 4/26/18 at 1:43 Pl	M, a second interview was		taken, and to determine	,		
	conducted with Resid	lent #11. He said he did not		and/or frequency of cont			
		is morning because he had		and make recommendat			
	the Resident council			monitoring for continued	l compliance.		
	Assistant was presen						
		I him she would give him his		The administrator and/o			
		ready to take it. Resident		the findings and recomn monthly QI committee to			
		ower team but he thought		executive QA committee			
	-	olved around the same time		recommendations and o			
		losed and those residents			J.		
		ce that time, showers have		The title of the person re			
	not been consistent a	and he rarely received a		implementing the accept	table plan of		
	shower.			correction.			

Facility ID: 923021

If continuation sheet Page 11 of 171

						O. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		04	C 04/26/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ODE		
(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 (ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 561	expected a resident's honored., 2. Resident #68 was diagnosis of major de Review of a grievanc #68 dated 3/23/18 re shower since 3/19/18 shower on 3/23/18 at changed. The grievan concerns were valida staff. He showers day and Friday on first sh Review of a grievanc #68 dated 4/10/18 re cloth and told him to requested a shower. held with Resident #6 requested a shower of assistance. The griev would receive staff as independence with h (ADLs). His quarterly Minimut indicated Resident #6 no behaviors. He was with bathing.	M, an interview was dministrator who stated she is choice of bath or shower be a admitted 8/10/16 with a epression and psychosis. The completed by Resident ad he had not received a B. Resident #68 requested a and for his shower days to be nice summary read his ated after interviews with ys were changed to Tuesday iff.	F 5		implementing		
		assistance with bathing.					

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			
		345293	B. WING			C 26/2018
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	shower on Wednesda shower days were ch Friday. He stated he o recently requesting hi and stated he was no scheduled. Review of Resident # indicated he received and 3/30/18 for a tota month of March 2018 4/6/18, 4/9/18, 4/12/1 4/23/18 for a total of 6 through April 25, 2100 documented refusals Interview on 4/26/18 a Assistant (NA) #11 st a shower on 4/25/18. refuse showers. Interview on 4/26/18 a Resident #68 receive shift up until recently shower days be chan #68 did not have a his Interview on 4/26/18 a	He stated he received a ay 4/23/18 but thought his anged to Tuesday and completed a grievance is shower days be changed at receiving his showers as 68's ADL documentation a shower on 3/4/18, 3/27/18 at of 3 showers during the the received a shower on 8, 4/16/18, 4/19/18 and 5 showers from April 1 8. There were no the stated he did not at 8:10 AM, Nursing ated she gave Resident #68 She stated he did not at 4:40 PM, NA #12 stated d his showers on second when he requested his ged. She stated Resident story of refusing showers. at 7:28 PM, the t was her expectation that t for showers be honored	F 56			
F 600 SS=D	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F 600			5/24/18
L						

Facility ID: 923021

If continuation sheet Page 13 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/2018 MAPPROVED 0. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	E SURVEY PLETED C
		345293	B. WING			04	
NAME OF PF	ROVIDER OR SUPPLIER			S	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	Continued From page	9 13	F	600			
	§483.12 Freedom from Exploitation	m Abuse, Neglect, and					
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and					
	treat the resident's me	ical restraint not required to edical symptoms.					
	§483.12(a) The facilit	y must-					
	physical abuse, corpo involuntary seclusion; This REQUIREMENT						
	by: Based on observation interviews with staff, p				F600		
	Practitioner (NP), the	facility neglected to provide for a cognitively impaired			The plan of correcting the specific deficiency		
	wandering behaviors inappropriate behavior the room of a cognitiv	and a history of sexually ors. Resident #45 entered ely impaired female or, and exposed his genital 3. This was for 1 of 1			The position of Richmond Pines Nu and Rehabilitation center regarding process that led to this deficiency – facility neglected to provide adequa supervision to prevent a resident-to-resident event- was knowledge deficit.	the the	
	The findings included	:			On 4/26/18, Resident # 45 was plac	red on	
	12/1/16 and most rec facility on 11/22/17 wi	mitted to the facility on ently readmitted to the th multiple diagnoses that th behavioral disturbance.			1-to-1 staff supervision which contir until 5/8/18 at which time the reside determined by the facility to be exhi no sexual behaviors, as evidenced documented behaviors.	nued nt was biting	
	The quarterly Minimu dated 3/3/18 indicated rarely/never understo				On 4/26/18, Resident #13 was obse by the staff LPN immediately post	erved	

Facility ID: 923021

If continuation sheet Page 14 of 171

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	. ,	E SURVEY
			A. BUILDIN	G		
		245202	B. WING			С
		345293				4/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
	1			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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 14	F 60	00		
		d short-term and long-term		incident. The LPN noted	t in the progress	
		id severely impaired decision		note at 0206 "no visible i		
	making. Resident #4			pain, no grimacing, no te		
		n and disorganized thinking.				
	He had no behaviors			On 4/26/18, Resident #1	3 was assessed	
	wandering during the	MDS review period.		at the hospital emergend	y department.	
	Resident #34 was inc	dependent with set up help		The physician performed	an "external	
		t of room and corridor. He		examination of the vagin	al area and rectal	
	was noted to be unst	eady on his feet, but he was		area; there is no evidence	e of injuryNo	
	able to stabilize witho	out staff assistance.		obvious bruising or injury	/ were visualized."	
				The facility was informed		
	Resident #45 ' s plan	of care included, in part, the		that the results of the rap	be kit will not be	
	focus areas of:			available for 2 to 3 mont	hs.	
		in which resident acts		On 4/26/18, to protect th		
		fective coping: wandering		related to the allegation		
		upervised exits from the		facility provided ongoing	-	
		empts to leave unit/building if		Resident #13 and 1-to-1		
		lent wandering in and out of		Resident #45. Resident		
		ms/exit seeking behavior at		the facility with no new o		
		ea was initiated on 5/8/17		emergency department		
		/26/17. The interventions ent to wander on the unit		Resident #13 was return assigned room, bed alar		
		nd last on revised 3/6/18).		staff if resident exited the		
		in which resident acts		#45 remained on 1-to-1		
		propriate behavior and		4/26/18, the quality impr		
		ent/care related to cognitive		nurse noted in the progre	. ,	
		us area was initiated on		sleeping peacefully until		
	8/21/17 and last revis			scoot chair, eating ice cr		
				about facility. Smiled wh	•	
		ated Resident #45 had				
	previously resided on	•				
		his unit was temporarily		The procedure for implei		
		18 for maintenance and had		acceptable plan of corre	ction for the	
		ed. All of the residents who		specific deficiency cited		
		cked memory care unit,				
	-	15, presently resided in		On 5/18/18, the QI nurse		
	unlocked units of the	facility.		in-service with all staff in	U	
				unlicensed, part time, as	needed (PRN),	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 15 of 171

		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	· · ·	TE SURVEY MPLETED
							С
		345293	B. WING			0	4/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
DICUMON				HIG	GHWAY 177 S BOX 1489		
RICHINON	D PINES REALINCARE	AND REHABILITATION CENTE		HA	MLET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 15	F 60	0			
1 000	Resident #45 was ob		F OU		and agapay, on babaylar managamar	.+	
		shuffled and slow gait on his			and agency, on behavior managemer including wandering, and sexual	it.	
	unit of the facility on	-			behaviors. This in-service will be		
		nimal speech that was			completed by 5/24/18. After 5/24/18,	no	
	garbled and indisting	-			staff will be allowed to work without th		
					in-service. This in-service will be adde	ed to	
		served ambulating with a			the orientation for newly hired staff,		
		t on a different unit at the			including licensed, unlicensed, part tir	ne,	
	facility on 4/23/18 at	4:00 PM.			PRN, and agency staff.		
	Resident #45 was ob	served standing in a			On 5/18/18, the QI nurse began an		
	common area of the	facility on 4/24/18 at 2:30			in-service with all staff including licens	sed,	
	PM.				unlicensed, part time, PRN, and agen	су,	
					on neglect. This in-service will be		
	-	ted 4/26/18 and completed			completed by 5/24/18. After 5/24/18,		
	•	d Resident #45 was found in			staff will be allowed to work without th	-	
		room (Resident #13) on the			in-service. This in-service will be added	ed to	
		ime indicated). Resident y a shirt and socks. His brief			the orientation for newly hired staff, including licensed, unlicensed, part tir	mo	
		rved laying at the head of			PRN, and agency staff.	ne,	
	-	There was no physical			Trivi, and agency stan.		
		staff between Resident #45			By 5/22/18, the staff facilitator, QI nur	se.	
		Resident #45 was able to be			director of nursing (DON) and/or	,	
		on Resident #13 ' s bed as			corporate consultant had reviewed all		
	Resident #13 was as	sisted out of the room.			residents with wandering behaviors		
	Resident #45 and Re				(based on last minimum data set		
		dent #13 ' s 1/15/18 quarterly			assessment and wandering risk		
		as rarely/never understood			assessment) to ensure interventions a		
	•	erstands). A physical			in place to protect the resident and ot	her	
		npleted of both residents and			residents that may be affected by the	onto	
		 Resident #45 was dressed and was then 			behavior. The audit revealed all reside with wandering behaviors have	ents	
		ervision. The Quality			interventions in place to protect the		
		se, Administrator, on call			resident and other residents that may	be	
		it, and the Responsible Party			affected by the behavior.	~~	
	(RP) of each resident						
					By 5/22/18, the staff facilitator, QI nur	se,	
	-	rt was completed on 4/26/18			DON and/or corporate consultant had		
	at 12:15 AM for the ir	ncident that occurred on the			reviewed all residents with sexual		

Facility ID: 923021

If continuation sheet Page 16 of 171

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>		. ,	E SURVEY PLETED
			/			С
		345293	B. WING		04	/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				HIGHWAY 177 S BOX 1489		
RICHMON	ID 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 16	F 60	0		
		Resident #45 and Resident	1.00	behaviors (based on care	e nlan) to ensure	
	#13. The allegation i			interventions are in place		
		and resident abuse. The		resident and other reside	-	
		indicated Resident #13 's		affected by the behavior.	-	
	bed alarm had sound	led in her room. A Nursing		sexual behaviors have a		
	Assistant (NA) went to the room and found			place with appropriate inf		
		l in a nightgown and brief		place to protect residents		
		her room with Resident #45		residents that may be aff	ected by the	
		Resident #45 was noted to		behavior.		
	be wearing only a sh			0	in also alterat	
	notified.	iated and the police were		On 4/26/18, current staff		
	nounea.			licensed, unlicensed, full PRN, and agency were in		
	The facility 's investi	gation of the 4/25/18 incident		related to sexual behavio		
	-	45 and Resident #13 was		by the DON, administrate		
		#13 ' s bed alarm was heard		social worker, and or stat		
		NA #9) on 4/25/18 around		Through interviews with s		
		ent to Resident #13 ' s room,		residents were identified		
	attempted to enter th	rough the door to the room,		behaviors.		
	but found the door wa	as blocked by something and				
		nter. NA #9 was able to		The monitoring procedure		
		's room by entering through		the plan of correction is e		
	an adjoining bathrooi			specific deficiency cited r		
		ent #13 was found sitting on		and/or in compliance with	n the regulatory	
		e door to her room. She		requirements		
		tgown and brief. Resident er her clothed in only a		The DON, staff facilitator		
	-	nd socks. Resident #45 had		and/or weekend manage		
		nd his brief. His pants were		review progress notes fro		
		13 's bed and his brief was		24 hours 5 times weekly	-	
		om. Staff assisted Resident		ensure all documented w		
	#13 off the floor, into	her wheelchair, and out of		sexual behaviors have a		
	her room. Resident a	#45 refused to exit the room		interventions to protect th		
		sed to be assisted with		other residents that may		
	-	ants back on. Resident #13		audit will be documented	in the progress	
		ere assessed for injuries with		note audit tool.		
		contact or injury. Resident			01	
		on 1 supervision. The		The DON, staff facilitator		
	police were notilied a	and Resident #13 remained		and/or corporate facility of		

Facility ID: 923021

If continuation sheet Page 17 of 171

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
				HIGHWAY 177 S BOX 1489	
RICHMON	ID 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 600	Continued From page	a 17	F 60	0	
	with staff in a commo police arrived. Follow Resident #13 was tra police accompanimer completion of a sexua staff evaluated Resid identifiable concerns related to the inciden the facility. The sexua forwarded to the loca The hospital Emerge 4/26/18 for Resident * #13 was brought in w for evaluation of poss officer present at the reported there was no struggle. A sexual as and Resident #13 wa obvious evidence of i discharged back to the evaluation. On 4/26/18 at 8:15 A conducted at the loca Police Captain and th report related to Resi was reviewed. The in indicated the crime in suspect was identified were noted to be disp approximately 1:00 A	nn area of the facility until ving the arrival of the police, insferred to the hospital with ht for an evaluation and the al assault sample. Hospital ent #13, found no to her physical status t, and she was returned to ial assault sample had been I police department. Incy Department note dated #13 was reviewed. Resident vith police accompaniment sible sexual assault. The hospital with Resident #13 o evidence of any kind of a assault sample was performed is examined. There was no njury. Resident #13 was he facility following the M an interview was al police department with a he incident/investigation dent #45 and Resident #13 hoident/investigation report in question was rape, the d as Resident #13. The police batched to the facility at M on 4/26/18. The QA		 review visually and throug documentation 5 residents high risk for wandering an behaviors. The review will on varying days and shifts days and all shifts) x 12 w will be documented on the behavior audit tool. The monthly QI committee results of the progress not tool and resident behavior monthly for 3 months for it trends, actions taken, and the need for and/or freque continued monitoring, and recommendations for mor continued compliance. Th and/or DON will present th recommendations of the r committee to the quarterly quality assurance (QA) co further recommendations The title of the person res implementing the accepta correction. The DON is responsible for the accepta plan of correction. 	s designated as d/or with sexual ll occur weekly s (to cover seven eeeks. This audit e resident e will review the te review audit audit tool dentification of to determine ency of l make nitoring for e administrator he findings and nonthly QI v executive ommittee for and oversight. ponsible for ble plan of
	Nurse provided the ir when he arrived at th indicated NA #9 disco Resident #13 ' s roon	ncident details to the officer e facility. The report overed Resident #45 inside n after a bed alarm was #45 had no pants or brief on,			

Facility ID: 923021

If continuation sheet Page 18 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/30/2018 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345293	B. WING		_		C 26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HGHWAY 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	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	room, and Resident # fully clothed. NA #9 f s room through the ba to the room next door move away from door from her room as Res NA #9 was interviewe #45 removed his cloth brief and clothing wer Nurse #5 was interviewe had observed Reside physical injuries were resident. Resident #7 for a sexual assault s reported that the resu sample could take an month to receive back based on the informa injuries observed on a 4/26/18 at 8:36 AM. S the unit where Reside resident. She reported both Resident #13 an during the 3:00 PM to indicated prior to leav her shift on 4/25/18, s the nurse 's station a saw Resident #13 bei room by NA #10 arou that Resident #45 's wandering through th reported he frequently resident 's rooms. S could be combative a	13 was sitting on her floor had to access Resident #13 ' athroom door that connected as Resident #45 refused to r. NA #9 removed Res #13 sident #45 refused to leave. and she stated Resident hing a lot. Resident #45 ' s re near Resident #13 ' s bed. weed and she stated she nt #45 with an erection. No observed on either 13 was taken to the hospital ample. The Police Captain lits of the sexual assault ywhere from a week to a k. He had confirmed that tion there were no physical	F 600				

Facility ID: 923021

If continuation sheet Page 19 of 171

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUT		INSTRUCTION	(X3)	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · · ·	MPLETED
							С
		345293	B. WING			0	4/26/2018
NAME OF PI	ROVIDER OR SUPPLIER	1	•	STRE	EET ADDRESS, CITY, STATE, ZIP COD	DE	
				HIGH	IWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAN	ILET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 600	Continued From page	e 19	F	600			
	inappropriate behavio						
	An interview was conducted with the QA Nurse on 4/26/18 at 9:10 AM. She stated Resident #45 wandered throughout the facility during most of the day. She reported he wandered into other residents ' rooms and was difficult to redirect at times. She indicated she believed he was unable to determine which room was his. The QA Nurse was asked if Resident #45 had any specific interventions related to the frequency of monitoring his whereabouts due to his frequent wandering and entering other residents ' rooms. She reported that prior to the incident last night (4/25/18) there were no specific timeframes in place for monitoring his whereabouts. She indicated Resident #45 was now on 1 on 1 supervision at all times.						
c c F c t f F F r r r r r i i	A phone interview wa on 4/26/18 at 11:10 A on the unit where Res resided on 4/25/18 du PM shift. She reporte observed Resident #* the incident that night approximately 10:30 Resident #45 was sea positioned in the hally Resident #13 was in 1 reported after that ob nurse ' s station to co indicated that there w from the nurse ' s stat Resident #45 ' s room						

Facility ID: 923021

If continuation sheet Page 20 of 171

DEPARTMENT OF HEA CENTERS FOR MEDIC						FOR	D: 05/30/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345293	B. WING				C /26/2018
NAME OF PROVIDER OR SUPPL	IER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMOND PINES HEALT	HCARE	AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489		
				ŀ	HAMLET, NC 28345		
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
she arrived at members were Resident #45 was seated or She reported I floor with her H ground. This phone int She indicated throughout the and sometime stated she wa exhibiting any recently, but s occurred some #45 was obse resident ' s ha #6 reported R behaviors, and indicated staff monitor his wh were no speci often Residen monitored. A second inter Nurse on 4/26 Resident #45 inappropriate no recent histo Resident #45, occurred about that incident, F to another ferr he was attemp	the roo e prese had no a the foo Resider crees b erview Reside e facility s into o s unaw sexual he had etime in rved ho nd and esident include d being tried to bereabo fic inter t #45 ' s view w /18 at 1 had any behavio	e 20 s room. She reported when im several other staff nt. Nurse #6 stated pants or brief on and he of of Resident #13 ' s bed. In #13 was seated on the event and her feet on the with Nurse #6 continued. In #45 frequently wandered r, up and down the hallways, other residents ' rooms. She are of Resident #45 ly inappropriate behaviors known of an incident that 0 2017 in which Resident olding another female going into her room. Nurse #45 occasionally had ed combativeness, verbal difficult to redirect. She to keep an eye on him and buts. She reported there ventions related to how s whereabouts were as conducted with the QA 11:20 AM. She was asked if y history of sexually or. She reported there was his type of behavior for ere was an incident that r ago. She indicated during it #45 had been seated next ident and it had appeared remove her pants. She pants were only slightly	F	600			

Facility ID: 923021

If continuation sheet Page 21 of 171

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M						FORM): 05/30/2018 / APPROVED). 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345293	B. WING					C 26/2018
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIF	CODE		
RICHMOND PINES HEALTHCARE A	ND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489			
			ŀ	HAMLET, NC 28345			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD B		(X5) COMPLETION DATE
residents were separated placed on 1 on 1 super (she was unable to reconsupervision was in placed there had been no othered sexually inappropriated since that occurrence. A phone interview was 4/26/18 at 12:35 PM. A the unit where Residered resided on 4/25/18 dur PM shift and she was a She reported the last to Resident #13 and Resident #145. She reported the last to Resident #13 and Resident #45, but working at the facility swith Resident #45, but worked with him she had frequently. NA #10 reporter staff members the into other residents ' resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident #45. A phone interview was 4/26/18 at 12:35 PM. A the unit where Resident resided on 4/25/18 dur AM shift, but she was a first phone was a	waist. She reported the two ted and Resident #45 was rvision for a period of time call how long this 1 on 1 ce). The QA Nurse stated er instances of any type of behavior for Resident #45 conducted with NA #10 on She stated she worked on nt #13 and Resident #45 ring the 3:00 PM to 11:00 assigned to both residents. ime she had observed ident #45 prior to the 5/18) was at approximately ted she had tried to perform Resident #45, but he had he left the facility around ted she had recently started so she was not too familiar in the three times she had ad seen him wander ported she had heard from hat Resident #45 wandered ooms at times. She stated in Resident #45 about every worked with him to check She indicated she had riate sexual behaviors for	F	600				

Facility ID: 923021

If continuation sheet Page 22 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/30/2018 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345293	B. WING		_		C 26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		_	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HGHWAY 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	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	she and NA #9 were a receiving their report about 11:20 PM on 4/ time (around 11:20 PI nurse's station and p of the unit that Reside resided on. She report the end of the hallway was heard sounding. Resident #13's room and she proceeded to NA #8 reported that we Resident #13's door unable to open it. Sh called for her assistan completed her care w with and she then we couple of minutes. N enter Resident #13's bathroom door that are reported she also had room through the adje door and she had obs on the floor in front of her legs bent and fee Resident #13 with his explained that Reside short-sleeved shirt an This interview with NA she had not regularly but she was aware he and entered other res were open. She indic inappropriate sexual I	sident #45. NA #8 reported at the nurse 's station from the prior shift until (25/18. She stated at that M), she and NA #9 left the proceeded down the hallway ent #13 and Resident #45 orted that when they got to y Resident #13 's bed alarm She stated NA #9 went to n to attend to the bed alarm o assist another resident. when NA #9 approached it was shut and she was re stated NA #9 had then note. She reported she with the resident she was nt to assist NA #9 within a A #8 stated NA #9 had to s room by going through the djoined the bedrooms. She d to enter Resident #13 's poining room 's bathroom served Resident #13 seated if the door to the room with t on the ground. She stated inding directly in front of a genitals exposed. NA #8 ent #45 was wearing only a	F 600				

If continuation sheet Page 23 of 171

		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	· · ·	TE SURVEY MPLETED
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG			
		0.15000				C	
		345293	B. WING			0	4/26/2018
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IWAY 177 S BOX 1489		
				HAN	ILET, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	o 23	F 6	00			
1 000			FO	00			
		4/26/18 at 1:22 PM. She ar with Resident #45. She					
		recent sexually inappropriate					
		ained that when he had					
		d memory care unit there					
		nt whom he spent a lot of					
		ther explained that she					
i		resident was the aggressor					
	in that situation.						
	A phone interview wa	as conducted with NA #9 on					
	4/26/18 at 1:25 PM.	She stated she was					
		t #13 and Resident #45 on					
		1:00 PM to 7:00 AM shift.					
		en she came on shift she					
		station receiving a report					
	· ·	ift until around 11:25 PM					
		ated that there was no visual nurse ' s station to Resident					
		#45 's rooms as both rooms					
		a corner. NA #9 reported					
		PM she and NA #8 left the					
		proceeded down the hallway					
	of the unit that Resid	ent #13 and Resident #45					
		ed that was when she had					
		s bed alarm sounding. She					
	•	Resident #13 's door and					
	found that it was clos						
		e door to the room, but she n it partially. She explained					
		nt #45 inside of Resident #13					
		partially opened door and					
		sh on the door to close it.					
	-	she was then unable to					
	reopen the door so s	he proceeded to enter the					
		h the door of the adjoining					
		She reported that when she					
		e observed Resident #13					
	seated on the floor in	front of the door with her	1				

Facility ID: 923021

If continuation sheet Page 24 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/30/2018 MAPPROVED O. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COM	E SURVEY PLETED
		345293	B. WING		C 04/26/2018	
NAME OF PRC	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
RICHMOND	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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
III Solation Fthe Mail Solation Structure Solation Structure Solation Structure Solation Structure Solation Structure Solation Structure Solation Structure Solation	tated Resident #45 v of Resident #13 with explained that he was short-sleeved shirt ar Resident #45 's pant #13 's bed and his bu NA #9 stated this was assistance from NA # ndicated she believe of her bed independe area near the door. Se #13 had completed th She confirmed that the even Resident #45 ar coming on shift that n This phone interview stated that Resident # and completed that the even Resident #45 ar coming on shift that n This phone interview stated that Resident # the common areas, a ooms. She stated he was difficult to redirect She indicated she ha excual behaviors for l aware of an incident for another [female] resid (ke that". NA #9 indic emale was the aggree had dementia and the pusband. An interview was con 1/26/18 at 3:15 PM. S	feet on the ground. She was standing directly in front his genitals exposed. She is wearing only a nd socks. She indicated that is and brief were on Resident rief was soaked with urine. is when she called for 8 and Nurse #5. NA #9 d Resident #13 had slid off ently and crawled over to the She explained that Resident his type of action in the past. his was the first time she had and Resident #13 since	F 60			

If continuation sheet Page 25 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/30/2018 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345293	B. WING		C 04/26/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345)E	
(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 APPROPRIATE	(X5) COMPLETION DATE
F 600	4/25/18 during the 11 She stated she was a around 11:15 PM on the previous shift. Sh no visual line of sight Resident #13 ' s and both rooms were loca Nurse #5 stated the N rounds after the previ their report. She indi began their rounds, N toward the nurse ' s s assistance to Reside stated she went to Re was unable to open the entered the room by adjoining room ' s bat Resident #13 was se the door with her legs ground. She stated F directly over Residen short-sleeved shirt ar exposed, and he had that Resident #45 ' s Resident #13 ' s bed with urine. Nurse #5 direct Resident #45 c became agitated. Sh able to get Resident a #13 ' s bed while Res her wheelchair and o it took several attemp redirected out of Res This interview with Ne stated she had been about two weeks, but previously worked her	:00 PM to 7:00 AM shift. at the nurse 's station until 4/25/18 receiving report from he indicated that there was from the nurse 's station to Resident #45 's rooms as ated around a corner. NAs began completing their ious shift finished providing cated shortly after the NA 's NA #9 came down the hall station and called for nt #13 's room. Nurse #5 esident #13 's door and she he door. She indicated she going through the door of the throom. She reported ated on the floor in front of s bent up and her feet on the Resident #45 was standing t #13, he was wearing only a nd socks, his genitals were an erection. She indicated pants and brief were on and his brief was soaked stated staff attempted to but of the room when he he indicated the staff were #45 to sit down on Resident sident #13 was assisted into ut of the room. She reported bits for Resident #45 to be ident #13 's room.	F 60			

Facility ID: 923021

If continuation sheet Page 26 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE O. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY IPLETED
		345293	B. WING		C 04/26/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
				HAMLET, NC 28345		1
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 26	F 60	n		
		allways. She indicated she	1.00	0		
		ppropriate sexual behaviors				
	The DON was unava	ilable for interview.				
	An interview was cor	nducted with the				
	Administrator on 4/26	6/18 at 7:20 PM. The				
		during the staff interviews				
	was reviewed with th	e Administrator. The the last observations of				
		esident #45 prior to the				
		around 10:30 PM by Nurse				
		interviews additionally				
		servation of Resident #13				
		as between the times of PM when Resident #13 ' s				
		lerting staff that Resident				
		bed. Staff then found				
		dent #13 ' s room, he had				
		s genitals were exposed to				
		dministrator stated she				
	expected staff to ade residents. She state					
	immediately placed c					
		incident. She indicated the				
	facility 's plan was to	continue 1 on 1 supervision				
		I the locked memory care				
	unit reopened.		F 62	2		1
E 602	inolice requirements	Poforo Transfor/Discharge		5		5/21/10
F 623 SS=C	CFR(s): 483.15(c)(3)	Before Transfer/Discharge -(6)(8)	1 02			5/24/18
	CFR(s): 483.15(c)(3) §483.15(c)(3) Notice	-(6)(8)	1 02			5/24/18
	§483.15(c)(3) Notice Before a facility trans	-(6)(8) before transfer. fers or discharges a	1 02			5/24/18
	§483.15(c)(3) Notice Before a facility trans resident, the facility n	-(6)(8) before transfer. ifers or discharges a nust-				5/24/18
	§483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident	-(6)(8) before transfer. ifers or discharges a nust-				5/24/18

Facility ID: 923021

If continuation sheet Page 27 of 171

STATEMENT OF DEFICI AND PLAN OF CORRECT NAME OF PROVIDER RICHMOND PINES (X4) ID PREFIX TAG F 623 Contin langua facility repres Long- (ii) Re discha accoro and (iii) Inc paragu §483.7 (i) Exc (c)(8) discha made	CIENCIES ECTION R OR SUPPLIER ES HEALTHCARE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I inued From page uage and manne by must send a cr sentative of the -Term Care Omb ecord the reason arge in the resid rdance with para nclude in the noti graph (c)(5) of th	r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or lent's medical record in Igraph (c)(2) of this section;		CROSS-REFERENCED TO TH DEFICIENCY	ORRECTION DN SHOULD BE COM IE APPROPRIATE	EY D
RICHMOND PINES (X4) ID PREFIX TAG F 623 Contin langua facility repres Long- (ii) Re discha accord and (iii) Ind paragu §483.2 (i) Exc (c)(8) discha made	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I inued From page uage and manne by must send a cr sentative of the -Term Care Omb ecord the reason arge in the resid rdance with para	AND REHABILITATION CENTE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 27 r they understand. The opy of the notice to a Office of the State oudsman. hs for the transfer or lent's medical record in lograph (c)(2) of this section; ice the items described in	ID PREFIX TAG	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ORRECTION DN SHOULD BE IE APPROPRIATE	(X5) IPLETION
RICHMOND PINES (X4) ID PREFIX TAG F 623 Contin langua facility repres Long- (ii) Re discha accord and (iii) Ind paragu §483.2 (i) Exc (c)(8) discha made	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I inued From page uage and manne by must send a cr sentative of the -Term Care Omb ecord the reason arge in the resid rdance with para	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ORRECTION ON SHOULD BE COM IE APPROPRIATE	(X5) IPLETION
(X4) ID PREFIX TAG F 623 Contin langua facility repres Long- (ii) Re discha accord and (iii) Ind parage §483.7 (i) Exc (c)(8) discha made	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I inued From page uage and manne by must send a cr sentative of the -Term Care Omb ecord the reasor narge in the resid rdance with para nclude in the noti graph (c)(5) of th	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	HAMLET, NC 28345 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	PLETION
(X4) ID PREFIX TAG F 623 Contin langua facility repres Long- (ii) Re discha accord and (iii) Ind parage §483.7 (i) Exc (c)(8) discha made	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I inued From page uage and manne by must send a cr sentative of the -Term Care Omb ecord the reasor narge in the resid rdance with para nclude in the noti graph (c)(5) of th	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	PLETION
F 623 Contin langua facility repres Long- (ii) Re discha accoro and (iii) Ino paragu §483.7 (i) Exo (c)(8) discha made	(EACH DEFICIENC REGULATORY OR I inued From page uage and manne by must send a co sentative of the -Term Care Omb ecord the reasor inarge in the resid rdance with para nclude in the noti graph (c)(5) of th	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 27 r they understand. The opy of the notice to a Office of the State oudsman. hs for the transfer or lent's medical record in hgraph (c)(2) of this section; ice the items described in	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	PLETION
langua facility repres Long- ⁻ (ii) Re discha accorc and (iii) Inc paragu §483. ⁻ (i) Exc (c)(8) discha made	uage and manne cy must send a consentative of the -Term Care Ombe ecord the reason arge in the reside rdance with para holude in the noting graph (c)(5) of the	r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or lent's medical record in Igraph (c)(2) of this section;	F 62	23		
langua facility repres Long- (ii) Re discha accord and (iii) Ind paragu §483.7 (i) Exc (c)(8) discha made	uage and manne cy must send a consentative of the -Term Care Ombe ecord the reason arge in the reside rdance with para holude in the noting graph (c)(5) of the	r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or lent's medical record in Igraph (c)(2) of this section;				
(ii) No before (A) Th be end this se (B) Th be end this se (C) Th allow a under (D) Ar require under (E) A r days. §483.1 notice	ccept as specified of this section, arge required ur e by the facility a ent is transferred otice must be ma re transfer or disc he safety of indivi- ndangered under section; he health of indivi- dangered, under section; he resident's he r paragraph (c)(7 an immediate tran red by the resider r paragraph (c)(7 a resident has no .15(c)(5) Content	ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would er paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 atts of the notice. The written ragraph (c)(3) of this section				

If continuation sheet Page 28 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	05/30/201 APPROVEI 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		345293	B. WING		C 04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HGHWAY 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 623	 (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individ §483.15(c)(6) Change If the information in the effecting the transfer- must update the recip 	of transfer or discharge; hich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which ets; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State oudsman; y residents with intellectual isabilities or related or and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act.	F 623			

If continuation sheet Page 29 of 171

		ND HUMAN SERVICES			PRINTED: 05/30/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·
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 (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 623	In the case of facility the administrator of the written notification prito the State Survey A State Long-Term Carr the facility, and the re- well as the plan for the relocation of the reside 483.70(I). This REQUIREMENT by: Based on staff interve facility failed to notify of discharge home on #280, Resident #287 #13, Resident #34, R #42) of 7 residents re- findings included: 1. Resident #280 was discharged home on Interview on 4/26/18 Worker (SW) stated as Regional Ombudsman discharge home on 4 thought it was the resident was discharge facility had to notify the resident was discharges and the stated of facility had to notify the resident was discharges and the stated of a stated she was re aware of who was re- Regional Ombudsman	closure, the individual who is he facility must provide ior to the impending closure agency, the Office of the e Ombudsman, residents of esident representatives, as he transfer and adequate dents, as required at § T is not met as evidenced views and record review, the the Regional Ombudsman the hospital for 7 (Resident I, Resident #50, Resident eviewed for discharge. The s admitted 2/19/18 and 4/4/18. at 9:27 AM, the Social she did not notify the un of Resident #280's /4/18. She stated she sponsibility of the Admissions at 9:30 AM, the she was not aware that the ne Regional Ombudsman if ged home or to the hospital. new to the facility was not sponsible for notifying the	F 623	F623 The plan of correcting the specific deficiency The position of Richmond Pines N and Rehabilitation regarding the p that led to this deficiency-failed to the regional ombudsman of reside discharged home or to the hospita knowledge deficit. By 5/24/18, the social worker (SW notify by fax and/or e-mail the regi ombudsman of Resident #280, #2 #13, #34, #38 and #42's discharge The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18, the director of nursing quality improvement nurse, staff far admissions director, and/or the administrator will audit all discharge the past 90 days for notification to	ursing rocess notify nts I- was) will onal 81, #50, es. ne ne (DON), acilitator, jes for
	She stated she was r aware of who was re Regional Ombudsma Interview on 4/26/18	new to the facility was not sponsible for notifying the in. at 9:40 AM, the Admission at she didn't notify the		quality improvement nurse, staff fa admissions director, and/or the administrator will audit all discharg	acilitator, jes for the

Facility ID: 923021

If continuation sheet Page 30 of 171

		MEDICAID SERVICES				NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		ATE SURVEY OMPLETED
	CONTRECTION	DENTI IOATION NOMBER.	A. BUILDING	3		
		0.45000			С	
		345293	B. WING			04/26/2018
NAME OF PF	OVIDER 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 30	F 62	3		
	Regional Ombudsma	n for any residents		could be located of regional or	Ibudsman	
	discharged to home of	or to the hospital.		notification for audited discharg	es. The	
				regional ombudsman was notifi		
	Interview on 4/26/18			e-mail of all discharges with loc		
		t was her expectation the		the past 90 days by social work	er on	
		n be notified for any resident		5/21/18.		
	discharged home or t	o the hospital.		Du 5/22/10 the director of pure		
	2 Decident #281 was	admitted 11/3/17 and		By 5/22/18, the director of nurs worker, and admission coordinates and	-	
	transferred to hospita			in-serviced by the administrator		
				notification of the regional omb		
	Interview on 4/26/18	at 9:27 AM, the Social		resident discharge including dis		
	Worker (SW) stated s			home or to the hospital.	0	
	Regional Ombudsma	n of Resident #281's				
	discharge to the hosp	oital on 11/8/17. She stated		Beginning 5/21/18, weekly x 12		
	she thought it was the			then monthly the social worker		
	Admissions Coordina			emailing the regional ombudsm		
	Interview on 4/26/18			discharges including reason. The		
		she was not aware that the ne Regional Ombudsman if		will be kept as verification in a f social workers office, in case of		
		ged home or to the hospital.		conversation between social w		
	-	new to the facility was not		regional ombudsman on 5/3/18		
		sponsible for notifying the		the preferred method for this	, onnañ io	
	Regional Ombudsma			communication.		
	Interview on 4/26/18	at 9:40 AM, the Admission		The monitoring procedure to er	sure that	
		at she didn't notify the		the plan of correction is effectiv		
	Regional Ombudsma			specific deficiency cited remain		
	discharged to home of	or to the hospital.		and/or in compliance with the re requirements	egulatory	
	Interview on 4/26/18					
		t was her expectation the		The administrator and/or DON		
	-	n be notified for any resident		all discharges weekly x 12 wee		
	discharged home or t	o the hospital.		ensure notification, including re		
	3 Resident #50 was	transferred to the bossitel on		transfer, of the regional ombude occurred. This audit will be doc		
		transferred to the hospital on 1/12/18. He was currently		on the Ombudsman Notiication		
	residing at the facility				, taun 1001.	

Facility ID: 923021

If continuation sheet Page 31 of 171

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	` <i>'</i>		COMPLETED
					С
		345293			04/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETI HE APPROPRIATE DATE
F 623	Continued From page	e 31	F 62	3	
	Worker (SW) stated as Regional Ombudsma discharge to the hosp She stated she thoug the Admissions Coord Interview on 4/26/18 Administrator stated as facility had to notify the resident was discharg She stated she was real Regional Ombudsma Interview on 4/26/18 Coordinator stated the Regional Ombudsma discharged to home of Interview on 4/26/18 Administrator stated in	n of Resident #50's bital on 11/4/17 or 1/12/18. ht it was the responsibility of dinator. at 9:30 AM, the she was not aware that the he Regional Ombudsman if ged home or to the hospital. hew to the facility was not sponsible for notifying the n. at 9:40 AM, the Admission at she didn't notify the n for any residents or to the hospital. at 7:28 PM, the t was her expectation the n be notified for any resident		 Notification Audit tool will be the administrator and/or DC presented to the monthly quimprovement (QI) committee 3months. Identification of the determine the need for furth and/or change in frequency monitoring. The administrator will present and recommendations of the committee meeting to the quexecutive quality assurance committee for further recommand oversight. The title of the person responsible correction. The administrator is responsible acceptable correction. 	DN and uality e monthly x rends will her action of required ent the findings e monthly QI uarterly e (QA) mendations onsible for le plan of sible for
	 4. Resident #34 was admitted to the facility on 5/4/17 and readmitted on 1/30/18 with diagnoses that included dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 4/11/18 indicated Resident #34 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. 				
				F623 The plan of correcting the s deficiency	pecific
		ent #34's medical records been transferred to the		The position of Richmond F	Pines Nursing

Facility ID: 923021

If continuation sheet Page 32 of 171

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY
						С
		345293	B. WING			04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				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 & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETIO DATE
F 623	Continued From pag	ie 32	F 62	23		
		ged from the facility on		and Rehabilitation regardin	a the process	
		admitted to the facility on		that led to this deficiency-fa		
	1/30/18.	,		the regional ombudsman o	•	
				discharged home or to the		
	A review of the socia	al service progress notes		knowledge deficit.		
		entation that the Ombudsman				
		g the date and the reason of		By 5/24/18, the social work		
	transfer to the hospi	tal.		notify by fax and/or e-mail t	•	
	0- 4/00/40 -+ 0-07 /			ombudsman of Resident #2		
		AM, the Social Worker (SW)		#13, #34, #38 and #42 s c	-	
		ne stated that she was new to al worker and she had not		The procedure for impleme acceptable plan of correction	•	
	-	man of any residents who		specific deficiency cited		
		d or discharged from the		specific deficiency cited		
		ed that the Admission		By 5/24/18 the director of n	ursina (DON).	
	-	e responsible for notifying the		quality improvement nurse,		
	Ombudsman.	1 , 3		admissions director, and/or		
				administrator will audit all d	ischarges for	
	On 4/26/18 at 9:40 A	AM, the Admission		the past 90 days for notifica	ation of the	
		erviewed. She stated that she		regional ombudsman. The	-	
		Ombudsman of any residents		ombudsman will be notified		
	who had been disch facility.	arged or transferred from the		e-mail of all discharges with the past 90 days.	n locations for	
	On 4/26/18 at 7:20 F	PM, the Administrator was		By 5/22/18, the director of r	nursing, social	
		Iministrator indicated that she		worker, and admission coo	-	
	didn't know that the	facility had to notify the		in-serviced by the administ		
		ng of residents who had been		notification of the regional of		
	discharged or transf	erred from the facility.		resident discharge including home or to the hospital.	g discharge	
		al service progress notes				
		entation that the Ombudsman		The monitoring procedure t		
		g the date and the reason of		the plan of correction is effe		
	transfer to the hospi	lai.		specific deficiency cited rer and/or in compliance with t		
	On 4/26/18 at 0.27 /	AM, the Social Worker (SW)		requirements	ne regulatory	
		he stated that she was new to				
		al worker and she had not		The administrator and/or D	ON will review	
		man of any residents who		all discharges weekly x 12		

Facility ID: 923021

If continuation sheet Page 33 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/30/2018 MAPPROVED O. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345293	B. WING		04	C I/26/2018
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	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 623	facility. She indicates Coordinator might be Ombudsman. On 4/26/18 at 9:40 A Coordinator was inte- had not notified the C who had been discha facility. On 4/26/18 at 7:20 P interviewed. The Add didn't know that the f Ombudsman in writin discharged or transfe 5. Resident #13 was 4/28/17 and most rec with multiple diagnos s and dementia witho The quarterly Minimu assessment dated 1/ #13 was rarely/never understands. Her sh memory were impaire impaired decision ma A review of the Resid revealed she had bee on 4/1/18 in the morr facility the same day, transferred to the hos	a or discharged from the d that the Admission e responsible for notifying the M, the Admission rviewed. She stated that she Ombudsman of any residents arged or transferred from the M, the Administrator was ministrator indicated that she acility had to notify the ng of residents who had been erred from the facility. admitted to the facility on cently readmitted on 4/9/18 ses that included Alzheimer ' but behavioral disturbance. Im Data Set (MDS) 15/18 indicated Resident - understood and rarely never nort-term and long-term ed and she had severely aking. dent #13's medical records en transferred to the hospital hing and returned to the . Resident #13 was again spital on 4/1/18 in the	F 62	 ensure notification of the region ombudsman occurred. This au documented on the ombudsmat tool. The results of the Ombudsmar Notification Audit tool will be control presented to the Quality Impro Committee monthly x 3months Identification of trends will deteneed for further action and/or of frequency of required monitorint The title of the person respons implementing the acceptable por correction. The Administrator is responsible implementing the acceptable por correction. 	dit will be an audit ompiled by and vement c. ermine the change in ng. ible for olan of le for	
	revealed no documer	I service progress notes ntation that the Ombudsman g the date and the reason of				

Facility ID: 923021

If continuation sheet Page 34 of 171

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345293	B. WING _			C 04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		TREET 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 DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DAT	
F 623	transfer to the hospital On 4/26/18 at 9:27 Af was interviewed. She the facility as a social notified the Ombudsm had been transferred facility. She indicated Coordinator might be Ombudsman. On 4/26/18 at 9:40 Af Coordinator was inter had not notified the O who had been discha facility. On 4/26/18 at 7:20 Pf interviewed. The Adm didn't know that the fa Ombudsman in writing discharged or transfe 6. Resident #38 was a 1/26/11 and last readu that included sepsis (pneumonia, chronic of disease and demential The quarterly Minimu 2/23/18 indicated Res understood and usual communication. He v cognition. A review of the Residu revealed that he had hospital and discharg following dates11/20	Al. M, the Social Worker (SW) e stated that she was new to worker and she had not han of any residents who or discharged from the d that the Admission responsible for notifying the M, the Admission viewed. She stated that she mbudsman of any residents rged or transferred from the M, the Administrator was ninistrator indicated that she acility had to notify the g of residents who had been rred from the facility. admitted to the facility on mitted 4/9/18 with diagnoses serious infection), bstructive pulmonary a. m Data Set (MDS) dated sident #38 was usually	F	523			

Facility ID: 923021

If continuation sheet Page 35 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345293	B. WING		C 04/26/2018		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 623	revealed no document was notified in writing transfer to the hospital On 4/26/18 at 9:27 Af was interviewed. She the facility as a social notified the Ombudsm had been transferred facility. She indicated Coordinator might be Ombudsman. On 4/26/18 at 9:40 Af Coordinator was inter had not notified the O who had been discha facility. On 4/26/18 at 7:20 Pf interviewed. The Adm didn't know that the fa Ombudsman in writing discharged or transfer 7. Resident # 42 was facility on 11/19/15 wi including neurogenic The quarterly Minimu assessment dated 2/2 Resident #42 ' s cogn	service progress notes nation that the Ombudsman the date and the reason of al. M, the Social Worker (SW) e stated that she was new to worker and she had not nan of any residents who or discharged from the d that the Admission responsible for notifying the M, the Admission viewed. She stated that she imbudsman of any residents rged or transferred from the M, the Administrator was ninistrator indicated that she acility had to notify the g of residents who had been rred from the facility. originally admitted to the th multiple diagnoses bladder and paraplegia. m Data Set (MDS) 21/18 indicated that	F	523			
		been transferred to the /19/18, 2/11/18 and 3/17/18.					

If continuation sheet Page 36 of 171
		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/30/20 [,] RM APPROVE IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345293	B. WING		0,	C 4/26/2018
NAME OF PF	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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 623	Review of the social s revealed no documer was notified in writing transfer to the hospita On 4/26/18 at 9:27 Pl was interviewed. She the facility as social w notified the Ombudsn had been transferred facility. She indicated	Service progress notes Intation that the Ombudsman I the date and the reason of al. M, the Social Worker (SW) e stated that she was new to vorker and she had not nan of any residents who or discharged from the	F 62	3		
F 625 SS=C	had not notified the C who had been discha facility. On 4/26/18 at 7:20 Pl interviewed. The Adr didn't know that the fa Ombudsman in writin discharged or transfe Notice of Bed Hold Pe CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfe the resident goes on nursing facility must p the resident or reside specifies- (i) The duration of the	viewed. She stated that she ombudsman of any residents rged or transferred from the M, the Administrator was ninistrator indicated that she acility had to notify the g of residents who had been rred from the facility. olicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to	F 62	5		5/24/18

Facility ID: 923021

If continuation sheet Page 37 of 171

		ID HUMAN SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489	
				IAMLET, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 625	Continued From page	e 37	F 625		
		sidence in the nursing			
	(ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, wh paragraph (e)(1) of the resident to return; and	payment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d pecified in paragraph (e)(1)			
	the time of transfer of hospitalization or the facility must provide t resident representativ specifies the duration described in paragrag	old notice upon transfer. At f a resident for rapeutic leave, a nursing o the resident and the ve written notice which of the bed-hold policy oh (d)(1) of this section.			
	Based on staff interv facility failed to provid Hold Policy upon tran (Resident #281, Resident Resident #34, Resident	iews and record review, the de information about the Bed asfer to the hospital for 6 dent #50, Resident 13, ent #38 and Resident #42) of for discharge. The findings		F625 The plan of correcting the specific deficiency The position of Richmond Pines Nu and Rehabilitation regarding the pro that led to this deficiency-failed to p	ocess
	transferred to hospital Interview on 4/26/18 Worker (SW) stated s resident or Responsil	at 9:27 AM, the Social she did not notify the ble Party (RP) of the Bed		information about the bed hold polic upon transfer to the hospital- was knowledge deficit. Residents # 281, #50, #13, #34, #3	су
	Hold Policy when Ret to the hospital on 11/	sident #281 was transferred 8/17. She stated she thought		were readmitted to the facility.	
	it was the responsibil Coordinator.	ity of the Admissions		The procedure for implementing the acceptable plan of correction for the specific deficiency cited	
	Interview on 4/26/18	at 9:30 AM, the			

Facility ID: 923021

If continuation sheet Page 38 of 171

			()(0) 14:			O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	` '	E SURVEY
						С
		345293	B. WING		0,	4/26/2018
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
	D FINES HEALINGARE			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)	SHOULD BE	(X5) COMPLETIO DATE
F 625	Continued From page	e 38	F 625	5		
	Administrator stated	she was new to the facility		On 5/18/18, the quality improv	vement (QI)	
		o was responsible for		and staff facilitator (SF) nurse	s began an	
		or RP of the facility Bed		in-service with all licensed nur		
	Hold Policy when trai	nsferred to the hospital.		including part time, as needed		
	Interview on 1/26/18	at 9:40 AM, the Admission		agency, on providing the bed upon transfer and documenta		
		at she didn't inform the		provision. This in-service will l		
		the facility Bed Hold Policy		completed by 5/24/18, any sta		
	at the time of a hospi			in-serviced by 5/24/18 will not	be allowed	
				to work until in-service comple		
	Interview on 4/26/18			hired licensed nurses, includir		
		it was her expectation the		prn, and agency, will be in-ser	viced during	
		esident or RP of the Bed Hold nt was transferred to the		orientation.		
	hospital.			By 5/22/18, the social worker	and	
				admissions director will audit		
	2. Resident #50 was	transferred to the hospital on		discharges for the past 90 day	/s for	
		1/12/18. He was currently		evidence bed hold policy bein		
	residing at the facility	at the time of the survey.		Nine residents were not provid		
	Interview on 1/26/19	at 0:27 AM the Second		policy at time of transfer. Bed		
	Worker (SW) stated s	at 9:27 AM, the Social		was provided by social work fit through 5/21/18 and documer		
		ble Party (RP) of the Bed		medical record.		
	-	sident #50 was transferred to				
	the hospital on 11/4/	17 or 1/12/18. She stated she		Beginning 5/24/18, based on	the above	
		sponsibility of the Admissions		in-service, the licensed nurses		
	Coordinator.			document the provision of the		
	Interview on 4/26/18	at 0.30 AM the		policy in a progress note in the record at time of transfer. Following		
		she was new to the facility		documentation of provision of		
		o was responsible for		hold policy will occur by the so		
		or RP of the facility Bed		on an as needed basis in the		
		nsferred to the hospital.		record.		
		at 9:40 AM, the Admission		The manufacture in the first state of the sta		
		at she didn't inform the		The monitoring procedure to e		
	at the time of a hospi	the facility Bed Hold Policy		the plan of correction is effect specific deficiency cited remain		
				and/or in compliance with the		
	Interview on 4/26/18	at 7:28 PM, the		requirements	· -galator y	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 39 of 171

TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489	1
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 625	Administrator stated i facility informs any re Policy when a resider hospital. 3. Resident #34 was a 5/4/17 and most rece with diagnoses that in behavioral disturbance The quarterly Minimu 4/11/18 indicated Res understood and rarely had short-term and lo and severely impaired A review of the Resid revealed that he had hospital and discharg 1/28/18. He was read 1/30/18. A review of the social revealed no documen policy was provided to to the hospital. On 4/26/18 at 9:27 Al was interviewed. She the facility as a social provide the bed hold discharge to the hosp Admission Coordinate	t was her expectation the sident or RP of the Bed Hold at was transferred to the admitted to the facility on ntly readmitted on 1/30/18 acluded dementia without ac. m Data Set (MDS) dated sident #34 was rarely/never y/never understands. He ang-term memory problems d decision making. ent #34's medical records been transferred to the ed from the facility on dmitted to the facility on service progress notes atation that the bed hold to the resident upon transfer M, the Social Worker (SW) e stated that she was new to worker and she didn't policy to the resident upon bital. She indicated that the or might be responsible for d policy to the resident or the	F 62	 The administrator and/or director of nursing will review all transfers wee 12 weeks to ensure the bed hold powas provided and documentation is present. This audit will be document the transfer audit tool. The results of the transfer audit tool be compiled by the administrator and director of nursing and presented to quality improvement (QI) committee monthly for three months. Identificat trends will determine the need for fuaction and/or change in frequency or required monitoring. The administrator and/or director of nursing will present transfer audit to findings and QI committee recommendations to the quarterly q assurance (QA) committee for further recommendations and oversight. 	kly x vlicy ted on will ud/or the tion of urther of vol uality
	On 4/26/18 at 9:30 Al	M, the Administrator stated			

If continuation sheet Page 40 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3) DATE	
		345293	B. WING	NO _			C 26/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2010
					IIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		н	IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	 she was new to the fa was responsible for n the facility Bed Hold F the hospital. On 4/26/18 at 9:40 AI Coordinator was inter didn't provide the resi policy when discharge the resident was com was their home. On 4/26/18 at 7:20 PI conducted with the Ac Administrator indicate staff to provide a copy policy when a resider hospital. 4. Resident #13 was a 4/28/17 and most rec with multiple diagnoses and dementia witho The quarterly Minimu assessment dated 1/7 #13 was rarely/never understands. Her she memory were impaired decision ma A review of the Resid revealed she had bee on 4/1/18 in the morn facility the same day. transferred to the hose evening and was admited the staff to the hose evening and was admited to the hose evening admited to th	Acility was not aware of who otifying the resident or RP of Policy when transferred to M, the Admission viewed. She stated that she dent or the RP the bed hold ed to the hospital because ing back anyway and this M, a follow up interview was dministrator. The ed that she expected the y of the facility's bed hold it was discharged to the admitted to the facility on ently readmitted on 4/9/18 es that included Alzheimer ' ut behavioral disturbance. m Data Set (MDS) 15/18 indicated Resident understood and rarely never ort-term and long-term ed and she had severely king. ent #13's medical records en transferred to the hospital ing and returned to the Resident #13 was again pital on 4/1/18 in the	F	625			

Facility ID: 923021

If continuation sheet Page 41 of 171

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			C
		345293	PREFIX (EACH CORRECTIVE ACTION			_ 26/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		Н	IIGHWAY 177 S BOX 1489		
				Н	IAMLET, NC 28345		
(X4) ID PREFIX				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
F 625	Continued From page	e 41	F	625			
	4/9/18.						
	to the hospital.						
	On 4/26/18 at 9 [.] 27 Al	M the Social Worker (SW)					
	-						
	resident's legal repres	sentative (RP).					
	On 4/26/18 at 9:30 Al	M, the Administrator stated					
	the hospital.						
	 the facility as a social worker and she didn't provide the bed hold policy to the resident upon discharge to the hospital. She indicated that the Admission Coordinator might be responsible for providing the bed hold policy to the resident or the resident's legal representative (RP). On 4/26/18 at 9:30 AM, the Administrator stated she was new to the facility was not aware of who was responsible for notifying the resident or RP of the facility Bed Hold Policy when transferred to the hospital. On 4/26/18 at 9:40 AM, the Admission 						
	In the second						
		ing back anyway and this					
		-					
	staff to provide a copy	y of the facility's bed hold					
		nt was discharged to the					
	nospital.						
	5. Resident #38 was	admitted to the facility on					

Facility ID: 923021

If continuation sheet Page 42 of 171

DEPARTMENT OF HEALTH AND HUMAN SERVICES							D: 05/30/2018 MAPPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345293	B. WING _				C 26/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, 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 625	that included sepsis (ipneumonia, chronic of disease and demential The quarterly Minimur 2/23/18 indicated Res understood and usual communication. He we cognition. A review of the Reside revealed that he had hospital and discharg following dates11/20 He was readmitted to 12/29/17 and 4/9/18. A review of the social revealed no document policy was provided to to the hospital. On 4/26/18 at 9:27 All was interviewed. She the facility as a social provide the bed hold discharge to the hosp Admission Coordinato providing the bed hold resident's legal represe On 4/26/18 at 9:30 All she was new to the fa-	mitted 4/9/18 with diagnoses serious infection), bstructive pulmonary a. m Data Set (MDS) dated sident #38 was usually ly understands vas severely impaired in ent #38's medical records been transferred to the ed from the facility on the 0/17, 12/25/17 and 4/5/18. the facility on 11/25/17, service progress notes tation that the bed hold o the resident upon transfer M, the Social Worker (SW) e stated that she was new to worker and she didn't policy to the resident upon ital. She indicated that the or might be responsible for d policy to the resident or the sentative (RP). M, the Administrator stated ucility was not aware of who obtifying the resident or RP of Policy when transferred to	F 6	525			

If continuation sheet Page 43 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE	
		345293	B. WING			C 04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	Coordinator was inter didn't provide the resi policy when discharge the resident was com was their home. On 4/26/18 at 7:20 PI conducted with the Ad Administrator indicate staff to provide a copy policy when a resider hospital. 6. Resident # 42 was facility on 11/19/15 wi including neurogenic The quarterly Minimu assessment dated 2/2 Resident #42 ' s cogn Review of the Reside revealed that he had hospital on 12/8/17, 1 Review of the social s revealed no documer policy was provided to to the hospital.	viewed. She stated that she dent or the RP the bed hold ed to the hospital because ing back anyway and this M, a follow up interview was dministrator. The ed that she expected the y of the facility's bed hold it was discharged to the originally admitted to the th multiple diagnoses bladder and paraplegia. m Data Set (MDS) 21/18 indicated that ition was intact. Int #42's medical records been transferred to the /19/18, 2/11/18 and 3/17/18. Service progress notes itation that the bed hold o the resident upon transfer M, the Social Worker (SW) e stated that she was new to vorker and she didn't provide the resident upon discharge indicated that the Admission responsible for providing the resident or the sentative (RP).	F	625			

If continuation sheet Page 44 of 171

			LE CONSTRUCTION	(X3) DATE SURVEY
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
	345293	B. WING		C 04/26/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
Coordinator was inter didn't provide the resi policy when discharge the resident was com was their home. On 4/26/18 at 7:20 Pl interviewed. The Adr	viewed. She stated that she ident or the RP the bed hold ed to the hospital because ing back anyway and this M, the Administrator was ninistrator indicated that she	F 62	5	
discharged to the hos Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy	of Assessments.	F 64	1	5/24/18
resident's status. This REQUIREMENT by: Based on record revi interview, the facility f Minimum Data Set (M areas of medications physical restraints (R daily living (ADL) (Re	is not met as evidenced iew, observation and staff failed to accurately code the IDS) assessments in the (Residents #37 & #52), esident #69) and Activities of sident #58) for 4 of 25		F641 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation regard the process that led to this deficiency-failure to accurately code	5
12/21/15 with multiple anxiety disorder. The dated 2/9/18 indicated received an antianxie assessment period. Resident #37 had a d	e diagnoses including e annual MDS assessment d that Resident #37 had not ty medication during the loctor's order dated 1/8/18		minimum data set (MDS) assessmen accurately- was staff failure to follow established policy and procedure. Resident #37's MDS assessment da 2/9/18 was modified to accurately ref the resident's use of an antianxiety medication on 5/3/18 by the MDS nu	ted flect
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Coordinator was inter didn't provide the resi policy when discharge the resident was com was their home. On 4/26/18 at 7:20 Pl interviewed. The Adr expected the staff to facility's bed hold poli discharged to the hos Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revi interview, the facility f Minimum Data Set (M areas of medications physical restraints (R daily living (ADL) (Re sampled residents rev 1. Resident #37 was 12/21/15 with multiple anxiety disorder. The dated 2/9/18 indicated received an antianxie assessment period. Resident #37 had a d for Xanax (antianxiety)	Provider 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 44 Coordinator was interviewed. She stated that she didn't provide the resident or the RP the bed hold policy when discharged to the hospital because the resident was coming back anyway and this was their home. On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she expected the staff to provide a copy of the facility's bed hold policy when a resident was discharged to the hospital. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Resident #69) and Activities of daily living (ADL) (Resident #69) for 4 of 25 sampled residents reviewed. Findings included: 1. Resident #37 was admitted to the facility on 12/21/15 with multiple diagnoses including anxiety disorder. The annual MDS assessment dated 2/9/18 indicated that Resident #37 had not received an antianxiety medication during the	ROVIDER OR SUPPLIER ID D PINES HEALTHCARE AND REHABILITATION CENTE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 44 F 62 Coordinator was interviewed. She stated that she didn't provide the resident or the RP the bed hold policy when discharged to the hospital because the resident was coming back anyway and this was their home. F 62 On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she expected the staff to provide a copy of the facility's bed hold policy when a resident was discharged to the hospital. F 64 Accuracy of Assessments F 64 CFR(s): 483.20(g) \$483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Resident #37 & #52), physical restraints (Resident #69) and Activities of daily living (ADL) (Resident #58) for 4 of 25 sampled residents reviewed. Findings included: 1. Resident #37 was admitted to the facility on 12/21/15 with multiple diagnoses including anxiety disorder. The annual MDS assessment dated 2/9/18 indicated that Resident #37 had not received an antianxiety medication during the assessment period. Resident #37 had a doctor's order dated 1/8/18 for Xanax (ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE INFORMATION INFORMATION INFORMATION CENTE INFORMATION INFORMATION CENTE INFORMATION INFORMATION INFORMATION <t< td=""></t<>

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 45 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
DICUMO			н	IIGHWAY 177 S BOX 1489	
RICHNOP	ID PINES REALINCARE	AND REHABILITATION CENTE	F	IAMLET, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 641	Continued From page	e 45	F 641		
	Records (MARs) for F she had received Xar 2018. On 4/24/18 at 4:30 Pl the MDS Nurse were verified that Resident during the assessmen stated that the antian have been coded 7 o assessment dated 2/9 coded incorrectly. On 4/26/18 at 7:20 Pl interviewed. She state MDS assessments to	9/18 but it was not, it was M, the Administrator was ted that she expected the b be coded correctly.		Resident #52's MDS assessment 4/15/18 was modified to accurate the resident's use of an antianxie medication on 5/3/18 by the MDS and transmitted to the national re on 5/3/18. Resident #69's MDS assessment 4/2/18 was modified to accurately the resident's use of a physical re on 5/3/18 by the MDS nurse and transmitted to the national reposit 5/3/18. Resident #58's MDS assessment 4/12/18 was modified to accurate the resident's activities of daily liv (ADL) function on 5/3/18 by the M nurse and transmitted to the national	Ily reflect ty S nurse pository t dated y reflect estraint tory on t dated ely reflect ring MDS
	 2. Resident #52 was admitted to the facility on 6/10/15 with multiple diagnoses including dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 4/15/18 indicated that Resident #52 had memory and decision making problems and she had not receive an antianxiety medication during the assessment period. Resident #52 had a doctor's order dated 12/12/17 for Buspar (antianxiety drug) 5 milligrams (mgs) by mouth 2 times a day. The April 2018 Medication Administration Records (MARs) revealed that Resident #52 had received Buspar from April 1-24, 2018. On 4/25/18 at 5:26 PM, the MDS Nurse was interviewed. The MDS Nurse verified that 			repository on 5/3/18. The procedure for implementing f acceptable plan of correction for specific deficiency cited By 5/22/18, the director of nursing will in-service the MDS coordinate MDS nurse on accuracy of MDS assessments including antianxiet medications, physical restraints, function based on the resident assessment instrument (RAI) ma Any newly hired MDS coordinato in-serviced prior to working indep with MDS assessments. By 5/24/18, the MDS nurse will ar residents to ensure comprehensit	the g (DON) or and y and ADL nual. r will be bendently udit all

Facility ID: 923021

If continuation sheet Page 46 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/30/2018 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345293	B. WING _			04	C 4/26/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	assessment period. S antianxiety medicatio on the quarterly MDS but it was not, it was On 4/26/18 at 7:20 P interviewed. She sta MDS assessments to 3. Resident # 69 was	ceived Buspar during the She stated that the n should have been coded 7 assessment dated 4/15/18 coded incorrectly. M, the Administrator was ted that she expected the	F 6	41	assessments are accurate for antiany medications, physical restraint, and A function that were completed and/or scheduled for the past 30 days. No o comprehensive assessments were for to be coded incorrectly for antianxiety medications, physical restraints, or A The monitoring procedure to ensure f the plan of correction is effective and specific deficiency cited remains corre and/or in compliance with the regulat requirements	DL ther und DLs. hat that ected	
	assessment dated 4/ #69 was not using a p Resident #69 had a c for self-release seat b decreased safety awa movements. On 4/24/18 at 9:32 A AM, Resident #69 wa chair with a self-relea	doctor's order dated 7/15/17 belt while out of bed due to areness and unsafe M and on 4/25/18 at 8:02 as observed out of bed in a use seat belt on.			The DON, administrator, and/or corport consultant will audit all MDS assessing completed and submitted to the nation repository weekly. The audits will be completed weekly on 100% of MDS assessments completed for 4 weeks, weekly 50% of MDS assessments completed for 8 weeks to ensure assessments were coded correctly for medications, physical restraints, and function. This audit will be documented the MDS audit tool.	nents nal then r ADL	
	Resident #69. Nurse #69 was cognitively in release the seat belt On 4/26/18 at 12:38 I was interviewed. She the quarterly MDS as Resident #69. The M that Resident #69 wa seat belt when she w	ted that she was assigned to #3 indicated that Resident mpaired and she not able to			The monthly quality improvement (QI committee will review the results of th MDS audits monthly for 3 months for identification of trends, actions taken, to determine the need for and/or frequency of continued monitoring, an make recommendations for monitorin continued compliance. The administrator and/or DON will pro- the findings and recommendations of monthly QI committee to the quarterly	and and g for esent the	

Facility ID: 923021

If continuation sheet Page 47 of 171

		ND HUMAN SERVICES			PRINTED: 05 FORM APF OMB NO. 093	PROVE	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURV COMPLETED		
		345293	B. WING		C 04/26/20	018	
	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CON	(X5) /IPLETION DATE	
F 641	Continued From page 47 that physical restraint should have been coded but it was not, it was coded incorrectly. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the MDS assessments to be coded correctly.		F 64 ⁻	executive quality assurance QA committee for further recommend and oversight. The title of the person responsible implementing the acceptable plan correction.	e for n of		
	2/22/18 and readmitte that included feeding vascular dementia wi and Parkinson' s.	admitted to the facility on ed on 3/9/18 with diagnoses difficulties, dysphagia, th behavioral disturbance,		The DON is responsible for imple the acceptable plan of correction.			
	assessment dated 4/ #58 was rarely/never understands. He had memory problems an making. Resident #5 the supervision of 1 s	ye Minimum Data Set (MDS) 12/18 indicated Resident understood and rarely/never d short-term and long-term d severely impaired decision 8 was coded as requiring staff member for eating. He he side of his upper and					
	4/19/18, included the eating related to dem cerebrovascular accid interventions indicate						
	his room during the lu PM. Resident #58 w	conducted of Resident #58 in unch meal on 4/23/18 at 1:00 as observed to be for eating assistance.					
	A family interview wa	s conducted for Resident					

Facility ID: 923021

If continuation sheet Page 48 of 171

TEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	CONTECTION	IDENTIFICATION NOMBER.	A. BUILDING			C
		345293	B. WING		0	4/26/2018
AME OF PF	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CC	DDE	
	D PINES HEALTHCARE	AND REHABILITATION CENTE	ню	GHWAY 177 S BOX 1489		
	-		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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 641		5 AM. She reported Resident	F 641			
	An observation was of his room during the lu PM. Resident #58 w	istance of staff for eating. conducted of Resident #58 in unch meal on 4/24/18 at 1:10 as observed to be for eating assistance.				
	Coordinator on 4/26/ significant change MI #58 required the sup was reviewed with th care plan that indicat dependent on the tot eating was reviewed She revealed the MD Resident #58 was de assistance for eating	ducted with the MDS 18 at 3:48 PM. The 4/12/18 DS that indicated Resident ervision of 1 staff for eating e MDS Coordinator. The ed Resident #58 was al assistance of staff with with the MDS Coordinator. DS should have indicated opendent on 1 staff . She stated she was going MDS for Resident #58.				
F 644 SS=D	she expected the MD	aducted with the 6/18 at 7:20 PM. She stated 0S to be coded accurately. ARR and Assessments	F 644			5/24/18
	pre-admission screer (PASARR) program u of this part to the max	tion. nate assessments with the ning and resident review under Medicaid in subpart C ximum extent practicable to ing and effort. Coordination				
	8483.20(a)(1)	prating the recommendations				

Facility ID: 923021

If continuation sheet Page 49 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER	I	I	STREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	D PINES HEAL THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
Rionwork	DTINEO NEAEMOARE			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 (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 644	Continued From page	a 40	F 644		
		vel II determination and the	F 044	*	
		report into a resident's			
		nning, and transitions of			
	care.				
	§483.20(e)(2) Referri	ng all level II residents and			
	all residents with new	ly evident or possible			
		ler, intellectual disability, or a			
		evel II resident review upon			
	a significant change in				
		is not met as evidenced			
	by:	ious and staff interviews the		F044	
		iew and staff interview, the a referral for re-evaluation		F644	
	-	inge in condition, for 1 of 1		The plan of correcting the specific	
	sampled residents (R	lesident #58) reviewed for hing Resident Review Level		deficiency	
	II status.	5		The position of Richmond Pines	
	The findings included	:		Healthcare and Rehabilitation Cen	ter
				regarding the process that led to th	nis
	Resident #58 was ad	mitted to the facility on		deficiency- failure to make a referra	al for
		ed on 3/9/18 with multiple		re-evaluation of pre-admission scre	
	-	ed mood disorder, delirium		and annual resident review (PASA	RR)
	due to known physiol	ogical condition, and		status after a significant change in	
	depression.			condition- was the social worker's knowledge deficit.	
	A review of the medic	al record revealed Resident			
	#58 was determined t			Resident #58 was referred to the	
	Preadmission Screen			PASARR authority on 5/7/18 by the	e social
	(PASRR) with no exp	-		worker (SW) for re-evaluation of le status.	
	A significant change	Minimum Data Set (MDS)			
	assessment dated 4/	12/18 for Resident #58		On 5/15/18, the social worker (SW	
		ly/never understood and		in-serviced by the licensed nursing	
	-	nds. He had short-term and		administrator on referring residents	
	long-term memory pro			PASARR authority when a signification	ant
		king. This assessment		change in condition occurs.	
		58 had a Level II PASRR		The propedure feeting langest (
	related to serious me	ntal illness and he was		The procedure for implementing th	е

Facility ID: 923021

If continuation sheet Page 50 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/2018 MAPPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			04	C / 26/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTE		HI	IGHWAY 177 S BOX 1489		
	DINEONEALMOARE			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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 644	Continued From page	e 50	F 6	44			
	receiving hospice ser				acceptable plan of correction for the specific deficiency cited		
	· ·	Resident #58, initiated on					
		ved on 4/19/18, included the			On 5/15/18, the social worker (SW) w		
		II PASRR. The plan of care us area of hospice care			in-serviced by the licensed nursing ho administrator on referring residents to		
		d last reviewed on 4/19/18.			PASARR authority when a significant	uic	
					change in condition occurs.		
	An interview was con						
	Coordinator on 4/26/				On 5/16/18, the SW audited all reside with a level 2 PASARR to ensure no	ents	
		tions related to Level II			significant change in condition		
	PASRRs.				assessments had been completed in	last	
					90 days. The findings revealed no		
		ducted with the SW on			additional failures to make a referral f		
	for the actions related	She stated was responsible d to Level II PASRRs. She			re-evaluation of PASARR status after significant change in condition.	а	
		58 had a Level II PASRR					
	-	te. The SW revealed she equirement for a referral for			Beginning 5/16/18, the minimum data (MDS) nurse is notifying the SW and	set	
	re-evaluation to the F	-			administrator if there is a significant		
	resident with a Level	-			change in a resident's condition. This		
		condition. She explained			notification occurs verbally during the		
		job as a SW in a long-term was still in the process of			morning meeting.		
	learning all of the req	-			The monitoring procedure to ensure t	hat	
		R Authority was not notified			the plan of correction is effective and		
	-	nificant change in condition			specific deficiency cited remains corre		
	related to his 4/12/18	MDS.			and/or in compliance with the regulate	ory	
	The DON was unava	ilable for interview.			requirements.		
					The administrator or director of nursin	-	
	An interview was con				(DON) will audit 100% of MDS signific	cant	
		6/18 at 7:20 PM. She stated In that the regulations related			change assessments completed and submitted to the national repository		
1	to PASRR were follow				weekly x 4 weeks then 50% weekly x	8	
					weeks to ensure the PASARR authori		
					has been notified if resident is a level		
					PASARR for re-evolution of status. The	nis	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 51 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/30/2018 MAPPROVED D. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING				26/2018
NAME OF P	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 644	Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and	Comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and		644	audit will be documented on the MDS audit tool. The monthly quality improvement (QI) committee will review the results of the MDS audits monthly for 3 months for identification of trends, actions taken, a to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The administrator and/or DON will press the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	and for sent he	5/24/18

Facility ID: 923021

If continuation sheet Page 52 of 171

		ID HUMAN SERVICES				FORM): 05/30/2018 I APPROVED
STATEMENT C	S FOR MEDICARE & PF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 26/2018
NAME OF PF	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTE		н	GHWAY 177 S BOX 1489		
	D FINES HEALTHCARE	AND REHABILITATION CENTE		H	AMLET, NC 28345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that	nprehensive care plan must g - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required	F	656			
	provided due to the re under §483.10, include treatment under §483 (iii) Any specialized so rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit	ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the					
	future discharge. Fac whether the resident's community was asse local contact agencie entities, for this purpo	als for admission and eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose.					
	plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on record rev facility failed to implet interventions to docu				F656 The plan of correcting the specific deficiency		
	#34, and #58) review The findings included				The position of Richmond Pines Nursi and Rehabilitation center regarding the		

Facility ID: 923021

If continuation sheet Page 53 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/30/201 RM APPROVE O. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345293	B. WING		04	C 1/26/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
DIGUMON				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From page	e 53	F 65	6		
	p9		1 00	process that led to this defici	iency was the	
	1. Resident #13 was	admitted to the facility on		staff failure to follow establis	•	
		cently readmitted on 4/9/18		procedure in implementing c		
		es that included Alzheimer '		intervention to document me	al intake	
	s and dementia witho	out behavioral disturbance.		percentages.		
	The significant change	ge Minimum Data Set (MDS)		On 5/21/18, the quality impro	ovement (OI)	
		12/18 indicated Resident		nurse, staff facilitator (SF) n		
		understood and rarely never		of nursing (DON), and charg		
		ort-term and long-term		observed a meal for Resider		
		ed and she had severely		and #58. The auditors ensur	ed the meal	
	-	aking. Resident #13 required		intake for the observed mea		
	the extensive assista	nce of 1 staff for eating.		# 13, #34, and #58 was accu		
	The plan of care for [Decident #12 initiated on		documented, meal intake wa	as correctly	
	-	Resident #13, initiated on entry reviewed on 4/19/18,		documented.		
		ea of assistance for eating.		The procedure for implemen	ting the	
	The interventions inc			acceptable plan of correction	-	
		sident #13 's meal intake for		specific deficiency cited		
	each meal (initiated o	on 5/1/17).		On 5/18/18 the QI and SF nu	urses initiated	
				an in-service for all nursing s	staff including	
	A review of the Nursi	•		licensed and unlicensed staf		
		al intake for Resident #13		as needed (PRN), and agen		
	-	3/31/18 and 4/9/18 through		following care plan intervent	•	
	-	3 was discharged to the d returned on 4/9/18). There		meal intake documentation.		
	•	g this timeframe with no		in-service will be completed After 5/24/18 no nursing stat		
		cumented for Resident #13.		allowed to work until this in-s		
				complete. This in-service wil		
	An interview was con	ducted with the Quality		the orientation process for ne	ew nursing	
		se on 4/25/18 at 3:45 PM.		staff including licensed, unlic		
	She stated that NAs	-		time, prn, and agency.		
		al intake percentage for all				
		assigned to for all meals that		On 5/21/18, the QI nurse, SF		
	occurred during their	Sillit.		and charge nurse completed all residents' meal intake doo		
	An interview was con	ducted with NA #7 on		for the previous 7 days. The		
		She stated NAs were		audit: greater than 25% of r		
	responsible for docur			missing or inaccurate meal in		1

Facility ID: 923021

If continuation sheet Page 54 of 171

		MEDICAID SERVICES				RM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345293	B. WING		a	C 4/26/2018
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 656	Continued From page	e 54	F 6	56		
	percentage for all res	idents they were assigned to urred during their shift.		documentation.		
	The DON was unava	ducted with the		On 5/21/18, the SF nur in-servicing licensed nu assistants on correct m documentation.	urses and nursing	
		6/18 at 7:20 PM. She stated e plan interventions to be		On 5/23/18, the corpor- consultant validated nu had adequate access t	o the electronic	
	1/4/16 and most rece	admitted to the facility on ently readmitted on 1/30/18 included dementia without ce.		health record for meal i documentation. The au nursing assistants and have access to docume	udit result: all licensed nurses	
	#34 was rarely/never understands. He had memory problems an	11/18 indicated Resident understood and rarely/never short-term and long-term d severely impaired decision 4 required the extensive		The monitoring procedulated the plan of correction is specific deficiency cited and/or in compliance we requirements The administrator, DOI will audit 20 residents we to ensure meal intake in the plan of correction of the second seco	s effective and that d remains corrected /ith the regulatory N, and/or QI nurse weekly x 12 weeks s documented per	
	on 4/18/18, included for eating. The interv	Resident #34, last reviewed the focus area of assistance ventions included, in part, sident #34 ' s meal intake for on 12/22/16).		care plan, including vis accuracy of percentage meal tray after the resid eating and reviewing th meal intake. This audit documented on the resi tool.	e by looking at the dent is finished ne documentation of t will be	
	percentage documen 2/21/18 through 4/24/ during this timeframe documented for Resid	ted of the NA ' s meal intake tation for Resident #34 from /18. There were 31 meals with no intake percentage dent #34.		The monthly QI commi results of the resident of monthly for 3 months for trends, actions taken, a the need for and/or free continued monitoring, a	care audit tool or identification of and to determine quency of	
		se on 4/25/18 at 3:45 PM.		recommendations for n continued compliance.		

Facility ID: 923021

If continuation sheet Page 55 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/ FORM APF OMB NO. 093	ROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURV COMPLETED	ΞY
		345293	B. WING		C 04/26/20	18
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COM THE APPROPRIATE	(X5) IPLETION DATE
F 656	 documenting the mearesidents they were a occurred during their An interview was conditional during their An interview was conditional meals that occur percentage for all rest for all meals that occur percentage for all rest for all meals that occur and the DON was unava An interview was conditional meals that occur and inistrator on 4/20 she expected the car followed. 3. Resident #58 was 2/22/18 and readmitter that included feeding vascular dementia with and Parkinson 's. The significant chang assessment dated 4/ #58 was rarely/never understands. He had memory problems an making. Resident #50 of 1 with eating. The plan of care for F on 4/19/18, included loss, inadequate intal related to cognitive in eat meals at times. The occur and set times. 	al intake percentage for all assigned to for all meals that shift. ducted with NA #7 on She stated NAs were menting the meal intake sidents they were assigned to urred during their shift. ilable for interview. ducted with the 5/18 at 7:20 PM. She stated e plan interventions to be admitted to the facility on ed on 3/9/18 with diagnoses difficulties, dysphagia, ith behavioral disturbance, ge Minimum Data Set (MDS) 12/18 indicated Resident understood and rarely/never d short-term and long-term id severely impaired decision i8 was coded as supervision Resident #58, last reviewed the focus area of weight ke, and decreased appetite mpairment and refusals to The interventions included, in of Resident #58 ' s meal	F 6	 The administrator and/or the findings and recomme monthly QI committee to the executive quality assuran committee for further record and oversight. The title of the person ress implementing the accepta correction. The director of nursing is restimplementing the accepta correction. 	endations of the the quarterly ce (QA) ommendations sponsible for able plan of esponsible for	

If continuation sheet Page 56 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345293	B. WING _				C /26/2018
NAME OF P	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 SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	56	F6	656			
	percentage document 3/10/18 through 4/24/ during this timeframe documented for Resid An interview was cont Assurance (QA) Nurs She stated that NAs we documenting the meat residents they were at occurred during their An interview was cont 4/25/18 at 5:15 pm. St responsible for docump percentage for all resident	ducted with the Quality e on 4/25/18 at 3:45 PM. were responsible for al intake percentage for all ssigned to for all meals that shift. ducted with NA #7 on She stated NAs were nenting the meal intake idents they were assigned to urred during their shift.					
F 657 SS=D		/18 at 7:20 PM. She stated e plan interventions to be I Revision	F6	657			5/24/18
	§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inf includes but is not lim (A) The attending phy	ensive Care Plans orehensive care plan must days after completion of ssessment. terdisciplinary team, that ited to					

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 57 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/20 FORM APPROVE OMB NO: 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/26/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 657	Continued From page	9 57	F 65	7	
	resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the resident and the resident and the resident and the An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and c	responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the			
	facility failed to review reflect the current sta	iew and staff interview, the v and revise plans of care to tus of the resident for 2 of nts #13 and #58) reviewed. :		F 657 The plan of correcting the sp deficiency	ecific
	2/22/18 and readmitte that included feeding	admitted to the facility on ed on 3/9/18 with diagnoses difficulties, dysphagia, th behavioral disturbance,		The position of Richmond Pir Healthcare and Rehabilitation regarding the process that le deficiency of failure to revise was staff failure to follow esta policy and procedure.	n Center d to the care plan
	dated 4/12/18 indicat rarely/never understo understands. He had memory problems an	od and rarely/never I short-term and long-term d severely impaired decision		On 4/26/18, the minimum dat coordinator revised Resident plan to accurately reflect the status of Resident #58's tran	#58's care current sfer needs.
	making. Resident #5 independent with tran			On 4/26/18, the MDS coordir Resident #13's care plan to a	

Facility ID: 923021

If continuation sheet Page 58 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	0: 05/30/20 1 APPROV 0. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		345293	B. WING			。 26/2018
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 657	Continued From page	= 58	F 657	7		
				reflect the current status of Res	ident #13's	
	The plan of care for F	Resident #58, last reviewed		meal assistance needs.		
	on 4/19/18, included	the focus area of assistance				
		one position to another				
	related to dementia, F			The procedure for implementing		
i	cerebrovascular accio	dent (CVA). The dent (CVA). The dent (CVA). The dent dent #58 required 2		acceptable plan of correction fo specific deficiency cited	r the	
	persons for constant			specific deficiency cited		
	assistance with trans			On 4/26/18, the MDS coordinate	or audited	
(current resident care plans for t		
	An interview was con			and meal assistance for accura	-	
		18 at 3:48 PM. The 4/12/18		ensure appropriate assistance i	-	
		DS that indicated Resident		to residents to transfer and duri	•	
		t with transfers was reviewed nator. The care plan that		mealtimes. There were no furth discrepancies identified.	er	
		58 required the 2 persons for				
		physical assistance with		On 4/26/18, the director of nurs	ing (DON)	
	transfer belt was revi			in-serviced the MDS coordinato	-	
	Coordinator. She rev	viewed the Nursing Assistant		MDS nurse on care plan revisio	ns. Any	
		related to transfers for the		newly hired MDS coordinator w		
		period and indicated the		in-serviced by the DON on care		
		urately. She stated Resident		revisions. The in-services will a		
	should have been rev	fluctuated and the care plan		ensuring the problem with MDS making timely and accurate car		
		n indicating he required the		revisions does not recur.	e plan	
		The MDS Coordinator				
		ing to revise the care plan				
		o it accurately reflected the		The monitoring procedure to en		
	status of Resident #5	8.		the plan of correction is effective		
	The DON was unava	ilable for interview.		specific deficiency cited remains and/or in compliance with the re-		
	An interview was con	ducted with the		requirements		
		6/18 at 7:20 PM. She stated				
		of care to be revised to		The DON, quality improvement	(QI)	
	reflect the resident 's			nurse, staff facilitator (SF) nurse		
				administrator will monitor throug	gh direct	
		admitted to the facility on		observation staff assisting resid		
	4/28/17 and most rec	ently readmitted on 4/9/18		transferring and eating at mealt	imes. The	

Facility ID: 923021

If continuation sheet Page 59 of 171

		MEDICAID SERVICES					0.0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING				LETED
							C
		345293	B. WING			04/	26/2018
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			177 S BOX 1489 , NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIC
F 657	Continued From page	e 59	F 65	57			
	with multiple diagnos	es that included Alzheimer '		audit	s will include 10 residents weekly	/ x 4	
		out behavioral disturbance.			s and then 5 residents weekly x		
				s to ensure transfer and mealtim	-		
		ge Minimum Data Set (MDS)			tance listed as the MDS care pla		
	assessment dated 4/			vention is appropriate and accura audit will be documented on the (
		understood and rarely never ort-term and long-term		_	Audit tool. Through observation		
		ed and she had severely			rvision of direct care staff, the	anu	
		aking. Resident #13 required			em with care plans/following care	•	
t ר		nce of 1 staff for eating.			/identifying the need to update a		
				care	plan should not recur.		
	-	Resident #13, initiated on					
		ently reviewed on 4/19/18, ea of assistance for eating.			monthly QI committee will review		
		luded, in part, "Provide			ts of the Care Plan Audit tool mon months for identification of trends	-	
		set up. Resident is able to			ns taken, and to determine the ne		
	feed self."				nd/or frequency of continued		
				monit	toring, and make recommendatio	ns	
		nducted with the MDS		for m	onitoring for continued compliand	ce.	
		18 at 12:35 PM. The 4/12/18					
		DS that indicated Resident			MDS coordinator, DON, and/or Q	1	
	for eating was review	ensive assistance of 1 staff			e will present the findings and mmendations of the monthly QI		
	Coordinator. The cal				nittee to the quarterly executive		
		d supervision with set up			ty assurance (QA) committee for		
		eviewed with the MDS			er recommendations and oversig	ht.	
		ated she needed to review					
		t (NA) documentation related					
		/18 MDS review period to			title of the person responsible for		
	Resident #13 ' s MDS	was a discrepancy between S and her care plan.			ementing the acceptable plan of ection.		
		nducted with the MDS Nurse			DON is responsible for implemen	ting	
	on 4/25/18 at 12:43 F			the a	cceptable plan of correction.		
		umentation related to eating					
		ried from supervision to with eating. She reported					
		accurately based on the NA					
		revealed the plan of care					

If continuation sheet Page 60 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/20 ⁻ FORM APPROVE OMB NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
	ROVIDER OR SUPPLIER D 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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 657 F 658 SS=D	accurately reflect Res MDS Nurse stated sh Resident #13 ' s care An interview was con 4/25/18 at 12:55 PM. #13 was readmitted of assistance to eat for a The DON was unava An interview was con Administrator on 4/26 she expected plans of reflect the resident ' s Services Provided Ma CFR(s): 483.21(b)(3) §483.21(b)(3) Compr The services provide as outlined by the con must- (i) Meet professional This REQUIREMENT by: Based on observation interviews, the facility s order for oxygen the residents who received therapy (Resident #3 physician ' s order for two of two residents w bracelets (Resident # included:	 Id have been updated to sident #13 's status. The he was going to revise plan related to eating. ducted with NA #4 on She stated since Resident on 4/9/18 she had required almost all meals. ilable for interview. ducted with the 5/18 at 7:20 PM. She stated of care to be revised to a current status. eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced in, record review and staff failed to have a physician ' erapy for one of two ed continuous oxygen 8) and failed to have a 'a wander guard bracelet for who had wander guard '38 and #16). The findings 	F 65	F658 F658 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation center regarding the process that led to the deficiency of failure to have a physicia order for continuous oxygen therapy a	ind
		vas readmitted to the facility liagnoses included chronic		use of a wander guard was staff failur follow established policy and procedu	

Facility ID: 923021

If continuation sheet Page 61 of 171

		ND HUMAN SERVICES			FOR	D: 05/30/20 ⁷ M APPROVE <u>D. 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C / 26/2018
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 658	Continued From pag obstructive pulmonar		F 658	3		
	pneumonia (4/9/18), failure and depender The quarterly Minimu 2/23/18 indicated Re impaired in cognition	shortness of breath, heart nee on supplemental oxygen. um Data Set (MDS) dated sident #38 was severely . Oxygen was documented the assessment period.		On 5/18/18, the staff nurse obtain order for Resident #38 to have co oxygen at a rate of three (3) liters minute. The order was placed or Resident #38' s medication administration record (MAR).	ontinuous per	
	A care plan last revis resident #38 had pot breathing pattern as dependence. Interve	ed on 2/27/18 stated ential for or actual ineffective related to oxygen entions included, in part, ree liters via nasal cannula		On 5/18/18, the staff nurse obtair order for Resident #16 and # 38 t wander guard placement. The w guard monitoring sheet was place wander guard monitoring binder.	ent #16 and # 38 to have lacement. The wander g sheet was placed in the	
	A review of the medie was no order for oxy	cal record revealed there gen.		The procedure for implementing t acceptable plan of correction for t specific deficiency cited		
	the survey (4/23, 4/2 was observed to wea nasal cannula each o			On 5/18/18, the quality improvement (QI) nurse and staff facilitator (SF) nurse began in-servicing all licensed nurses and medication aides, including part time (PT as needed (PRN), and agency, in an effo	rse irses and ime (PT), n an effort	
	a physician order sho oxygen. She stated continuous oxygen a	lurse Practitioner who stated ould be written for the use of Resident #38 was on nd he did have an order but		to protect residents in similar situations from using oxygen without a correct oxygen order and/or wander guard order from the physician. The in-service covered oxygen use per physician order		
	to the hospital and ca was also a standing of	ten transferred when he went ame back. She stated there order related to oxygen use.		and wander guard per physician of and/or care plan intervention. The in-service will be completed by 5/ No licensed nurse or medication including PT_PRN_and agons (M	e 24/18. aide,	
	regarding the use of	orders revealed the following oxygen: may start oxygen at nasal cannula as needed for x 24 hours).		including PT, PRN, and agency w allowed to work until the in-servic completed. This in-service will be in the orientation of all new licens nurses and medication aides, inc	e is included ed	
	On 4/26/18 at 10:11	AM, an interview was		PT, PRN, and agency staff.		

Facility ID: 923021

If continuation sheet Page 62 of 171

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES			OMB N	M APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		345293	B. WING		04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
RICHMON	RICHMOND 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	Continued From page	e 62	F 65	8		
		Quality Assurance Nurse.				
		ation was for an order to be		On 5/18/18, the director of nu	ursing (DON),	
	written if a resident u	sed oxygen.		QI nurse, SF nurse, and char	0	
				initiated an audit to ensure al		
	On 4/26/18 at 7:21 P	-		using oxygen on a regular ba		
	physician 's order sh	dministrator. She stated a		physician s order, including minute. The audit results: 2	•	
	resident required and			were without correct flow rate		
				physician orders.		
	b. Resident #38 was	readmitted to the facility				
		liagnoses included major		On 5/23/18, the QI nurse clar		
	depressive disorder,	dementia and agitation.		orders with the physician/pro		
	The quarterly Minimu	ım Data Set (MDS) dated		updated the medication admi record (MAR) with the new of		
		sident #38 was severely			xygen orders.	
		. There were no episodes of		On 5/23/18, the SF nurse cor	mpleted an	
	psychosis or behavio			audit to ensure all residents u		
	assessment period.			wander guard have a physici		
				The audit results: 14 orders		
	-	15/18 indicated Resident #38		available in the resident heal		
	unsupervised exits fr	ering and/or at risk for		The SF nurse and QI nurse of the physician/provider 14 ord		
	-	. Resident #38 had a history		validate the use of a wander		
		der guard bracelet with nail		resident.	guala ion a	
		ns included, in part, ensure				
		name was on the wandering				
	resident board.			The monitoring procedure to		
	An interview with the	Nurse Practitioner was		the plan of correction is effect specific deficiency cited remain		
		8 at 9:30 AM. She stated		and/or in compliance with the		
		ysician 's order for a wander		requirements	- <u>-</u>	
	-			The DON, QI nurse, SF nurse	e, or	
	On 4/26/18 at 9:48 A			administrator will audit 20 res		
conducted with the Administrator.			weekly x 12 weeks to ensure			
		their practice for wander		and/or wander guard is in pla		
	a wander guard brace	e Administrator said any time		to the physician order. This a documented on the physiciar		
		andering, the must be a		tool.		

Facility ID: 923021

If continuation sheet Page 63 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-039
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
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 Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 658	expectation. On 4/26/18 at 11:15A observed sitting in his white band on his leg observed to have a w on his right ankle. A review of the medic revealed there was n guard bracelet. On 4/26/18 at 7:21 Pl conducted with the A expectation was for a guard bracelet, a phy place. 2. Resident #16 was cumulative diagnoses Accident (CVA) Hemi Review of Resident # he voiced threats of L and a wander guard was	She stated that was her M, Resident #38 was s room. He stated he had a l. Resident #38 was white wander guard bracelet cal record for Resident #38 ot an order for a wander M, an interview was dministrator who stated her resident that had a wander sician ' s order must be in admitted 4/8/16 with s of Cerebral Vascular plegia and Diabetes. E16's nursing notes indicated eaving the facility on 7/9/17 was placed on him. al Minimum Data Set dated derate cognitive impairment	F 658	 The monthly QI committee will review results of the physician order audit to monthly for 3 months for identificatio trends, actions taken, and to determine the added monitoring ensures that the problem does not recur. The QI nurse and/or DON will present findings and recommendations of the monthly QI committee to the quarter executive quality assurance (QA) committee for review of the facility's progress and make sure the solution sustained. The QA committee may refurther recommendations and require additional oversight by the administration. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction. 	ool n of ine if ne nt the e ly is are make e ator.
	1/22/18 indicated Res wandering. Review of Resident # 2/22/18 indicated he	ng Risk Assessment dated sident #16 was at risk for 16's care plan revised on was at risk for wandering ervised exits from the facility.			
		for the use of a wander			

If continuation sheet Page 64 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/30/2018 M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COM	E SURVEY PLETED
		345293	B. WING			/26/2018
NAME OF PI	ROVIDER OR SUPPLIER	R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		1 01		
		AND REHABILITATION CENTE	1	HGHWAY 177 S BOX 1489		
RICHWON	D FINES HEALTHCARE	AND REHABILITATION CENTE	I	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 658	Continued From page	e 64	F 658			
		at 4:40 PM, the here was no physician order ander guard implemented				
	conducted on 4/26/18	rse Practitioner (NP) was 3 at 9:30 AM. She stated /sician's order for a wander				
F 675 SS=D	their practice for wan- time a wander guard risk for wandering, the order. She stated this	at 9:48 AM, the the facility was changing der guards. She stated any was placed on a resident at ere must be a physician s was her expectation.	F 675			5/24/18
	applies to all care and residents. Each resid facility must provide t necessary care and s the highest practicabl psychosocial well-bei resident's comprehen of care. This REQUIREMENT	damental principle that d services provided to facility dent must receive and the				
	record review, the fac psychological service	esident interviews and cility failed to provide s as ordered for 1 (Resident viewed for unnecessary		F675 The plan of correcting the specific deficiency		

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 65 of 171

CENTER					FORM APPR OMB NO. 0938-	-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		04/26/2018	8
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	P CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLE D THE APPROPRIATE DAT	ETION
F 675	Continued From page	e 65	F 67	75		
	medications. The find					
		-		The position of Richmond		
		Imitted 8/10/16 with a		and Rehabilitation center	5 5	
	diagnosis of major de	epression and psychosis.		process that led to this de to provide psychological s		
				ordered- was failure to fo		
		ric evaluation dated 4/21/17		for following physician's o	orders.	
		as experiencing mild anxiety J. He stated he was sleeping		On 1/26/19 nurse prestit	ionor (ND) wroto	
		ately and reported his		On 4/26/18, nurse practition an order for "schedule res		
		note indicated psychiatric		follow-up every 6 months		
	follow up as needed.			review - history of depres	sion, psychosis".	
				On 5/1/18, Resident # 68	was seen by	
		d Consultation Report read		psychiatric services. The	re were no new	
		ing seen due to mood and pressant was increased and		orders given on 5/1/18.		
		onsidered for additional		On 5/15/18, the provider	dave a new order	
	support.			to "Initiate Remeron 7.5m		
				every night for depression	n."	
	Review of a nursing I	note dated 5/3/17 read				
	Resident #68 was se			The procedure for implen		
		ncreased. Social services amily regarding hospice		acceptable plan of correct specific deficiency cited	tion for the	
	services.	aning regarding hospice		specific deficiency ched		
				On 5/23/18, the medical r		
	Docidant #68's proce	ribed an antidepressant was		performed an audit to pro similar situations. The m		
		There were no additional		clerk audited all residents		
		ents in his antidepressant		residents with orders for	psychiatric	
	since 5/3/17.			services are receiving services		
				ordered. The medical rec		
	Resident #68 was ca	re planned for sadness,		psychological services fro	-	
		ecreased appetite and		psychological service pro	wider to the new	
		Interventions included		psychological service pro		
	psychological service	es.		results: several resident	-	
				adjustment from the prev	-	,

Facility ID: 923021

If continuation sheet Page 66 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/3 FORM APPR OMB NO. 0938	ROVE
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		345293	B. WING		C 04/26/201	8
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	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPI	(5) LETIO ATE
F 675	increased profanity to 1/18/18, refusal of aid and 2/4/18 and pouri 2/28/18. Review of Resident # indicated he had exp anxiousness since 3/ His quarterly Minimu indicated Resident # coded for no behavio the following: Little interest or pleas Feeling down, depres Trouble falling and st Feeling tired or little of Feelings of being a fa Trouble concentrating Moving and speaking Resident #68's last ro 4/5/18 included feeling	 #68's nursing notes indicated oward his room-mate on de assistance on 1/21/18 ng urine in the sink on #68's behavior monitoring erienced three episodes of /20/18. m Data Set dated 4/2/18 68 was cognitively intact and ors. His mood was coded as sure in doing things ssed or hopeless taying asleep energy ailure g g g slow evised care plan dated 	F 67		the ctor of d quality -service part time, eferral p the sure cal ie. This 4/18. ng staff nd d quality -service cial pcess, ric vice was ure that and that	
	orders read he was r (antidepressant) 20 r			and/or in compliance with the reg requirements. The administrator or director of nu (DON) will audit 20 residents wee 12 weeks to ensure any residents orders for psychiatric services are provided psychiatric services to p quality of life. This audit will be	ursing kly for s with	

Facility ID: 923021

If continuation sheet Page 67 of 171

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) D.	NO. 0938-03 ATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	3	CC	OMPLETED	
		345293	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE,		04/26/2018	
				HIGHWAY 177 S BOX 1489			
RICHMOND 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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 675	Continued From page	e 67	F 67	75			
1 0/0	1.5	He stated he was slightly	FU	documented on the Re	sident Care Audit		
		ke he made bad life choices		Tool.			
		he had trouble sleeping and		The monthly quality im	provement (QI)		
		e stated nobody from		committee will review t			
		nad visited him in a long ould not recall the last time		Resident Care Audit To	-		
	he was seen by psyc			months for identification taken, and to determine			
				and/or frequency of col			
				and make recommendation	-		
		ility Nurse Consultant was		monitoring for continue	d compliance.		
		8 at 2:24 PM and stated she					
		y. She stated she reviewed cal record and found no		The administrator and/ the findings and recom			
	evidence that he was			monthly QI committee			
		She stated she could		executive quality assur			
		time last spring, there was		committee for further re			
		iatric providers and that was		and oversight related to			
		ay, he was seen by two		of life - psychological/p	sychiatric services.		
		he stated he was removed ist for unknown reason and					
	had not been seen si			The title of the person i	responsible for		
				implementing the acce			
	Interview with the Nu	rse Practitioner was					
		t 9:30 AM. She stated it was		The DON is responsibl			
s F a	-	Resident #68 was being		the acceptable plan of	correction.		
		ervices given his medical, cation history. She stated it					
		"he fell through the cracks."					
		with the Nurse Practitioner					
		M, she stated she wrote 68 to be evaluated now and					
		She stated there were gaps					
	in his psychiatric serv	vices and he must have					
		e was a brief change in					
	psychiatric services p	provider. She stated he					

If continuation sheet Page 68 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/20 FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
				STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489	
RICHMON	ICHMOND 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 675	Continued From page		F 675		
	required psychiatric s management.	ervices for medication			
	Psychiatric Nurse Pra She stated it appeare saw Resident #68 wa there was documenta was discharged from 9/15/17 but there was	was conducted with the actitioner on 4/26 at 9:55 AM. ed the last time her agency as 4/21/17. She also stated ation in her computer that he her agencies services on a no rationale documented. If see Resident #68 on			
F 677 SS=D	Resident #68 be seen needed and as order	t was her expectation that n by psychiatric services as ed. or Dependent Residents	F 677		5/24/18
	out activities of daily services to maintain of personal and oral hyd This REQUIREMENT by: Based on record rev interview, the facility care (Resident #69) a for 2 of 8 sampled res activities of daily livin	is not met as evidenced iew, observation and staff failed to provide incontinent and nail care (Resident #9)		F677 The plan of correcting the specific deficiency The position of Richmond Pines Nursin and Rehabilitation center regarding the	-
		diagnoses including anxiety		process that lead to this deficiency- fai to provide incontinent care and nail ca was failure to follow established	led

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 69 of 171

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE	CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMP	LETED
						С	
		345293	B. WING			04/	26/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICUMON				н	IGHWAY 177 S BOX 1489		
RICHIVION	RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			H	AMLET, NC 28345		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677	Continued From page	e 69	F 6	77			
	The quarterly Minimu				procedure.		
		2/18 indicated that Resident					
		I decision making problems			On 4/25/18, the nursing assistant (NA)#	4	
	and she required tota	I staff assistance with			assisted Resident #9 with nail care,		
		ne assessment further			including trimming and filing of nails on		
	indicated that the resi bowel and bladder.	ident was incontinent of			bilateral hands.		
					On 4/26/18, NA #4 and NA #5 assisted		
		plan dated 4/2/18 was			Resident #69 with incontinent care,		
		e care plan problems was			including a new brief and clean pants.		
		istance with toileting. The					
	-	lent to remain dry of urine.					
		uded to check resident			The precedure for implementing the		
	frequently for incontin	lent episodes.			The procedure for implementing the acceptable plan of correction for the		
	On 4/26/18 at 12.06 F	PM, 12:33 PM, 1:01 PM and			specific deficiency cited		
		59 was observed up in the					
		seat belt on. She was			By 5/24/18, the director of nursing (DON	۷).	
		ts and her pants were			quality improvement (QI) nurse, staff	,,	
		n the crotch and thigh areas.			facilitator (SF) nurse, admissions director	or	
					(nurse), social worker (SW),		
	On 4/26/18 at 1:15 Pl	M, Nurse Aide (NA) #5 was			administrator, manager on duty (MOD),		
		e room of Resident #69 with			and/or staff nurses will observe		
	-	vas observed to set up the			incontinent residents during meal times	in	
		ident and was about to feed			the dining room and resident rooms to		
	her.				ensure residents are not soiled or wet		
	On 4/26/18 at 1.16	M, NA #5 was interviewed			immediately prior to or during meals. Incontinent care audit results: 0 residen	te	
		eding Resident #69. She			were wet or soiled immediately prior to		
		the resident at 11:30 AM			wet during meal observations.		
		or on the diaper and she was					
		she didn't get the chance to			By 5/24/18, the activity department		
	check her again beca	ause "it was kind of hectic			director and activity assistant will		
		#5 looked at the resident's			complete a 100% audit of resident nails		
		was wet". NA #5 and NA #6			The audit results will be submitted to the	е	
		Resident #69 in bed using a			DON. Finger nail audit results: 10		
		n in bed, Resident #69's			residents were noted with long nails		
		soaking wet on the buttock			during audit. The long nails for the 10		
	area. Her diaper was	soaking wet and was soiled			residents were trimmed and filed on		

Facility ID: 923021

If continuation sheet Page 70 of 171

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 04/26/2018	
	345293		B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 677	Continued From pag	je 70	F 677	7		
	with feces. Her thigh dried feces.	ns were observed to have		5/23/18 by nursing assistant staff assigned by the DON.		
	observed to provide	PM, NA #4 and #5 were incontinent care to Resident new diaper and clean pair of		By 5/24/18, the SF nurse or DON re-educate staff to help ensure the problem does not recur. All licens nurses and NAs, including part tim	e sed ne, as	
	interviewed. She sta staff to check resider meals for incontinen 2. Resident #9 was a	PM, the Administrator was ated that she expected the nt frequently and before t episodes. admitted 9/10/16 with a tures and feeding difficulties.		needed (PRN), and agency, will b in-serviced on 1) incontinent care including residents must be clean prior to meals to promote dignity a nail care is to be provided as part routine resident care. No license or NA, including part time, prn, an agency, will be allowed to work af	, and dry and 2) of ed nurse id	
	4/10/18 indicated se with no behaviors. R	Data Set (MDS) dated vere cognitive impairment esident #9 was coded for with his personal hygiene.		5/24/18 until the in-service comple This in-service will be added to th staff orientation process for licens nurses and NAs, including part tin and agency.	e new ed	
	indicated he required hygiene due to his b	an last revised on 4/16/18 d assistance with his personal ilateral and contractures. total assistance of his		To protect residents in similar situ as added measures: 1) the admin will instruct department heads to i during angel rounds, looking for d issues, 2) the department heads, making "angel rounds", will obser- residents for dignity issues includi ensuring resident have clean, dry	nistrator include, ignity while ve ing	
	finger nails were not contracted hands. The	/18 at 1:00 PM, Resident #9's ed to be long on his bilateral, he finger nails on his left l leaving an indentation in the e to his contractures.		and clean, trimmed finger nails, a any observation of dignity issues immediately reported and correct assigned nurse then noted on the administrative rounds sheet for fo by the DON, SF nurse, and/or QI	nd 3) will be ed to the llow up	
	finger nails were not	/18 at 9:12 AM, Resident #9's ed to be long on his bilateral, he finger nails on his left		The monitoring procedure to ensu the plan of correction is effective a		

Facility ID: 923021

If continuation sheet Page 71 of 171

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,	E CONSTRUCTION	· · ·	NO. 0938-039 TE SURVEY	
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED	
		345293	B. WING			C 04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO			4/20/2010	
				HIGHWAY 177 S BOX 1489			
RICHMON	RICHMOND 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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 677	Continued From page	e 71	F 67	7			
	 hand were observed leaving an indentation in the palm of his hand due to his contractures. Observation on 4/25/18 at 8:30 AM, Resident #9's finger nails were noted to be long on his bilateral, contracted hands. The finger nails on his left hand were observed leaving an indentation in the palm of his hand due to his contractures. Resident #9 was moved off the 400 Hall and onto the 200 Hall on 4/25/18. Nursing Assistant (NA) #4 stated Resident #9 was moved to the 200 Hall around 11:30 AM and she noticed his fingernails were long so she trimmed them. She stated he was cooperative with nail care. Resident #9's fingernails were observed indentation to the palm of his left hand. 			specific deficiency cited re and/or in compliance with requirements			
				The DON, SF nurse, QI nu data set (MDS) nurse, and consultant will audit 20 res for 12 weeks prior to or du ensure residents are clean promote dignity and nails a The purpose of the audit is demonstrate more visual s "inspecting what is expected validating the re-education	/or corporate idents weekly ring a meal to and dry to are not long. to upervision, ed", and		
				results are effective and ac problem does not recur. T documented on the Reside Tool The monthly QI committee results of the resident care	ccurate so the his audit will be ent Care Audit will review the audits monthly		
	Resident #9 was more She stated she notice were long on 4/23/18 look for nail clippers	at 1:10 PM, NA #11 stated ved off 400 Hall earlier today. ed Resident #9's fingernails 8. She stated she went to but could not find one. She pok again or let anyone know		for 3 months for identificati actions taken, and to deter for and/or frequency of cor monitoring, and make reco for monitoring for continue The administrator and/or D	mine the need ntinued ommendations d compliance.		
	that she could not fin	d the nail clippers. She id not have a history of		the findings and recomment monthly QI committee to the executive quality assurance committee for further recommittee for further recommittee and oversight.	ndations of the ne quarterly ne (QA)		
	Supply Clerk stated t	at 10:35 AM, the Central here was nail care supplies he nurse station or in the		The title of the person resp implementing the acceptat			

Facility ID: 923021

If continuation sheet Page 72 of 171
SUMMARY ST. (EACH DEFICIENC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345293 AND REHABILITATION CENTE	. ,		COM	E SURVEY PLETED C
D PINES HEALTHCARE SUMMARY ST. (EACH DEFICIENC		B. WING			C
D PINES HEALTHCARE SUMMARY ST. (EACH DEFICIENC	AND REHABILITATION CENTE		· · · · · · · · · · · · · · · · · · ·	04/26/201	
SUMMARY ST. (EACH DEFICIENC	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY ST. (EACH DEFICIENC			HIGHWAY 177 S BOX 1489		
(EACH DEFICIENC	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		HAMLET, NC 28345		
REGULATORY OR I	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) COMPLETIO DATE
Continued From page	272	F 67	7		
Assurance Nurse stat	ted it was her expectation		The DON is responsible for im		
she did not notice Re long on 4/23/18 while stated Resident #9 di stated the facility had the nurses station or	sident #9's fingernail being working second shift. She d not refuse nail care. She a nail kit that was keep and there were likely clippers in				
Administrator stated i nail care be done as not be located, staff v know or inquire with t	t was her expectation that needed and if supplies could vere to let management he Central Supply Clerk.	F 68	6		5/24/18
					0,24,10
§483.25(b)(1) Pressu Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and c ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, pre- new ulcers from deve	re ulcers. whensive assessment of a hust ensure that- is care, consistent with ls of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent hdards of practice, to vent infection and prevent loping.				
	that Resident #9's be Interview on 4/26/18 a she did not notice Re long on 4/23/18 while stated Resident #9 di stated the facility had the nurses station or the central supply roc Interview on 4/26/18 a Administrator stated i nail care be done as i not be located, staff v know or inquire with t Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and c ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, prev new ulcers from deve This REQUIREMENT by:	Assurance Nurse stated it was her expectation that Resident #9's be trimmed as needed. Interview on 4/26/18 at 4:40 PM, NA #12 stated she did not notice Resident #9's fingernail being long on 4/23/18 while working second shift. She stated Resident #9 did not refuse nail care. She stated the facility had a nail kit that was keep and the nurses station or there were likely clippers in the central supply room. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that nail care be done as needed and if supplies could not be located, staff were to let management know or inquire with the Central Supply Clerk. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and	that Resident #9's be trimmed as needed. Interview on 4/26/18 at 4:40 PM, NA #12 stated she did not notice Resident #9's fingernail being long on 4/23/18 while working second shift. She stated Resident #9 did not refuse nail care. She stated the facility had a nail kit that was keep and the nurses station or there were likely clippers in the central supply room. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that nail care be done as needed and if supplies could not be located, staff were to let management know or inquire with the Central Supply Clerk. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	that Resident #9's be trimmed as needed. 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Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	that Resident #9's be trimmed as needed. Interview on 4/26/18 at 4:40 PM, NA #12 stated she did not notice Resident #9's fingernail being long on 4/23/18 while working second shift. She stated Resident #9 did not refuse nail care. She stated the facility had a nail kit that was keep and the nurses station or there were likely clippers in the central supply room. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that nail care be done as needed and if supplies could not be located, staff were to let management know or inquire with the Central Supply Clerk. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b)(Skin Integrity §483.25(b)(Skin Integrity §483.25(b)(Skin Integrity gased on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 73 of 171

TATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE	<u>D. 0938-039</u> E SURVEY PLETED	
		245000	B. WING			С		
		345293	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HWAY 177 S BOX 1489 MLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 686	Continued From page	e 73	Í -	686				
			I	000				
		failed to provide treatment to lered and failed to follow			The plan of correcting the specific			
		hended by the wound care			deficiency			
		ampled residents reviewed			acholonoy			
		esident # 39). Findings			The position of Richmond Pines Nurs	sing		
	included:	, 3			and Rehabilitation Center regarding			
					process that led to the deficiency of t	he		
	Resident #39 was ad	lmitted to the facility on			facility failing to provide treatment to	а		
		diagnoses including anxiety			pressure ulcer as ordered and failing			
		rly Minimum Data Set (MDS)			follow treatment plan as recommended	-		
	assessment dated 2/				wound care specialist was knowledge	е		
		oderate cognitive impairment			deficit.			
	· ·	nsive assistance with bed						
		ment further indicated that stage 4 pressure ulcer that			On 4/25/18, the treatment nurse contacted the wound care specialist	for		
		ssion and an unstageable			Resident #39.			
	pressure ulcer that w	-						
	admission.				On 4/25/18, the treatment nurse rece	eived		
					a clarification treatment order from th			
	Resident #39's care	plan dated 2/28/18 was			wound care specialist for Resident #			
	reviewed. One of the	e care plan problems was						
	pressure ulcer to bila	teral lower extremities. The						
		ent pressure ulcer not to			The procedure for implementing the			
	included to provide tr	next review. The approaches reatment as ordered by the			acceptable plan of correction for the specific deficiency cited			
	physician.				On 5/21/18, the quality improvement	(QI)		
	The wound care spec	cialist evaluation notes for			nurse, director of nursing (DON), and	ł		
	Resident #39 were re	eviewed.			corporate consultant audited all would			
					care specialist notes for the past 30 c	-		
		cialist notes dated 2/2/18			to ensure orders have been transcrib			
		ssure ulcer on the right heel			and treatments are being provided a			
		e ulcer measured 4.5 x (by)			ordered, to protect residents in simila			
		(cm), 90% necrotic and with			situations. The audit result: no othe	r		
	odor. The recommer				residents seen by the wound care			
	-	t (an antibiotic) daily, silver			specialist had missing or inaccurately transcribed orders. All orders were co			
		agyl (an antibiotic) 500 mgs ays. The notes dated			on the treatment administration reco			
	l crushed daily 101 3 08	t the pressure ulcer had			on the treatment authinistration fecol	u	1	

Facility ID: 923021

If continuation sheet Page 74 of 171

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		· · ·	ATE SURVEY
			A. BUILDIN	IG		С
		345293	B. WING			04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		04/20/2010
				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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 686	Continued From page	e 74	F6	86		
	improved and to conf Gentamycin ointmen	inue the treatment of t and silver alginate daily.		specialist and/or physician's la recommendations.	ıst	
	The notes dated 3/16/18 revealed that the pressure ulcer had improved and to change the treatment to negative pressure once weekly for 30 days. The notes dated 3/23/18 revealed that the pressure ulcer had deteriorated and the recommended treatment was silver alginate daily. The notes dated 3/30/18 and 4/13/18 revealed that Resident #39 was seen by the wound care specialists and recommended to continue the treatment of silver alginate once daily.			By 5/24/18, the staff facilitator will in-service staff to ensure the does not recur due to many ne The in-service for all licensed	ne problem ew staff nurses,	
				including part time, as needed agency staff, will cover provid care/treatments as ordered pe or wound care specialist, and orders correctly including wou	ing wound r physician transcribing	
TI M ul fra fra W T re G	The Treatment Admir March 2018 revealed ulcer was treated with from March 1-31, 201	nistration Records (TARs) for I that the right heel pressure h Gentamycin ointment daily 18. The recommendations specialist for silver alginate		Any licensed nurse not in-serv 5/24/18 will not be allowed to v the in-service is completed. T in-service will be part of the or process for newly hired license including part time, PRN, and	riced by work until his ientation ed nurses,	
	reviewed. On 3/9/18 Gentamycin ointmen The TARs for April 20	ers for Resident #39 were , there was an order for t to right heel once a day. 018 revealed that the right vas treated with Gentamycin		The monitoring procedure to e the plan of correction is effecti specific the deficiency cited re corrected and/or in compliance regulatory requirements	ve and that mains	
		Iginate daily from April 1-24,		The director of nursing (DON), SF nurse, charge nurse, and/o consultant will audit all wound	or corporate	
	observed during the	M, Resident #39 was dressing change. Nurse #7 as observed to clean the		specialist recommendations by review weekly including recom	mendations	
	pressure ulcer on the	e right heel with anasept er alginate was applied and		received all shifts seven days including weekends, x12 week orders are transcribed so treat provided as ordered. This visu	to ensure ments are	
	On 4/25/18 at 10:05	AM, Nurse #7 was		be documented on the Wound as a verification of intervention	Audit tool	
		ted that she followed the during wound rounds and		solutions being sustained.		

Facility ID: 923021

If continuation sheet Page 75 of 171

TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING			
		345293		STREET ADDRESS, CITY, STATE, ZIP CODE	04	/26/2018
	ROVIDER OR SUPPLIER	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 (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 686	she read her weekly She was responsible as recommended by Nurse #7 indicated th order to discontinue t and she failed to writ alginate. On 4/26/18 at 7:20 A interviewed. She sta Treatment Nurse to v	notes/recommendations. for writing treatment order the wound care specialist. that she forgot to write an the Gentamycin ointment e a new order for the silver M, the Administrator was ted that she expected the write treatment orders as a wound care specialist and	F 686	 The monthly QI committee will revires results of the Wound Audit tool, motor for 3 months for identification of treactions taken, and to determine the for and/or frequency of continued monitoring, and make recommend for monitoring for continued complitations of the treatment nurse, QI nurse and DON will present the findings and recommendations of the monthly C committee to the quarterly executive quality assurance (QA) committee further recommendations and over The title of the person responsible implementing the acceptable plan of correction. 	onthly ends, e need ations iance. l/or QI ve for rsight. for of	
F 688 SS=D	CFR(s): 483.25(c)(1) §483.25(c) Mobility. §483.25(c)(1) The far- resident who enters to range of motion does range of motion unles- condition demonstration of motion is unavoidation §483.25(c)(2) A resider motion receives appro- services to increase to	cility must ensure that a he facility without limited a not experience reduction in ss the resident's clinical es that a reduction in range	F 688	\$		5/24/18

If continuation sheet Page 76 of 171

STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DAT	0. 0938-039 E SURVEY IPLETED
		345293	B. WING		04	C 4/26/2018
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP C 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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 688	§483.25(c)(3) A resid receives appropriate assistance to maintai the maximum practica reduction in mobility i This REQUIREMENT by: Based on observatio record review, the fact hand splints as order reviewed for contract Resident #9 was adm diagnosis of contract Review of a Rehabilit Nursing form dated 5 was to receive restoration indicated Resident #9 right hand splinting 9/ he was admitted to refer Review of a Rehabilit Nursing form dated 1 #9 was to receive restoration receive of a Rehabilit Nursing form dated 1 #9 was to receive restoration to his left-hand. He was daily for three to four	ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable. is not met as evidenced ns, staff interviews and cility failed to utilize bilateral ed for 1 (Resident #19) ures. The findings included: hitted 9/10/16 with a ures and feeding difficulties. ation Communication to /19/17 indicated Resident #9 ative nursing for splinting to s to wear his right-hand burs. There was no mention hand. tive nursing documentation 9 was receiving services for /1/18 through 10/5/17 when ehabilitation services. ation Communication to 0/19/17 indicated Resident torative nursing for splinting as to wear a left-hand splint hours.	F 6	 F688 The plan of correcting the sideficiency The position of Richmond F and Rehabilitation center reprocess that led to the deficito utilize bilateral hand splir for contractures was failure procedure. On 4/26/18, the restorative bilateral splints to Resident On 4/26/18, the restorative assistant documented the aremoval, and skin observat bilateral hand splinting for F hands. On 4/26/18, the minimum d nurse updated Resident #9's sch bilateral hand splinting. The procedure for impleme acceptable plan of correction specific deficiency cited 	Pines Health egarding the ciency of failing nts as ordered to follow aide applied #9's hands. aide/nursing application, ion regarding Resident #9's lata set (MDS) 's care guide edule of	
		tive nursing documentation was receiving services for		On 5/15/18, the administrat audit of all residents with sp		

Facility ID: 923021

If continuation sheet Page 77 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE,	•
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	(EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 688	Continued From page		F 68		
	1/17/18 when he was services.	linting 10/20/17 through admitted to rehabilitation		care plan, therapy, and ensure documentation support splints used as revealed the list of resi for splints, care plans,	was present to s ordered. The audit idents with an order care guides, and
	dated 2/8/18 8 indicat due a decline in his fe decreased right shou with Resident #9 able	ation Discharge Summary ted Resident #9 was seen beding abilities related to Ider ROM. Goals were met to manage his cup and was no evidence of a nursing.		splint wear schedule d 23 residents with splin plans, care guides, and updated by the minimu (MDS) and/or MDS co 5/23/18, which corrected audit findings.	t orders had care d wear schedule um data set nurse ordinator on
	4/10/18 indicated sev with no behaviors. Re extensive assistance	Data Set (MDS) dated ere cognitive impairment esident #9 was coded for with his activities of daily functional limitations with tremities.		On 5/21/18 through 5/2 of nursing (DON), qual (QI) nurse, charge nur facilitator (SF) nurse a with splints care plan a ensure the splint wear The 23 residents with care plans, care guide schedule updated by th	lity improvement se, and staff udited all residents and care guide to schedule is correct. splint orders had s, and wear
	Nursing form dated 4, was to receive restora and exercise to his lo no mention of splintin	ation Communication to /11/18 indicated Resident #9 ative nursing for ambulation wer extremities. There was g to Resident #9's left and		On 5/21/18, the DON MDS and MDS and MDS and MDS coordin	or MDS coordinator ected the negative will in-service the
		tive nursing documentation) was receiving services for		planning including (car This in-service will be MDS nurse during orie	e guide) splint use. given to any new
	ambulation and ROM starting 4/18/18 to 4/2	to his lower extremities		By 5/24/18, the SF/QI all nursing staff, includ assistants (NAs), part (PRN), and agency sta as ordered, including of use. Any staff not in-se	ing nursing time, as needed aff on utilizing splints locumentation of
	Resident #9's care pl	an last revised on 4/18/18		will not be allowed to v	

Facility ID: 923021

If continuation sheet Page 78 of 171

STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	<u>NO. 0938-039</u> TE SURVEY MPLETED	
		345293	B. WING			C 04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		4/20/2010	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 688	Continued From page 78 indicated he was receiving active range of motion (AROM) to his lower extremities and ambulation with contact guard assistance. He was active in the restorative nursing program. There was no mention of any AROM or splinting to his bilateral hand contractures.		F 6	88 until the in-service is cor in-service will be part of process for newly hired i including NAs, part time, agency staff.	the orientation nursing staff,		
	indicated he was rec ambulation and ROM	#9's undated Care Guide eiving restorative nursing for 1 to his lower extremities. on of his left and right-hand		The monitoring procedur the plan of correction is specific deficiency cited and/or in compliance wit requirements	effective and that remains corrected		
	bilateral hands were	'18 at 1:00 PM, Resident #9's severely contracted. There lints in place or observed		The SF nurse, QI nurse, corporate consultant will residents weekly on vary days per week to ensure days are covered x 12 w splints are applied, remo documented on accordir	audit 20 ying shifts seven e all shifts and yeeks to ensure oved and ng to the plan of		
	bilateral hands were	(18 at 9:12 AM, Resident #9's severely contracted. There lints in place or observed		care/care guide this aud checks. The audit will be the Resident Care Audit The monthly QI committe results of the Resident C	e documented on tool. ee will review the		
	bilateral hands were	/18 at 8:30 AM, Resident #9's severely contracted There lints in place or observed		monthly for 3 months for trends, actions taken, ar the need for and/or frequ continued monitoring, ar recommendations for mo continued compliance.	nd to determine uency of nd make		
	conducted on 4/25/18 she evaluated Reside contractures earlier of Restorative Aide (RA	Phabilitation Manager was 8 at 12:45 PM. She stated ent #9 for his bilateral hand on 4/25/18 because the A) asked her about the splints ated Resident #9 was		The SF nurse, QI nurse present the findings and recommendations of the committee to the quarter quality assurance (QA) of further recommendations	monthly QI rly executive committee for		

Facility ID: 923021

If continuation sheet Page 79 of 171

TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED	
		345293	B. WING			C 4/26/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		04/20/2010	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 688	F 688 Continued From page 79 supposed to be wearing his bilateral hand splints three-four hours daily since he was discharged to restorative nursing 10/19/17. She stated somehow, his splinting was dropped off the task for restorative nursing task to perform. She stated both of his hand splints were found in his room 4/25/18.		F 688	The title of the person respons implementing the acceptable p correction. The DON is responsible for im the acceptable plan of correcti	plan of		
	Resident #9 was cur services for ambulati stated she was unce	estorative Aide was 8 at 12:50 PM. She stated rently receiving restorative on and ROM to his legs. RA rtain if he was to wear but recalled he did wear					
	1:00 PM, she stated program and she wa bilateral hand splints stated it was likely th admitted to rehabilita discharged from rest overlooked for his sp	DS Coordinator on 4/25/18 at she was over the restorative s unsure why Resident #9's were not being applied. She at when Resident #9 was tition services 1/17/18 and orative services, he was linting. She stated he was rative nursing program as of plinting.					
	9:30 AM, stated it wa Resident #9 wear his	urse Practitioner on 4/26/18 at as her expectation that a bilateral hand splints three prevent worsening of his					
		at 11:20 AM, the Quality ted it was her expectation					

If continuation sheet Page 80 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 05/30/201 APPROVE	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMPL	SURVEY LETED	
		345293	B. WING		-	C 4/26/2018	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE	H	TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 177 S BOX 1489 IAMLET, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	Continued From page 80 that Resident #9 receiving restorative nursing and wear his bilateral hand splints as ordered.		F 688				
	Resident #9 wore bila	at 1:10 PM, NA #11 stated ateral hand splints in the past stated at one time, the RA d splints daily.					
		at 4:40 PM, NA #12 stated at Resident #9 was to wear					
F 689	Resident #9 receive t nursing and wear his ordered.	at 7:28 PM, the t was her expectation that herapy services, restorative bilateral hand splints as ards/Supervision/Devices	F 689			5/24/18	
SS=E	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The res	(2)					
	supervision and assis accidents. This REQUIREMENT by: Based on observatio	esident receives adequate stance devices to prevent is not met as evidenced ns, record reviews, and		F689			
	Practitioner (NP), the fall risk interventions	, staff, police, and the Nurse facility failed to implement for Resident #13 for two e sustained a nasal fracture.		The plan of correcting the specific deficiency			

Facility ID: 923021

If continuation sheet Page 81 of 171

							O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION		E SURVEY PLETED
			A. BUILDING	;			
		245002	B. WING				С
		345293	B. WING			04	/26/2018
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			WAY 177 S BOX 1489		
				НАМІ	LET, NC 28345		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
F 689	Continued From page	e 81	F 68	9			
	The facility also failed	I to provide adequate		ті	he position of Richmond Pines Nurs	ing	
		nitively impaired male			nd Rehabilitation center regarding th	-	
		5) to prevent him from			rocess that led to this deficiency-fail		
	exposing his genital r				implement fail risk interventions,		
	impaired female resid		pr	rovide adequate supervision to prev	ent a		
	facility additionally fai		re	esident-to-resident event, failure to			
	s wanderguard (a dev	vice used to monitor exit		m	onitor a wander guard, and failure t	0	
	seeking behaviors for	cognitively impaired		th	oroughly analyze falls to determine		
	residents) and failed	to thoroughly analyze falls to		Ca	ausative factors and implement		
	determine causative f	factors and implement		a	ppropriate interventions to prevent f	alls-	
		ons to prevent further falls			as a system-wide failure to follow		
	(Residents #22, #50,	and #69). This was for 6 of		es	stablished policy and procedures.		
	7 residents reviewed	for accidents.					
					esident #13 was noted by the staff r		
	The findings included	:			have a functioning alarm and fall m		
					y the bed, according to the care plar		
		admitted to the facility on			23/18 by the director of nursing (DC	DN).	
		diagnoses that included			he care plan was reviewed by the		
	Alzheimer 's, demen				inimum data set (MDS) nurse on 5/	3/18	
		kidney disease, Diabetes		w	ith no new interventions added.		
	Mellitus, and muscle	weakness.					
					esident #45 was assessed, remove		
		#13 's plan of care, initiated			om the room, and directly supervise		
		he was at risk for falls due			26/18 by the licensed facility nurse.		
		mpaired cognition and a			are plan was reviewed by the MDS i	nurse	
	-	nterventions included, in			n 5/3/18 with no new interventions		
	-	or when Resident #13 was in		a	dded.		
	bed (initiated on 6/15	(17).			ocidant #16's wandar sward was		
	The quarterly Minimu	m Data Set (MDS)			esident #16's wander guard was necked by the supply clerk on 4/25/	18	
		15/18 indicated Resident			nd the wander guard was functionin		
		understood and rarely never			ppropriately.	Э	
		ort-term and long-term			opiopilatory.		
		ed and she had severely		P	esident #50's care plan was reviewe	ed by	
		king. Resident #13 was			ie interdisciplinary team (IDT). The	Jaby	
		ition, disorganized thinking,			terdisciplinary team consists of the	MDS	
	and an altered level of				pordinator, MDS nurse, DON, quality		
		She had other behavioral			nprovement (QI) nurse, staff facilitat		
		lays during the MDS review			SF) nurse, social worker (SW), dieta		

Facility ID: 923021

If continuation sheet Page 82 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/201 MAPPROVE D. 0938-039
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	СОМ	E SURVEY PLETED
		345293	B. WING			C 04/26/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				HIG	HWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		НА	MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
					,		
F 689	Continued From page	e 82	F	689			
	period. Resident #1	3 required the extensive			bookkeeper, activities, and/or		
		ore staff with bed mobility			administrator. The IDT reviewed Re		
		sistance of 1 staff with			#50's falls to analyze the resident's	falls,	
		tion on the unit. She was			to determine causative factors, and		
	-	ore staff for toileting and			ensure appropriate interventions are		
		d dependent on 1 staff for . Resident #13 was not			place to prevent falls/injuries. No ne interventions were added.	ew	
		id she was only able to			interventions were added.		
	•	sistance. She was assessed			Resident # 22's care plan was revie	wed	
		pairment with range of			by the IDT regarding falls to analyze		
		ed a wheelchair. Resident			resident's falls, to determine causati		
	#13 was always inco	ntinent of bladder and bowel.			factors, and ensure appropriate		
					interventions are in place to prevent		
		#13 's plan of care related			falls/injuries. No new interventions w	/ere	
	to the risk for falls wa intervention of a bed				added.		
					Resident #34's care plan was review	-	
		ted 4/1/18 and completed by			the IDT for falls to analyze the reside		
	Nurse #1 indicated R				falls, to determine causative factors,		
		1/18 at 6:25 AM. Nurse #1			ensure appropriate interventions are place to prevent falls/injuries. No ne		
		rted by a Nursing Assistant 13 was found on the floor of			interventions were added.	vv	
		vay from her bed. She was					
		n an open wound on the			Resident #69's care plan was review	ved bv	
		nd droplets of blood were			the IDT for falls, to analyze resident		
	-	he wound was cleaned and			to determine causative factors, and		
		 Emergency Medical 			ensure appropriate interventions in I	blace	
		contacted as the wound			to prevent falls/injuries. No new		
		ed to determine if sutures			interventions were added.		
		ent #13 was noted to be					
		to provide information on Responsible Party (RP)			The procedure for implementing the		
	were notified.	TOSPONSIBLE LALLY (ITF)			acceptable plan of correction for the		
	word notified.				specific deficiency cited		
	A nursing note dated	4/1/18 and completed by					
	-	esident #13 was toileted and			On 5/18/18, the DON initiated an		
		t 6:15 AM. She was left in			in-service for the QI nurse, SF nurse) ,	
	-	omfortable. At 6:25 AM			MDS nurse coordinator and MDS nu		
	Resident #13 was for	und crawling on the floor of			on thoroughly analyzing falls to dete	rmine	

Facility ID: 923021

If continuation sheet Page 83 of 171

		MEDICAID SERVICES				OMB N	O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	E SURVEY PLETED
		345293	B. WING			С	
	ROVIDER OR SUPPLIER	545235			REET ADDRESS, CITY, STATE, ZIP CODE	04	/26/2018
NAIVIE OF PI	ROVIDER OR SUPPLIER						
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	· · ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETIO
F 689	Continued From pag	e 83	F 68	39			
	her room with blood	droplets noted on the floor.			causative factors and implement		
	There was a lacerati	on on her nose that was			appropriate interventions to prevent		
		ne laceration was cleaned			repeat falls/prevent injury. During the		
		sing applied. EMS was			in-service, the DON discussed using		
		ent #13 was transported the			"5 Whys" root cause analysis process	sand	
	Emergency Room (E	:R) at 6:45 AM.			the DON's expectation that the team	mino	
	An ER note dated 4/	1/18 indicated Resident #13			"digs" deeper to investigate and deter the root cause of the incident/accider		
		pital following a fall at the			This in-service was completed by 5/2		
		sustained an injury to her			This in-service will be included during		
	-	idence of bleeding with no			orientation of any new nursing	,	
		d. Resident #13 was			management positions (QI nurse, SF		
	assessed with a clos	ed fracture of the nasal bone			nurse, MDS nurse coordinator and/or		
	and a superficial nas	al laceration that required no			MDS nurse).		
	suturing. She was di	scharged back to the facility.					
					By 5/18/18, the SF nurse and QI nurs		
		4/1/18 indicated Resident			began an in-service with all staff inclu		
	#13 returned from th	•			part time, as needed (PRN), and age	•	
	lacerations and nasa	ll fracture.			staff, on behavior management includ		
	An incident report de	ted 4/1/18 and completed by			wandering, and sexual behaviors. Th in-service will be completed by 5/24/1		
	Nurse #2 indicated F				Any staff who have not completed this		
		/1/18 around 9:00 PM.			in-service by 5/24/18 will not be allow		
		und on the floor of her room			work in the facility until the in-service		
	near the foot of her b	bed. She was face down with			completed. This in-service will be add		
		her. Resident #13 was			to the orientation for newly hired staff		
		. She was noted as able to			including part time, PRN, and agency		
		She had an approximate			staff.		
	-	o the left elbow and 2					
	superficial 1-inch abi				By 5/21/18, the SF nurse, QI nurse, D		
		ert with confusion and she			and/or corporate consultant initiated a		
	NP and RP were not	le information on the fall. The			in-service for all licensed nurses, inclu-	-	
		illeu.			part time, as needed (PRN), and age staff, on implementing an interventior	-	
	A nursing note dated	4/1/18 and completed by			after each fall to prevent a repeat	1	
	-	Resident #13 was found on			fall/prevent injury; wander guard chec	ck	
		. She was assessed for			schedule including documentation. Th		
		oximate quarter sized bruise			in-service will be completed by 5/24/1		
		elbow as well as 2			any staff not in-serviced by 5/24/18 w		

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 84 of 171

		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
			A. BOILDING		с
		345293	B. WING		04/26/2018
NAME OF PR	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	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 689	Continued From page	e 84	F 68	9	
	superficial 1-inch abra	asions.		be allowed to work in the facility u	until the
				in-service is completed. This in-service	ervice
		ndicated Resident #13 was		will be included during the orienta	
		aluation on 4/1/18 and she		all newly hired licensed nurses, ir	
	was admitted to the h	nospital.		part time, PRN, and agency staff	
	The hospital record ir	ndicated Resident #13		By 5/21/18, the SF nurse, QI nurse	se. DON.
		on the evening of 4/1/18 with		and/or corporate consultant initia	
		f a fall. She was assessed		in-service for all nursing staff, inc	
	-	h, but laboratory results and		nursing assistants (NAs), part tim	
		diagnoses that included		needed (PRN), and agency staff,	
	-	n (UTI), sepsis secondary to		following fall interventions based	
		high concentrations of s (white cells above the		resident care plan. This in-service completed by 5/24/18. Any staff	
		hronic kidney disease.		in-serviced by 5/24/18 will not be	
	,			to work in the facility until the in-s	
	A Facility Concern/Gr	rievance Form dated 4/2/18		completed. This in-service will be	
		e was completed for Resident		during orientation for all newly hir	
		grievance included concerns		nursing staff, including NAs, part	time,
		13 's recent falls. The form		PRN, and agency staff.	
		was held on 4/2/18 at 10:30		By 5/22/18, the SE purse, OI pure	
		3 ' s family, the Quality se, the MDS Coordinator,		By 5/22/18, the SF nurse, QI nurs and/or corporate consultant will re	
		er (SW). The meeting		falls for the past 30 days to ensur	
		sident #13 's family reporting		interventions on the care plan we	
		er fall and nasal fracture.		place at the time of the fall. Also,	
		or stated during the meeting		nurse, QI nurse, DON and/or cor	porate
		NA Care Guide interventions		consultant will review documenta	
	included a fall mat an	nd a bed alarm.		the analysis to determine causati	
	The medical record in	ndicated Desident #12 was		factors and look for implementation	
	readmitted to the faci	ndicated Resident #13 was		appropriate interventions to preve repeat falls/injuries. The audit wa	
				completed on 5/23/18. The audit	
	A Facility Concern/Gr	rievance Form dated 4/9/18		1) care plan interventions were in	
	-	e was completed for Resident		the time of the fall, 2) causative fa	-
		ber. The grievance included		were examined, and 3) as approp	
		Resident #13 ' s fall mat not		new interventions were in place to	o prevent
				future falls.	
	#13 by a family memi concerns related to R being in place and the	ber. The grievance included		were examined, and 3) as approp	oriate,

Facility ID: 923021

If continuation sheet Page 85 of 171

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING AMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CO PREFIX TAG PROVIDER'S PLAN OF CO CROSS-REFERENCED TO TH DEFICIENCY	(X3) DAT COM 04	O. 0938-039 E SURVEY IPLETED C I/26/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO. RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID PROVIDER'S PLAN OF CO. YAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE	DE	-
HIGHWAY 177 S BOX 1489 HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION)	DE	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE KAMLET, NC 28345 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CONTRACTOR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION)	ORRECTION	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION) PREFIX TAG (EACH CORRECTIVE ACTION)	ORRECTION	
	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
 F 689 Continued From page 85 9:00 PM) or at the time of her readmission on 4/9/18. The Grievance Summary Response form confirmed there was no fall mat in place and the bed alarm was not intact during either of Resident #13 's falls on 4/1/18 or at the time of readmission on 4/9/18. The An interview was conducted with Resident #13 's RP or 4/23/18 at 12:15 PM. The RP reported Resident #13 returned to the facility later that same morning. Resident #13 's RP stated that on the same evening (4/1/18), another family member was visiting Resident #13 's RP stated that on the same evening (4/1/18), another family member was visiting Resident #13 's RP reported that later that vening dark fin, unable to recall the name of the staff member, that the fall mat and bed alarm were not in place. Resident #13 had another fall. The RP indicated Resident #13 's RP reported the facility. Resident #13 's RP reported the facility. Resident #13 's RP reported the fall mat and bed alarm were still not in place when she was admitted to the facility. Resident #13 's RP reported the fall mat and bed alarm were still not in place when she was readmitted to the facility of 4/10/18. An observation was conducted on 4/23/18 at 12:55 PM of Resident #13 's room. A fall mat a bed alarm were in place. An interview was conducted with the QA Nurse on 	reviewed all haviors ment) to blace to seidents that avior. The th wandering in place to er residents behavior. I nurse, DON, reviewed all iors (based on ntions are in and other ed by the all residents a care plan in rentions in and other ed by the all residents a care plan in reviewed all is to ensure act and esult: all guards had d functioning	

Facility ID: 923021

If continuation sheet Page 86 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET
F 689	Continued From page	e 86	F 689		
	4/25/18 at 8:30 AM.	The incident reports dated 13 's morning fall and		requirements	
	Grievance Summary filed on 4/9/18 that in	iewed with QA Nurse. The Response for the grievance dicated Resident #13 ' s fall		The DON, QI nurse, SF nurse, a charge nurse will audit 100% of weekly x 12 weeks to ensure fall	falls II
	intact for either fall or	and the bed alarm was not a 4/1/18 or at the time of her ewed with the QA Nurse.		interventions listed on the reside plan were in place at the time of and the fall was thoroughly anal	f the fall,
	#13 had occurred on	of these falls for Resident a weekend (Sunday) and strative staff in the building.		determine causative factors and implement appropriate intervent prevent repeat falls. The "5 Why	ions to
	She explained that be administrative staff in	ecause there was no		process will be used to help iden causative factors. These audits documented on the fall audit too	ntify will be
	mat and bed alarm) v	why these interventions (fall vere not in place when admitted from the hospital on		The DON, SF nurse, QI nurse, a weekend manager on duty (MO	
	4/9/18 she stated Reation to a different bed and	sident #13 had been moved I she thought that may have		review all progress notes 5 time for 12 weeks to ensure all wand	s weekly ering
	An interview was con	ntions were not in place. ducted with the MDS		and/or sexual behaviors have a interventions to protect the resid other residents that may be affe	lent and
	that she was not in th	18 at 8:35 AM. She reported he facility at the time of either		audit will be documented in the note audit tool.	progress
	when she went to Re	Ils on 4/1/18. She revealed sident #13 ' s room on all mat in her room. She		Licensed nurses, restorative NA DON, administrator, SF nurse, 0 MDS nurse, and/or corporate fa	QI nurse,
		vas a bed alarm. She and bed alarm should have v were interventions on		consultant will visually observe a residents with wander guards at daily (including all shifts) seven	t least days per
		plan. The MDS Resident #13 was in the f this observation on 4/2/18.		week, to ensure the wander gua present and functioning. These documented on the wander gua sheet, located in the wander gua	is rd flow
	on 4/25/18 at 9:54 AM	as conducted with Nurse #1 M. She stated she was the		The monthly QI committee will r	eview the
	of 4/1/18 when she fe	esident #13 on the morning all and fractured her nose. formation in the incident		results of fall audits, progress no tools, and wander guard flow sh monthly for 3 months for identifi	leets

Facility ID: 923021

If continuation sheet Page 87 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345293	B. WING				C / 26/2018
	ROVIDER OR SUPPLIER	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 PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	revealed there was n if this fall on the more unsure if a bed alarm not recalled a bed alars stated she completed and she had implement for Resident #13 as s the ER. An interview was con 4/25/18 at 10:20 AM. nurse assigned to Res 4/1/18 when Residen She confirmed the int report and nursing no revealed there was n of the fall. She was u place, but she had no sounding. Nurse #2 aware of the fall Resi (4/1/18) when she ca reported that prior to evening (4/1/18), she mat in place in her ro reported that Resider informed her on 4/1/1 that there was no fall revealed she had loo fall mat, but she could she had not looked o there were any extra A phone interview wa 4/25/18 at 11:06 AM. #2 were assigned to time of the morning fa fractured her nose. N	be related to this fall. She o fall mat in place at the time ning of 4/1/18. She was o was in place, but she had arm sounding. Nurse #1 d her shift shortly after the fall ented no new interventions she was out of the facility at adducted with Nurse #2 on She stated she was the esident #13 on the evening of tt #13 fell around 9:00 PM. formation in the incident of a bed alarm was in ot heard a bed alarm indicated she was made dent #13 had that morning me on shift at 3:00 PM. She Resident #13 's fall that e observed there was no fall om. She additionally nt #13 's family member 18 prior to the evening fall mat in her room. Nurse #2 ked on her unit for an extra d not find one. She stated n the other units to see if	F 6	89	trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance in the areas of providing an environment as free of accident hazards as is possible and providing adequate supervision and assistance devices to prevent accider The administrator and/or DON will pre- the findings and recommendations of monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendation and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implement the acceptable plan of correction.	nts. esent the	

If continuation sheet Page 88 of 171

CENTERS FOR MEDICARE & MEDIC	MAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) P	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE	
	345293	B. WING				C 26/2018
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/	20/2010
			н	GHWAY 177 S BOX 1489		
RICHMOND PINES HEALTHCARE AND R			H	AMLET, NC 28345		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 Continued From page 88 unsure if Resident #13 was fall mat, and she could not if fall mat in place at the time 4/1/18. NA #1 also stated v alarm was in place, but she alarm sounding. NA #1 was made aware of fall risk inter and she indicated the care interventions listed. She was reviewed the care plan prior Resident #13 on 4/1/18 and not. NA #2 was unavailable for i A phone interview was cond 4/25/18 at 12:00 PM. A phone interview was cond 4/25/18 at 12:00 PM. She stated she had not kno was supposed to have a fall at the time the evening fall of the first time she had worke confirmed there was no fall bed alarm sounded. NA #3 was made aware of fall risk residents and she indicated care guide had the interven asked if she had reviewed t guide prior to working with f 4/1/18 and she stated she f The Director of Nursing (DC for interview. <	recall if there was a of this morning fall on was unsure if a bed a had not heard a bed a asked how she was rventions for residents plan had the as asked if she had in to working with d she stated she had interview. ducted with NA #3 on stated she was on the evening of econd fall that day. own if Resident #13 Il mat or a bed alarm on 4/1/18 as that was ed with her. NA #3 mat in place and no 8 was asked how she a interventions for d the care plan and the tions listed. She was the care plan or care Resident #13 on had not. DN) was unavailable	F 6	589			

Facility ID: 923021

If continuation sheet Page 89 of 171

		ND HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ripi F	CONSTRUCTION	(X3) DATE	D. 0938-0391
-	CORRECTION	IDENTIFICATION NUMBER:	` '			COMPLETED	
							С
		345293	B. WING			04/	26/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489		
				Н	IAMLET, NC 28345		1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	F	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	~	CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 689	Continued From page	- <u>90</u>		~~~			
1 009		3 09	F	689			
	2. 2. Resident #45 wa	as admitted to the facility on					
		ently readmitted to the					
	•	ith multiple diagnoses that					
	included dementia wi	th behavioral disturbance.					
	The quarterly Minimu	m Data Set assessment					
	dated 3/3/18 indicate						
	rarely/never understo						
		short-term and long-term					
	memory problems an making. Resident #4	d severely impaired decision					
		n and disorganized thinking.					
	He had no behaviors,	. .					
	wandering during the	-					
		dependent with set up help					
		t of room and corridor. He eady on his feet, but he was					
	able to stabilize witho	-					
	Posidont #45 ' s plan	of care included, in part, the					
	focus areas of:	or care included, in part, the					
		nner in which resident acts					
		fective coping: wandering					
		upervised exits from the empts to leave unit/building if					
		lent wandering in and out of					
		ms/exit seeking behavior at					
		ea was initiated on 5/8/17					
		/26/17. The interventions ent to wander on the unit					
		nd last on revised 3/6/18).					
	-	nner in which resident acts					
		propriate behavior and					
		nt/care related to cognitive					
	8/21/17 and last revis	us area was initiated on sed on 4/23/18.					

If continuation sheet Page 90 of 171

	-	ID HUMAN SERVICES				FORM	M APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MUI		E CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	, í			· /	PLETED
				_			с
		345293	B. WING			04/	26/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489		
					HAMLET, NC 28345		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
E 690		- 00	_				
F 689	Continued From page		F	689			
A record review inc previously resided							
		his unit was temporarily					
		18 for maintenance and had					
		d. All of the residents who					
		cked memory care unit,					
	unlocked units of the	I5, presently resided in facility					
		idenity.					
	Resident #45 was ob	served ambulating					
		shuffled and slow gait on his					
	unit of the facility on 4						
	garbled and indisting	nimal speech that was					
	garbied and maleung.						
		served ambulating with a					
	-	t on a different unit at the					
	facility on 4/23/18 at 4	4:00 PM.					
	Resident #45 was ob	served standing in a					
		facility on 4/24/18 at 2:30					
	PM.						
		ted 4/26/18 and completed d Resident #45 was found in					
	-	room (Resident #13) on the					
		me indicated). Resident					
		a shirt and socks. His brief					
		rved laying at the head of					
		There was no physical staff between Resident #45					
	-	esident #45 was able to be					
	directed to sit down o	n Resident #13 ' s bed as					
		sisted out of the room.					
	Resident #45 and Re						
		lent #13 ' s 1/15/18 quarterly as rarely/never understood					
	and rarely/never under	-					
	-	pleted of both residents and					

Facility ID: 923021

If continuation sheet Page 91 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	DING		COMPLETED	
							С
		345293	B. WING			04/	26/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489		
				п	IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 689	Continued From page		F	689			
	no injuries were noted	d. Resident #45 was dressed and was then					
	placed on 1 on 1 sup						
		e, Administrator, on call					
		t, and the Responsible Party					
	(RP) of each resident	were notified.					
	A 24-hour initial repor	t was completed on 4/26/18					
	-	ncident that occurred on the					
	•	Resident #45 and Resident					
	#13. The allegation in	ncluded reasonable and resident abuse. The					
	-	indicated Resident #13 's					
		ed in her room. A Nursing					
	Assistant (NA) went t						
		in a nightgown and brief					
	-	her room with Resident #45 Resident #45 was noted to					
	be wearing only a shi						
		ated and the police were					
	notified.						
	The facility 's investion	gation of the 4/25/18 incident					
		45 and Resident #13 was					
	reviewed. Resident #	#13 ' s bed alarm was heard					
	· ·	NA #9) on 4/25/18 around					
		nt to Resident #13 ' s room, rough the door to the room,					
	-	-					
		ter. NA #9 was able to					
		's room by entering through					
		u					
		tgown and brief. Resident					
	#45 was standing ove	er her clothed in only a					
		nd socks. Resident #45 had					
		•					
	she was unable to en access Resident #13 an adjoining bathroor Resident #13. Reside the floor in front of the was clothed in a nigh #45 was standing ove short-sleeved shirt an removed his pants an	' s room by entering through n of the room next to ent #13 was found sitting on e door to her room. She tgown and brief. Resident er her clothed in only a					

Facility ID: 923021

If continuation sheet Page 92 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE		
		345293	B. WING			C 04/26/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
		AND REHABILITATION CENTE		н	IIGHWAY 177 S BOX 1489			
RICHWON	ID FINES HEALTHCARE	AND REHABILITATION CENTE		н	IAMLET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	on the floor in her roo #13 off the floor, into her room. Resident # and he had also refus putting a brief and pa and Resident #45 we no signs of physical of #45 was placed on 1 police were notified a with staff in a commo police arrived. Follow Resident #13 was tra police accompanimer completion of a sexua staff evaluated Residuidentifiable concerns related to the incident the facility. The sexua forwarded to the local The hospital Emerger 4/26/18 for Resident # #13 was brought in w for evaluation of poss officer present at the reported there was no struggle. A sexual as and Resident #13 wa obvious evidence of in discharged back to the evaluation. On 4/26/18 at 8:15 Al conducted at the local Police Captain and th report related to Resii was reviewed. The ir indicated the crime in	m. Staff assisted Resident her wheelchair, and out of 445 refused to exit the room sed to be assisted with nts back on. Resident #13 re assessed for injuries with contact or injury. Resident on 1 supervision. The nd Resident #13 remained n area of the facility until ving the arrival of the police, nsferred to the hospital with th for an evaluation and the al assault sample. Hospital ent #13, found no to her physical status t, and she was returned to al assault sample had been I police department. httplice accompaniment ible sexual assault. The hospital with Resident #13 o evidence of any kind of a issault sample was performed s examined. There was no njury. Resident #13 was the facility following the	F	689				

Facility ID: 923021

If continuation sheet Page 93 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING _		C 04/26/2018
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP C 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 689	were noted to be disp approximately 1:00 A Nurse provided the ir when he arrived at the indicated NA #9 disco Resident #13 ' s roor activated. Resident # he was blocking the o room, and Resident # fully clothed. NA #9 s room through the b to the room next doo move away from doo from her room as Re NA #9 was interviewe #45 removed his clot brief and clothing we Nurse #5 was intervie had observed Reside physical injuries were resident. Resident # for a sexual assault s reported that the rest sample could take ar month to receive bac based on the informa injuries observed on A phone interview wa 4/26/18 at 8:36 AM. the unit where Reside PM shift, but she was resident. She reporte both Resident #13 ar during the 3:00 PM to indicated prior to leave	as Resident #13. The police batched to the facility at M on 4/26/18. The QA incident details to the officer e facility. The report by ered Resident #45 inside in after a bed alarm was #45 had no pants or brief on, door to Resident #13 ' s #13 was sitting on her floor had to access Resident #13 ' athroom door that connected r as Resident #45 refused to r. NA #9 removed Res #13 sident #45 refused to leave. ed and she stated Resident hing a lot. Resident #45 ' s re near Resident #13 ' s bed. ewed and she stated she ent #45 with an erection. No e observed on either 13 was taken to the hospital sample. The Police Captain ults of the sexual assault pywhere from a week to a k. He had confirmed that tion there were no physical	F 6	389	

Facility ID: 923021

If continuation sheet Page 94 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	
		345293	B. WING				26/2018
NAME OF PI	ROVIDER OR SUPPLIER		- I	SI	FREET 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 SC 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 689	saw Resident #13 bei room by NA #10 arou that Resident #45 's i wandering through the reported he frequently resident 's rooms. Si could be combative a she had not witnessed inappropriate behavio An interview was con- 4/26/18 at 9:10 AM. Si wandered throughout the day. She reported residents ' rooms and times. She indicated to determine which roo was asked if Residen interventions related t monitoring his wherea wandering and enterin She reported that price (4/25/18) there were re place for monitoring his indicated Resident #4 supervision at all time A phone interview wa on 4/26/18 at 11:10 A on the unit where Resi resided on 4/25/18 du PM shift. She reported observed Resident #1 the incident that night approximately 10:30 f Resident #45 was sea	round 9:00 PM and she last ing assisted back to her ind 9:30 PM. NA #7 stated normal routine included e halls of the facility. She y wandered into other he indicated Resident #45 ind difficult to redirect, but d him with any sexually yr. ducted with the QA Nurse on She stated Resident #45 the facility during most of d he wandered into other d was difficult to redirect at she believed he was unable om was his. The QA Nurse t #45 had any specific to the frequency of abouts due to his frequent ing other residents ' rooms. or to the incident last night no specific timeframes in his whereabouts. She to se conducted with Nurse #6 M. She stated she worked sident #13 and Resident #45 iring the 3:00 PM to 11:00 ed the last time she had 13 and Resident #45 prior to (4/25/18) was at PM. She stated at that time, ated on a chair that was vay outside of his room and	F	689			

Facility ID: 923021

If continuation sheet Page 95 of 171

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED
	CONTECTION	BERTHORTON NOWDER.	A. BUILDING			C
		345293	B. WING		0	4/26/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489 IAMLET, 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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	e 95	F 689			
	nurse 's station to co indicated that there w from the nurse 's stat Resident #45 's room located around a corr was getting ready to e PM on 4/25/18 when the 11:00 PM to 7:00 her to Resident #13 ' she arrived at the roo members were prese Resident #45 had no was seated on the foo She reported Resider floor with her knees b ground. This phone interview She indicated Resider throughout the facility and sometimes into o stated she was unaw exhibiting any sexual recently, but she had occurred sometime in #45 was observed ho resident 's hand and #6 reported Resident behaviors that include behaviors, and being indicated staff tried to	nt. Nurse #6 stated pants or brief on and he of of Resident #13 ' s bed. Int #13 was seated on the bent and her feet on the with Nurse #6 continued. Int #45 frequently wandered y, up and down the hallways, other residents ' rooms. She are of Resident #45 ly inappropriate behaviors known of an incident that in 2017 in which Resident				
		s whereabouts were as conducted with the QA 11:20 AM. She was asked if				

Facility ID: 923021

If continuation sheet Page 96 of 171

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED	
					с	
		345293	B. WING		04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	MPLETIO DATE
F 689	Continued From page	e 96	F 68	39		
	Resident #45 had an					
		or. She reported there was				
		his type of behavior for				
		ere was an incident that				
	occurred about a yea	ar ago. She indicated during				
		nt #45 had been seated next				
		sident and it had appeared				
		remove her pants. She				
		pants were only slightly				
	-	waist. She reported the two				
		ated and Resident #45 was				
	-	ervision for a period of time ecall how long this 1 on 1				
	•	ace). The QA Nurse stated				
		her instances of any type of				
		e behavior for Resident #45				
	since that occurrence					
	A phone interview wa	as conducted with NA #10 on				
	4/26/18 at 12:35 PM.	She stated she worked on				
	the unit where Reside	ent #13 and Resident #45				
	resided on 4/25/18 d	uring the 3:00 PM to 11:00				
		s assigned to both residents.				
	· ·	time she had observed				
		esident #45 prior to the				
		25/18) was at approximately ated she had tried to perform				
		Resident #45, but he had				
		she left the facility around				
		ated she had recently started				
		so she was not too familiar				
		ut in the three times she had				
		had seen him wander				
		eported she had heard from				
		that Resident #45 wandered				
		rooms at times. She stated				
	she tried to lav eves	on Resident #45 about every				
		e worked with him to check				

Facility ID: 923021

If continuation sheet Page 97 of 171

	S FOR MEDICARE &					<u>IO. 0938-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
			A. BUILDING			С	
		345293	B. WING		0	4/26/2018	
	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP COE		04/20/2010	
0.002 01 1				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
F 689	Continued From page	97	F 689				
	observed no inapprop Resident #45.	oriate sexual behaviors for					
	Resident #45. A phone interview was conducted with NA #8 on 4/26/18 at 12:35 PM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 11:00 PM to 7:00 AM shift, but she was not assigned to either resident. She indicated NA #9 was assigned to Resident #13 and Resident #45. NA #8 reported she and NA #9 were at the nurse ' s station receiving their report from the prior shift until about 11:20 PM on 4/25/18. She stated at that time (around 11:20 PM), she and NA #9 left the nurse ' s station and proceeded down the hallway of the unit that Resident #13 and Resident #45 resided on. She reported that when they got to the end of the hallway Resident #13 ' s bed alarm was heard sounding. She stated to the bed alarm and she proceeded to assist another resident.						
	Resident #13 's door unable to open it. Sh called for her assistar completed her care w	vhen NA #9 approached it was shut and she was he stated NA #9 had then hce. She reported she vith the resident she was nt to assist NA #9 within a					
	couple of minutes. N enter Resident #13 's bathroom door that a reported she also had	A #8 stated NA #9 had to s room by going through the djoined the bedrooms. She d to enter Resident #13 ' s					
	door and she had obs on the floor in front of	oining room ' s bathroom served Resident #13 seated the door to the room with t on the ground. She stated					
	Resident #45 was sta	anding directly in front of genitals exposed. NA #8					

Facility ID: 923021

If continuation sheet Page 98 of 171

					FORM	APPROVED 0938-0391
CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE COMP	SURVEY LETED
	345293	B. WING		04/26/2018		
SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
EALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE		(X5) COMPLETION DATE
d From page	98	F 68	89			
rview with Na not regularly vas aware he red other res en. She indic riate sexual iew was con her (NP) on 4 he was famili he had no r s. She expla- on the locked male residen und. She fur that female re- cuation. interview wa at 1:25 PM. to Resident during the 11 orted that wh- e nurse 's s previous shi b. She indica ght from the nd Resident ated around ound 11:25 I station and p it that Reside siden #13 ' she went to at it was clos	A #8 continued. She stated worked with Resident #45, a wandered all of the time sidents ' rooms if the doors cated she had observed no behaviors for Resident #45. ducted with the Nurse 4/26/18 at 1:22 PM. She ar with Resident #45. She ecent sexually inappropriate ained that when he had memory care unit there t whom he spent a lot of ther explained that she resident was the aggressor s conducted with NA #9 on She stated she was #13 and Resident #45 on :00 PM to 7:00 AM shift. en she came on shift she tation receiving a report ft until around 11:25 PM ted that there was no visual nurse ' s station to Resident #45 ' s rooms as both rooms a corner. NA #9 reported PM she and NA #8 left the proceeded down the hallway ent #13 and Resident #45 ed that was when she had s bed alarm sounding. She Resident #13 ' s door and ed. She stated she					
	EDICARE & CIES CIES EN EALTHCARE EALTHCARE SUMMARY ST. ACH DEFICIENC GULATORY OR I COMMARY ST. ACH DEFICIENC GULATORY OR I COMMARY ST. ACH DEFICIENC GULATORY OR I SUMMARY ST. ACH DEFICIENC GULATORY OR I COMMARY ST. ACH DEFICIENC COMMARY ST. ACH D	IDENTIFICATION NUMBER: 345293 SUPPLIER EALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ed From page 98 rview with NA #8 continued. She stated not regularly worked with Resident #45, was aware he wandered all of the time red other residents ' rooms if the doors en. She indicated she had observed no riate sexual behaviors for Resident #45. riew was conducted with the Nurse her (NP) on 4/26/18 at 1:22 PM. She he was familiar with Resident #45. She I he had no recent sexually inappropriate s. She explained that when he had on the locked memory care unit there male resident whom he spent a lot of und. She further explained that she that female resident was the aggressor	EDICARE & MEDICAID SERVICES CIES DN (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTII A. BUILDIN 345293 B. WING ISUPPLIER EALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ad From page 98 F 6: rview with NA #8 continued. She stated not regularly worked with Resident #45, was aware he wandered all of the time red other residents' rooms if the doors en. She indicated she had observed no riate sexual behaviors for Resident #45. riew was conducted with the Nurse her (NP) on 4/26/18 at 1:22 PM. She he was familiar with Resident #45. She the had no recent sexually inappropriate s. She explained that when he had on the locked memory care unit there male resident whom he spent a lot of und. She further explained that she that female resident was the aggressor tuation. interview was conducted with NA #9 on at 1:25 PM. She stated she was t to Resident #13 and Resident #45 on during the 11:00 PM to 7:00 AM shift. rted that when she came on shift she here nurse ' s station receiving a report previous shift until around 11:25 PM). She indicated that there was no visual ght from the nurse ' s station to Resident nd Resident #45 's rooms as both rooms at a corner. NA #9 reported ound 11:25 PM she and NA #8 left the station and proceeded down the hallway it that Resident #13 and Resident #45 on. She stated that was when she had esident #13 's bed alarm sounding. She she went to Resident #13 's door and at it was closed. She stated she d to open the door to the room, but she	EDICARE & MEDICAID SERVICES CIES (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER: (P2) MULTIPLE CONSTRUCTION A BUILDING SUPPLIER B. WING EALTHCARE AND REHABILITATION CENTE STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 SUMMARY STATEMENT OF DEFICIENCIES GULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF C GROSS-REFERENCED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ad From page 98 F 689 rview with NA #8 continued. She stated not regularly worked with Resident #45, was aware he wandered all of the time red other residents' rooms if the doors en. She indicated she had observed no riate sexual behaviors for Resident #45. She explained that when he had on the locked memory care unit there make resident whom he spent a lot of und. She further explained that she that famale resident was the aggressor tuation. interview was conducted with NA #9 on at 125 PM. She stated she was I to Resident #13 and Resident #45 on Juring the 11:00 PM to 7:00 AM shift. Tred that when she came on shift she the nurse's station to Resident previous shift until around 11:25 PM previous shift until around 11:25 PM previous shift until around 11:25 PM previous shift and Resident #45 on station and proceeded down the hallway it that Resident #13 and Resident #45 on. She stated that was when she had station and proceeded down the hallway it that Resident #13 and Resident #45 on. She stated that was when she had sident #13 's bed alarm sounding. She she went to Resident #13 's door and at it was closed. She stated she d to open the door to the room, but she	HEALTH AND HUMAN SERVICES EDICARE & MEDICAID SERVICES CIES (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	HEALTH AND HUMAN SERVICES FORM. DICARE & MEDICAID SERVICES OMB NC N (X1) PROVIDERSUPPLICALIA LESTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COMP 345293 B. WING 040 SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 047 BUILDING BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 047 SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 047 BUILDING CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX STREET ADDRESS, CITY, STATE, ZIP CODE MULTIPLE CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX STREET ADDRESS, CITY, STATE, ZIP CODE MULTIPLE CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX TRACE ADDRESS, CITY, STATE, ZIP CODE MULTIPLE CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX TRACE ADDRESS, CITY, STATE, ZIP CODE MULTIPLE CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX TRACE ADDRESS, CITY, STATE, ZIP CODE MULTIPLE CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX TRACE ADDRESS, CITY, STATE, ZIP CODE MULTIPLE CONSTRUCTION OF DESTIFYING INFORMATION; PDFTX TRACE ADDRESS, CITY, STATE, ZIP CODE MULTIPLE ZONA STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE

Facility ID: 923021

If continuation sheet Page 99 of 171

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		· · ·	E SURVEY IPLETED
			A. BUILDING	;		
		345293	B. WING		C 04/26/2018	
	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CO		+/20/2010
			HIGHWAY 177 S BOX 1489		DL	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETIO
F 689	Continued From page	e 99	F 68	q		
		nt #45 inside of Resident #13	1 00			
		partially opened door and				
	-	sh on the door to close it.				
		she was then unable to				
		he proceeded to enter the				
		gh the door of the adjoining				
		She reported that when she				
		e observed Resident #13				
		front of the door with her				
		feet on the ground. She				
		was standing directly in front				
		his genitals exposed. She				
	explained that he wa					
		nd socks. She indicated that				
	Resident #45 's pant	ts and brief were on Resident				
		rief was soaked with urine.				
	NA #9 stated this was	s when she called for				
	assistance from NA #	#8 and Nurse #5. NA #9				
	indicated she believe	d Resident #13 had slid off				
	of her bed independe	ently and crawled over to the				
	area near the door.	She explained that Resident				
	#13 had completed th	his type of action in the past.				
	She confirmed that th	nis was the first time she had				
	seen Resident #45 a	nd Resident #13 since				
	coming on shift that r	night (4/25/18).				
	This phone interview	with NA #9 continued. She				
	stated that Resident	#45 had previously removed				
		othed in a nightgown when				
		out she had not seen him				
		he reported that Resident				
		he time through the halls,				
		and into other residents '				
		e had moments when he				
		ct and became agitated.				
		d observed no inappropriate				
		Resident #45, but she was that occurred last year when				

If continuation sheet Page 100 of 171

		MEDICAID SERVICES					NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDIN	NG			С
		345293	B. WING			04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD		4/20/2010
					VAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			.ET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	<	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
F 689	Continued From page	e 100	F 6	89			
	another [female] resid	dent ' s hand or something					
		cated she believed the					
	female was the aggressor in that situation as she had dementia and thought Resident #45 was her						
	husband.						
	An interview was con	nducted with Nurse #5 on					
		She indicated she was					
		t #13 and Resident #45 on					
		:00 PM to 7:00 AM shift.					
		at the nurse ' s station until					
		4/25/18 receiving report from					
		he indicated that there was					
	-	from the nurse 's station to Resident #45 's rooms as					
	both rooms were loca						
		NAs began completing their					
		ious shift finished providing					
		icated shortly after the NA 's					
		NA #9 came down the hall					
	toward the nurse 's s						
		nt #13 ' s room. Nurse #5					
		esident #13 's door and she					
		he door. She indicated she going through the door of the					
		throom. She reported					
		ated on the floor in front of					
		s bent up and her feet on the					
	ground. She stated F	Resident #45 was standing					
		t #13, he was wearing only a					
		nd socks, his genitals were					
		an erection. She indicated					
		pants and brief were on and his brief was soaked					
		stated staff attempted to					
		but of the room when he					
		ne indicated the staff were					
	able to get Resident						

Facility ID: 923021

If continuation sheet Page 101 of 171

CENTERS FOR MEDICARE & MEDICAID SERVICES	3			FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME	CLIA (X2) MU	LTIPLE CONSTRUC	TION	(X3) DATE S COMPL	SURVEY _ETED	
345293	B. WINC	B		-	<i>,</i> 26/2018	
NAME OF PROVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STATE, ZIP CODE			
RICHMOND PINES HEALTHCARE AND REHABILITATION (CENTE	HIGHWAY 177 HAMLET, NO				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FI TAG REGULATORY OR LSC IDENTIFYING INFORMAT		FIX (E	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
 F 689 Continued From page 101 her wheelchair and out of the room. She re it took several attempts for Resident #45 to redirected out of Resident #13 's room. This interview with Nurse #5 continued. She stated she had been working at the facility for about two weeks, but indicated she had previously worked here in the past. She rep Resident #45 wandered throughout the facil and down all of the hallways. She indicated had observed no inappropriate sexual beha for Resident #45. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. The information received during the staff intervie was reviewed with the Administrator. The interviews indicated the last observations of Resident #13 and Resident #45 prior to the 4/25/18 incident was around 10:30 PM by N #6 and NA #10. The interviews additionally indicated the next observation of Resident #13 bed alarm sounded alerting staff that Residen #13 was no longer in bed. Staff then found Resident #45 in Resident #13 's room, he h shut the door, and his genitals were expose Resident #13. The Administrator stated she expected staff to adequately supervise the residents. She stated Resident #45 was immediately placed on 1 on 1 supervision following the 4/25/18 incident. She indicate facility 's plan was to continue 1 on 1 super for Resident #45 until the locked memory ca unit reopened. 3. Resident #16 was admitted 4/8/16 with 	ported be or ported ity up I she viors wws lurse t13 f s - s ent had d to e d the vision	- 689				

Facility ID: 923021

If continuation sheet Page 102 of 171

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	ING _		(с
		345293	B. WING				C 26/2018
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		F	HGHWAY 177 S BOX 1489		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
F 689	Continued From page	e 102	F	689			
		s of Cerebral Vascular					
		16's nursing notes indicated eaving the facility on 7/9/17					
		(preventive device designed					
	to prevent a person a	t risk for leaving a facility					
	unsupervised) was pla	aced on him.					
	Review of a Wanderir	ng Risk Assessment dated					
		ident #16 was at risk for					
		ng Risk Assessment dated					
	8/25/17 indicated Res wandering.	sident #16 was at risk for					
		ng Risk Assessment dated sident #16 was at risk for					
		ng Risk Assessment dated esident #16 was at risk for					
		al Minimum Data Set dated derate cognitive impairment haviors.					
		ng Risk Assessment dated sident #16 was at risk for					
		ation Record (MAR) and his tion Record (TAR) included or assessment for his					

Facility ID: 923021

If continuation sheet Page 103 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345293	B. WING			C 04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE					IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 689	Log for January 2018 testing documented of Monday 1/1/18 Saturday 1/13/18 Sunday 1/14/18 Monday 1/15/18 Tuesday 1/16/18 Friday 1/26/18 Review of Resident # 2/22/18 indicated he wander guard. Care p included a daily check proper function and vi guard was in place ev Review of an incident PM, Resident #16 was the facility on the fron about his wander guar removed it last night". Review of Resident # and his TAR included assessment for his was function until 2/23/18 The nursing staff were placement on every s Review of the wander Log for February 2018 testing documented of	r guard Transmitter Testing indicated there was no on the following dates: 16's care plan revised on was at risk for wandering ervised exits from the facility. for a history of removing his planned interventions < of the wander guard for isualization that the wander very shift. report dated 2/22/18 at 3:40 s discovered sitting outside t porch. When questioned ird, he stated "someone 16's February 2018 MAR no staff observation or ander guard placement or when it added to his MAR. e to verify the wander guard hift. r guard Transmitter Testing 8 indicated there was no	F	689			
	testing documented o Saturday 2/3/18	n the following dates:					

Facility ID: 923021

If continuation sheet Page 104 of 171

	-	D HUMAN SERVICES				FORM	APPROVED	
	<u>S FOR MEDICARE & </u> DF DEFICIENCIES		(X2) MULT			OMB NO. 0938-0391 (X3) DATE SURVEY		
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		PLETED	
				_			C	
		345293	B. WING			04/26/2018		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				IIGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID	SUMMARY ST	Y STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION			(X5)	
PRÉFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION DATE				
F 689	Continued From page	104						
F 009	Continued From page Saturday 2/10/18		F	589				
	Friday 2/16/18							
	-	3 (Wander guard was						
	Review of Resident #	16's March 2018 MAR and						
		taff on observation or						
	assessment for his wa	ander guard placement or						
		guard Transmitter Testing						
	Log for March 2018 ir testing documented o							
	Sunday 3/4							
	Friday 3/9/1							
	Saturday 3/ Thursday 3							
	Friday 3/30							
		ng Risk Assessment dated						
	4/16/18 indicated Res wandering.	sident #16 was at risk for						
	Review of Resident # TAR included no staff	16's April 2018 MAR and his						
		ander guard placement or						
	function.							
		guard Transmitter Testing						
		icated there was no testing						
	documented on the fo	nowing uales.						
	Wednesday							
	Monday 4/9	0/18						
		y Minimum Data Set dated derate cognitive impairment						

Facility ID: 923021

If continuation sheet Page 105 of 171

		ID HUMAN SERVICES				FORM	MAPPROVED	
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _				
		345293	B. WING				C 4/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page and he was coded for	e 105 wandering behaviors.	F	689				
	#16 read Resident #1 (wander guard). Ther	d Care Guide for Resident 6 had an alarm bracelet e was no listed task for the ssess the wander guard n.						
	Nursing (DON) stated the door monitor and	at 3:30 PM, the Director of I the facility did away with implemented wander ts assessed as risk for						
		18 11:36 AM, Resident #16 There was an observed right ankle.						
	Assurance (QA) Nurs previous Administrato Resident #16 was obs on the front porch. He stated he cut off his w before. The QA Nurse removed wander gua	at 5:00 PM, the Quality be stated on 2/22/18, the or notified the DON that served sitting unsupervised was cooperative and vander guard the night e stated she found the rd in his nightstand. A new aced on Resident #16.						
	Resident #16 had not exit the facility and sta on nice days. She sta unsupervised outside	at 8:25 AM, Nurse #4 stated displayed any attempts to ated he likes to sit outside ted he was not to be . Nurse #4 stated she guard for placement on her						

Facility ID: 923021

If continuation sheet Page 106 of 171

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDIN	NG			с
		345293	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489		
				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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689		e 106 other nurses check it on	F 6	89			
	wander guard on his was not aware of any to remove his wander	ted Resident #16 wore a right ankle. She stated she vattempts by Resident #16 r guard. She stated thought lerk checked Resident #16's					
	notebook where the v	the facility had a separate wander guards were tested Supply Clerk and tested on					
	Testing Log for Resid was unaware that the consistently checking of the wander guards Administrator stated t their practice for wan wander guard monito function on every shift stated the task of che function of the wander	she reviewed the Transmitter ent #16's wander guard and a managers were not the placement and function on weekends. The the facility was changing der guards to include ring for placement and ft and not just daily. She also					
	Supply Clerk stated c	at 10:35 AM, the Central check checked Resident for placement and function					

If continuation sheet Page 107 of 171

		APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			
345293 B. WING		C 26/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	•		
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			
HAMLET, NC 28345			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION)	3E	(X5) COMPLETION DATE	
F 689 Continued From page 107 F 689			
daily Monday through Friday but she was not at			
the facility on weekends. It was her understanding			
the manager on duty was to check all wander guards on the weekends.			
Interview on 4/26/18 at 4:40 PM, NA #12 stated			
she had heard rumors of Resident #16 asking			
staff to remove his wander guard but he had not			
asked her. She stated she did not assess his wander guard on second shift because the			
Central Supply Clerk did it daily.			
Interview on 4/26/18 at 7:28 PM, the			
Administrator stated it was her expectation that all			
residents with wander guards be assessed on every shift for wander guard placement and function.			
4. Resident #50 was admitted to the facility on			
9/21/17 with cumulative diagnoses of Cirrhosis and fracture of left femur.			
Resident #50's admission care plan dated			
9/22/17 indicated he was at risk for falls related a history of falls. Interventions included to analyze			
any falls to determine whether a pattern or trend could be addressed.			
Review of an incident report dated 12/27/17 at			
8:29 AM read Resident #50 was lying on the floor in front of his bathroom. He stated he was going			
to the bathroom. There was no evidence of a fall			
investigation and no evidence that his care plan was revised.			

Facility ID: 923021

If continuation sheet Page 108 of 171
	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING				C 26/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	9 108	F	689			
	AM read Resident #5 the bathroom door. T	report dated 1/5/18 at 8:05 0 was sitting on the floor at here was no evidence of a no evidence that his care					
	He was readmitted or a necrotic left hip and	n 1/14/18 with diagnoses of repeated falls.					
	AM read Resident #5 and knees between h stated he was trying t was no evidence of a plan was revised on 1	report dated 1/24/18 at 8:23 0 was found on his hands is bed and wheelchair. He o go to the bathroom. There fall investigation. The care I/25/18 with intervention to inned to gown when in bed.					
	PM read Resident #5 his room stating he w There was no evident	report dated 1/28/18 at 7:00 0 was sitting on the floor in anted to go to the bathroom. ce of a fall investigation and ised 1/29/18 to ensure his of clutter.					
	dated1/31/18 indicate admitted to hospice s severe cognitive impa Resident #50 was coo	ervices. He was coded with airment and no behaviors. ded for extensive assistant eting. He was also coded for					

Facility ID: 923021

If continuation sheet Page 109 of 171

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMF	PLETED
		345293	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343233		ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/	26/2018
					GHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	PM read Resident #5 doorway of his bathro evidence of a fall inve documented evidence revised. Review of an incident AM read Resident #5 his bed. His wheelch brakes unlocked. The investigation and his to provide rest period Review of an incident PM read Resident #5 his bed on his floor m bed, floor and wheelc evidence of a fall inve was revised n 3/12/18 positions slowly. Review of Resident # Assessment dated 4/ for falls.	a report dated 3/5/18 at 1:04 0 was on the floor in the bom. There was no estigation and no e that his care plan was a report dated 3/6/18 at 11:27 0 was on his knees beside air was behind him with the ere was no evidence of a fall care plan was revised 3/6/18 s as needed. a report dated 3/11/18 at 2:22 0 was on his knees beside lat with feces noted in the shair. There was no estigation and his care plan 8 to transfer and change 50's most recent Fall Risk 14/18 indicated a high risk at 10:56 AM Resident #50	F 6	89	DEFICIENCY)		
	fall mat. Interview on 4/25/18	at 8:25 AM, the Quality					

Facility ID: 923021

If continuation sheet Page 110 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/30/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345293	B. WING				C 26/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	20/2010
		AND REHABILITATION CENTE		н	IIGHWAY 177 S BOX 1489		
RICHWON	D FINES HEALTHCARE	AND REHABILITATION CENTE		н	IAMLET, NC 28345		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 689	Continued From page Assurance (QA) Nurs investigate each fall for but each fall was revie up meetings. Interview on 4/26/18 a Assistant (NA) #11 sta consistently use his c always incontinent of In a second interview QA Nurse stated she investigation process analysis with proper in Interview on 4/26/18 a Resident #50 was inc bell. She stated his co he was continent if tal Interview on 4/26/18 a Administrator stated in every fall be investiga cause and identify tre 5. Resident #22 was 5/12/16. Cumulative unspecified psychosis known physiological of of coordination, difficu unsteadiness on his for The quarterly Minimu 1/30/28 indicated resi impaired in cognition.	e 110 e stated she did not or the root cause analysis ewed in the morning stand at 12:30 PM, Nursing ated Resident #50 does not all bell. She stated he was bowel and bladder. on 4/26/18 at 12:00 PM, the started a new fall today to include root cause nterventions. at 4:40 PM, NA #12 stated onsistent with using his call ognition had improved and ken to the bathroom. at 7:28 PM, the t was her expectation that ted to determine the root nds or patterns. admitted to the facility diagnoses included: a not due to a substance or condition, chronic pain, lack ulty in walking and eet. m Data Set (MDS) dated dent #22 was moderately He required supervision	F	689		ATE	DATE
		ation in the room and hall d off the unit.Resident #22					

Facility ID: 923021

If continuation sheet Page 111 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345293	B. WING				C 26/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	STR	EET 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	since the last assess The last Fall Risk ass indicated Resident #2 of 14. A score of 10 of for falls. A care plan for falls da reviewed 4/25/18 stat for falls characterized related to generalized mobility and history of included in care plan: factors causing falls s needs, mobility, trans A review of the incide Resident #22 from De present revealed the 12/31/17 at 3:03 PM- the left side of his bed and fell off bed onto h red mark from above around to residents le investigation done; no 1/17/18 at 2:02 PM st January 16, Resident while trying to go to th remember when the i was no investigation do done. 2/9/18 at 8:31 PM, Re	more falls without injury ment. eessment dated 3/22/18 22 was a fall risk with a score for more indicates a high risk ated 5/23/16 and last ted Resident #22 was at risk by multiple risk factors tweakness, decreased f falls. Recent interventions monitor and intervene for such as bowel/ bladder fers, etc. ints and accidents for ecember 31,2017 through	F 68	89			
	bed. Resident #22wa floor and without injur						

If continuation sheet Page 112 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/26/2018
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP C	-
RICHMON	D PINES HEAL THCARE	AND REHABILITATION CENTE	н	IGHWAY 177 S BOX 1489	
	D I INEO NEAEINIOANE		н	IAMLET, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 689	Continued From page	112	F 689		
1 000		o root-cause-analysis done.	1 009		
		-			
	4/1/18 at 6:38 PM, sta Resident #22 ' s room	aff was summoned to 1. He was lying on floor next			
		partially sitting up. The			
	wheelchair was in the				
	Resident #22 stated h	ne did not know what o toe assessment was done			
	and no injuries were				
	•	o root-cause-analysis done.			
	4/1/18 at 6:50 PM. Re	esident #22 was noted to be			
		allway. His wheelchair was			
	-	Resident #22 said he didn ' t			
		omething knocked him out to toe assessment was			
		re noted. There was no			
	investigation done; no	o root-cause-analysis done.			
	On 4/26/18 at 12:10 F	PM, an interview was			
		uality Assurance (QA) Nurse			
		The QA Nurse stated they			
		investigations with the falls definition of the falls			
	every morning and di	scuss falls and what they			
		ace for the fall. The QA			
	-	4/26/18, she would start put all her investigation in			
		this would be put in the plan			
	of correction. The Ad	lministrator stated she			
	expected a root-caus done with each fall.	e-analysis (investigation) be			
		admitted to the facility on			
	1/20/11 with multiple	diagnoses including anxiety			
		rly Minimum Data Set (MDS)			
		2/18 indicated that Resident decision making problems			
	and she had falls with	÷ .			
	assessments.				

Facility ID: 923021

If continuation sheet Page 113 of 171

STATE MENT OF DERIGENCIES AND FLAW OF CORRECTION (X1) PROVIDER QUERY INJUST (X2) ALL SUPPORT (X2) ALL SUPPORT MANE OF PROVIDER OR SUPPLIER 345283 B.W.B.G			D HUMAN SERVICES				FORM): 05/30/2018 // APPROVED). 0938-0391	
Addition C 345293 B: WING CHIMOND PINES HEALTHCARE AND REHABILITATION CENTE STREET ADDRESS. CITY. STATE. 2P CODE MAIL OF PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY. STATE. 2P CODE MAIL OF PROVIDER OF SUMMARY STATEMENT OF DEFICIENCIES PREFX PREFX (EADI OEPICIENCY MUSTER PROCEED BY FULL REGULTATORY OR LSC DENDIFYING INFORMATION PREFX TAG PREFX PRESIDENT #59°S care plan dated 4/18/18 was reviewed. One of the care plan problem was Resident #69°s care plan dated 4/18/18 was reviewed. One of the care plan problem was Resident #69 woal for Sustain serious injury Through the next review date. The approaches induced on 7220/11, fall mas on floor when in bed (initiated on 1720/11), fall mas on floor when in bed (initiated on 120/16/11) and low bed with high profile winged mattress (initiated on 110/16/11) and low bed with high profile winged mattress (initiated on 120/17), fall mas on floor when in bed (initiated on 120/17), fall mas on floor when is bed childled on 120/16/11, fall mas on floor when the SRSB. There was no thorough investigation as to the cause of the fall. On 1/20/17, Resident #69 had a fall from the scoot chair with SRSB on. On 4/20/18 at 2:32 PM, Resident #69 had a fall from the scoot chair with SRSB on. On 4/20/18 at 2:32 PM, Resident #69 had a fall from the scoot chair with SRSB on. On 4/20/18 at 2:32 PM, Resident #69 had a fall from the bed. There was no thorough investigation as to the cause of the fall. On 4/20/18 at 2:32 PM, Resident #69 had a fall from the scoot chair	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		CONSTRUCTION	(X3) DATE	SURVEY	
345293 BINNO 04/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE STREET ADDRESS, CITY, STATE, 2P CODE MORE OF PROVIDER OF RANDOW PROFINENCE AND REHABILITATION CENTE PROVIDER STATE, 2P CODE Continued From Demicipations STREET ADDRESS, CITY, STATE, 2P CODE (%1) [0] SUMMARY SINTEMENT OF DEPERSINGES PROVIDER STATE, 2P CODE Continued From Demicipations (%1) [0] SUMMARY SINTEMENT OF DEPERSINGES PROVIDENCE AND RECORDER TO IN PROPENSATE (%1) [0] SUMMARY SINTEMENT OF DEPERSINGES PROVIDENCE AND RECORDER TO IN PROPENSATE (%1) [0] SUMMARY SINTEMENT OF DEPERSINGES PROVIDENCE AND RECORDER TO IN PROPENSATE (%1) [0] SUMMARY SINTEMENT OF DEPERSINGES PROVIDENCE AND RECORDER TO IN PROPENSATE PROVIDENT OF THE ADD PROPENSATE CONSTRUCT PROVIDENT OF THE ADD PROPENSATE CONSTRUCT CONSTRUCT PROVIDENT ADD PROPENSATE CONSTRUCT <th c<="" td=""><td>AND FLAN OF</td><td>CORRECTION</td><td>IDENTIFICATION NOMBER.</td><td>A. BUILDI</td><td>NG _</td><td></td><td></td><td></td></th>	<td>AND FLAN OF</td> <td>CORRECTION</td> <td>IDENTIFICATION NOMBER.</td> <td>A. BUILDI</td> <td>NG _</td> <td></td> <td></td> <td></td>	AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE HIGHWAY 177 5 BX 1489 HAMLET, NC 2834 PHETRX TXG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISSING BE PRECEDED BY YULL RECULTORY OR US: DEPTIFYING INFORMATION) IPRETIX TXG PREVIDENT CONSISTER PRECEDED BY YULL RECULTORY OR US: DEPTIFYING INFORMATION) IPRETIX TXG PREVIDENT CONSISTER PRECEDED BY YULL RECULTORY OR US: DEPTIFYING INFORMATION) IPRETIX TXG PREVIDENT CONSISTER PRECEDED BY YULL RECULTORY OR US: DEPTIFYING INFORMATION) IPRETIX TXG PREVIDENT CONSISTER PRECEDED BY YULL RECULTORY OR US: DEPTIFYING INFORMATION) IPRETIX TXG IPRETIX (EACH 0005 AEREFERENCE) TO THE APPROPRIATE DEFICIENCY) OUT DEFICIENCY) IPRETIX TXG IPRETIX (EACH 0005 AEREFERENCE) TO THE APPROPRIATE DEFICIENCY) IPRETIX TXG IPRETIX (EACH 0005 AEREFERENCE) IPRETIX (EACH 0005 AEREFERENCE) TO THE APPROPRIATE DEFICIENCY) IPRETIX TXG IPRETIX (EACH 0005 AEREFERENCE) IPRETIX (EACH 0005 AEREFERENCE) <t< td=""><td></td><td></td><td>345293</td><td>B. WING</td><td></td><td></td><td></td><td></td></t<>			345293	B. WING					
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE HAMLET, NC 28345 (M) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICE/W MIST BERECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CARDS REFERENCED TO THE APPROPRIATE DEFICIENCY) 009 COMMENTING DEFICIENCY) F 689 Continued From page 113 F 689 Resident #69's care plan dated 4/18/18 was reviewed. One of the care plan problems was Resident #69 woal risk for fail. The goal was Resident #69 woal risk for fail. The goal was Resident #69 woal of be (initiated on 10/16/11) and low bed with high profile winged mattress (initiated on 11/1/17). F 689 Review of the nurse's notes and incident reports revealed that Resident #69 had fails on 12/30/17, 1/19/18 and 4/17/18, Resident #69 had fail from the scoot chair with BSRS. There was no thorough investigation as to the cause of the fail. On 1/2/30/17, Resident #69 had a fail from the bed. There was no thorough investigation as to the cause of the fail. On 4/26/18 at 2.35 PM, Resident #69 was observed in bed. SRS B. There was no thorough investigation as to the cause of the fail. On 4/26/18 at 2.35 PM, Resident #69 was observed in bed. SRS B. On 4/25/18 at 2.35 PM, Resident #69 was observed in bed. She had a winged mattress on each side of the bed. On 4/26/18 at 12.05 PM, The Quality Assurance (QA)/Infection Control (C) Nurse was interviewed. She tated that the was responsible	NAME OF PF	ROVIDER OR SUPPLIER							
Pričeju TXG (EACH DEFICIENCY NUST BE PRECEDBE DY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Préjnx TXG CEACH CORRECTIVE ACTION BHOLD BE CROSS-REFERENCE OD THE APPROPRIATE COMPLETIO BATE F 689 Continued From page 113 F 689 F 680 <td>RICHMON</td> <td>D PINES HEALTHCARE</td> <td>AND REHABILITATION CENTE</td> <td></td> <td></td> <td></td> <td></td> <td></td>	RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE						
Resident #69's care plan dated 4/18/18 was reviewed. One of the care plan problems was Resident #69 was at risk for fall. The goal was Resident #69 would not sustain serious injury through the next review date. The approaches included scoot chair and self-release seat belt (SRSB) when out of bed (initiated on 7/20/11), fall mat on floor when in bed (initiated on 7/20/11), fall and low bed with high profile winged mattress (initiated on 11/1/17). Review of the nurse's notes and incident reports revealed that Resident #69 had falls on 12/30/17, 11/19/18 and 4/17/18. On 12/30/17, Resident #69 had a fall from the scoot chair with the SRSB. There was no thorough investigation as to the cause of the fall. On 1/19/18 and 4/17/18. Resident #69 had a fall from the bed. There was no thorough investigation as to the cause of the fall. On 4/24/18 at 9:32 AM and on 4/25/18 at 8:02 AM, Resident #69 was observed out of bed in a chair with SRSB on. On 4/25/18 at 2:35 PM, Resident #69 was observed in bed. She had a winged mattress on each side of the bed. On 4/26/18 at 12:05 PM, The Quality Assurance (QA)/Infection Control (IC) Nurse was interviewed. She stated that she was responsible	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
reviewed. One of the care plan problems was Resident #69 would not sustain Serious injury through the next review date. The approaches included scoot chair and self-release seat belt (SRSB) when out of bed (initiated on 71/20/11), fall mat on floor when in bed (initiated on 10/16/11) and low bed with high profile winged mattress (initiated on 11/1/17). Review of the nurse's notes and incident reports revealed that Resident #69 had falls on 12/30/17, 1/19/18 and 4/17/18. On 12/30/17, Resident #69 had a fall from the scoot chair with the SRSB. There was no thorough investigation as to the cause of the fall. On 1/19/18 and 4/17/18, Resident #69 had a fall from the bed. There was no thorough investigation as to the cause of the fall. On 4/24/18 at 9:32 AM and on 4/25/18 at 8:02 AM, Resident #69 was observed out of bed in a chair with SRSB on. On 4/25/18 at 2:35 PM, Resident #69 was observed in bed. She had a winged mattress on each side of the bed. On 4/26/18 at 12:05 PM, The Quality Assurance (QA)Infection Control (IC) Nurse was interviewed. She stated that she was responsible	F 689	Continued From page	9 113	F	689				
for investigating the falls. She indicated that all department heads had a morning meeting every day to discuss falls. She indicated that she had		Resident #69's care p reviewed. One of the Resident #69 was at p Resident #69 would n through the next revie included scoot chair at (SRSB) when out of b mat on floor when in H and low bed with high (initiated on 11/1/17). Review of the nurse's revealed that Residen 1/19/18 and 4/17/18. On 12/30/17, Residen scoot chair with the S thorough investigation On 1/19/18 and 4/17// from the bed. There w investigation as to the On 4/24/18 at 9:32 Al AM, Resident #69 wa chair with SRSB on. On 4/25/18 at 2:35 PP observed in bed. She each side of the bed. On 4/26/18 at 12:05 F (QA)/Infection Contro interviewed. She stat for investigating the fa department heads ha	Alan dated 4/18/18 was care plan problems was risk for fall. The goal was not sustain serious injury aw date. The approaches and self-release seat belt bed (initiated on 7/20/11), fall bed (initiated on 10/16/11) a profile winged mattress anotes and incident reports at #69 had falls on 12/30/17, at #69 had a fall from the RSB. There was no as to the cause of the fall. 18, Resident #69 had a fall was no thorough a cause of the fall. M and on 4/25/18 at 8:02 s observed out of bed in a M, Resident #69 was a had a winged mattress on PM, The Quality Assurance I (IC) Nurse was red that she was responsible alls. She indicated that all d a morning meeting every						

If continuation sheet Page 114 of 171

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 689 F 695 SS=D	starting today (4/26/1 investigation and put On 4/26/18 at 7:20 Pl interviewed. She sta QA/IC Nurse to inves root cause and to imp intervention to prever Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirato tracheostomy care ar The facility must ensu- needs respiratory car care and tracheal suc care, consistent with practice, the compret care plan, the resider and 483.65 of this su This REQUIREMENT by: Based on observatio and staff interviews, f clean air filters for the machine for two of tw were on continuous of #38 and #37). The fil	gation. She added that 8) she would document her them in a green folder. M, the Administrator was ted that she expected the tigate every falls to find the olement appropriate at further falls. stomy Care and Suctioning ry care, including du tracheal suctioning. ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. is not met as evidenced m, record review, resident the facility failed to maintain e oxygen concentrator to sampled residents who oxygen therapy (Resident ndings included: admitted to the facility	F 68		the as the
	Cumulative diagnose obstructive pulmonar pneumonia 4/9/18, he	s included chronic		follow the practice related to maintai clean air filters for the oxygen concentrator machines. On 4/25/18, the central supply clerk cleaned the oxygen concentrator filte	ning

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 115 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/30/2018 ORM APPROVED NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		DATE SURVEY COMPLETED
		345293	B. WING				04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		0
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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	2/23/18 indicated Res impaired in cognition. as being used during	m Data Set (MDS) dated sident #38 was severely Oxygen was documented the assessment period.	F	695	the concentrator used by Resident # Resident #38 reported being able to an improvement after the concentrat filter was cleaned.	tell	
	breathing pattern as r dependence. Interve oxygen therapy at thr continuous as ordere On 4/24/18 at 11:07 A oxygen concentrator	ential for or actual ineffective related to oxygen ntions included, in part, ee liters via nasal cannula d. AM, an observation of the for Resident #38 was done. ator filter was dirty with white			The procedure for implementing the acceptable plan of correction for the specific deficiency cited The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corrand/or in compliance with the regular requirements	that d that rected	
	oxygen concentrator oxygen concentrator concentrator filter was covering the entire filt On 4/25/18 at 6:15 Pl Resident #38 ' s oxyg conducted with the Q Nurse. The oxygen fil material covering the The QA Nurse stated one who was suppos concentrators and ch clean the filters. She someone take that po	s still dirty with white dust ter. M, an observation of len concentrator filter was uality Assurance (QA) liter had white dust like entire filter on the machine. the supply person was the ed to maintain the ange oxygen tubing and stated they had just had osition within the last week or e filter on the concentrator			On 4/25/18, the quality improvement nurse informed the new central supp clerk that it is the responsibility of the central supply clerk to check/change oxygen tubing and clean the filters of oxygen concentrators. On 5/14/18, the pharmacy nurse representative completed an audit of oxygen concentrators. The audit res all concentrator internal filters require cleaning or replacement. The pharm representative placed an order for me internal filters for all oxygen concentrators. By 5/16/18, the supply clerk was	n the n all sult: ed nacy	
	On 4/25/18 at 6:20 Pl conducted with the C				in-serviced by the administrator and staff facilitator related to the cleaning schedule and procedure for oxygen concentrator filters and oxygen tubin	9	

Facility ID: 923021

If continuation sheet Page 116 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/3 FORM APPF OMB NO. 0938	ROVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		345293	B. WING		C 04/26/201	18
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •	
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE	H	IIGHWAY 177 S BOX 1489		
			ŀ	IAMLET, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMP	X5) PLETIOI ATE
F 695	Continued From page	e 116	F 695			
		d the nebulizer equipment	1 090	be changed every 7 days.		
		equipment in a bag. She				
		as also responsible for		On 5/16/18, the central supply		
		xygen tubing, cleaning the		identified and made a list of res		
		t had to do with the oxygen		using an oxygen concentrator.		
	concentrator.			result: 12 residents were identi previously using an oxygen cor		
	On 4/25/18 at 6.20 P	M, the Central Supply Clerk		1 resident was in the hospital; §		
	cleaned the oxygen of			had a current order. The centra		
		could tell a difference and		clerk worked with the QI nurse		
	the air smelled freshe			minimum data set (MDS) nurse		
				sure the list of residents using a		
	On 4/26/18 at 9:00AM	A, a second interview was		concentrator was updated and		
	conducted with the Q	A Nurse who stated they				
	÷ -	licy regarding cleaning of the		On 5/16/18, the central supply		
		tated she could not find		performed an audit in effort to p	protect	
	-	of the supply clerk to		other residents using oxygen		
		g, clean filters and they did		concentrators. The central sup		
	not keep a record of			audited the filters on the oxygen		
	On 4/26/18 at 7:21 P			concentrators to ensure the air		
		dministrator who stated she equipment to be cleaned		clean. The audit result: all oxy concentrator filters had been clean	•	
	weekly.	equipment to be cleaned			caneu.	
		admitted to the facility on		On 5/18/18, the supply clerk an		
	12/21/15 with multiple			maintenance assistant complet		
	•	ulmonary disease (COPD).		cleaning/replacing oxygen cond		
	The annual Minimum	. ,		internal filters for all concentrate		
		9/18 indicated that Resident		including oxygen concentrators Resident #37 and Resident #38	-	
		intact and she was receiving a resident at the facility.				
				By 5/18/18, the administrator co		
		AM and on 4/25/18 at 8:20		in-servicing all department head		
	•	as observed in bed with		to maintaining clean oxygen co		
		on the oxygen concentrator		filters. The administrator perfor		
	was observed to be c	in ty/uUSty.		demonstration and made it clea	-	
	On 1/25/18 at 6.20 D	M, the Supply Clerk was		the in-service that all department are required to immediately clear		
		ted that she took the position		out the outside filter of an oxyg		
I						

Facility ID: 923021

If continuation sheet Page 117 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	05/30/2018 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		345293	B. WING		C 04/2	6/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	aware that she was r oxygen filters. On 4/26/18 at 2:15 P (QA)/Infection Contro She stated that the S for cleaning the oxyg she had observed the #37 and it looked too cleaned for a while. On 4/26/18 at 7:20 P interviewed. She sta	e 117 responsible for cleaning the M, the Quality Assurance ol(IC) Nurse was interviewed. Supply Clerk was responsible en filters. She stated that e oxygen filter for Resident o dirty, it looked like it was not M, the Administrator was thed that she expected the leaned at least once a week.	F 69	 the responsibility of the central second clear, and backed-up by the main director, to ensure the internal fill oxygen concentrators are replaced least annually or according to manufacturer guidelines. Beginning 5/24/18, the departmet began auditing oxygen concentrators to ensure they are clean while contheir daily rounds. Documentatic completed on the rounds tool 5 d week. The auditing for cleanline: oxygen concentrators will be ongoing-term as part of department is daily "angel" rounds to ensure all residents are protected when usit oxygen concentrators. The monthly QI committee will reference to the audits monthly for a for identification of trends and to determine if the department head monitoring during "angel" rounds sufficient to sustain the solution of maintaining clean filters on oxygen concentrators. The QI committee review the maintenance annual preventative maintenance log for concentrators to ensure oxygen concentrator internal filters are reference of the findings and recommendation monthly QI committee to the qual executive quality assurance (QA committee for further recommendation monthly QI committee to the qual executive quality assurance (QA committee for further recommendation monthly QI committee to the qual executive quality assurance (QA committee for further recommendation monthly QI committee for further recommendation monthly QI committee to the qual executive quality assurance (QA committee for further recommendation monthly QI committee for further recommendation for further	Antenance ters of ed at ent heads ator filters ompleting on will be days a ss of going head l ing eview the 3 months d daily s is of en e will also r oxygen eplaced urer will present ns of the urterly)	
) (02-99) Previous Versions Ob	solete Event ID: SXJZ	11 1			

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 118 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345293	B. WING		C 04/26/2018			
	ROVIDER OR SUPPLIER D 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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION			
F 695	Continued From page	e 118	F 695	and oversight.				
				The title of the person responsible implementing the acceptable plan correction.				
				The director is responsible for implementing the acceptable plan correction.	of			
F 756 SS=E	Drug Regimen Review CFR(s): 483.45(c)(1)	w, Report Irregular, Act On (2)(4)(5)	F 756		5/24/18			
		imen Review. ug regimen of each resident east once a month by a						
	§483.45(c)(2) This re of the resident's medi	view must include a review ical chart.						
	irregularities to the at facility's medical direc and these reports mu (i) Irregularities inclu	armacist must report any tending physician and the ctor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph						
	 (d) of this section for (ii) Any irregularities r during this review mu separate, written report 	an unnecessary drug. noted by the pharmacist st be documented on a						
	director and director of minimum, the resider and the irregularity th (iii) The attending phy	of nursing and lists, at a it's name, the relevant drug, e pharmacist identified. /sician must document in the						
		cord that the identified reviewed and what, if any,						

If continuation sheet Page 119 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/30/20 ⁷ RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	TE SURVEY MPLETED
		345293	B. WING			0	C 4/26/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEAI THCARE	AND REHABILITATION CENTE		н	IGHWAY 177 S BOX 1489		
				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		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 756	Continued From page	a 110		756			
1 750	10			756			
		n to address it. If there is to					
	-	nedication, the attending					
	the resident's medica	ument his or her rationale in					
	§483.45(c)(5) The fac	cility must develop and					
		procedures for the monthly					
	drug regimen review	that include, but are not					
	limited to, time frame	s for the different steps in					
		s the pharmacist must take					
		ifies an irregularity that					
		n to protect the resident.					
		is not met as evidenced					
	by:						
	Based on record rev	-			F756		
		nterview, the Pharmacy					
		lentify and to report drug			The plan of correcting the spec	ITIC	
		hysician for 1 of 6 sampled			deficiency		
	(Residents #39). Fin	r unnecessary medications			The position of Richmond Dine	o Nuroina	
	(Residents #39). Fill	ungs included.			The position of Richmond Pine and Rehabilitation Center regar		
					process that led to the deficient	0	
	1 Resident #30 was	admitted to the facility on			pharmacy consultant failing to i		
	12/7/17 with multiple				to report drug irregularities to th	•	
		terly Minimum Data Set			physician resulting in the nursir		
		ated 2/28/18 revealed that			administering an antipsychotic		
	. ,	derate cognitive impairment			to a resident without a physicia		
		an antipsychotic medication			was the staff failure to follow po		
	during the assessme				regarding following physician o		
					reconciling medication orders w		
	Review of the Physic	ian's orders revealed that			medication administration reco	rd.	
		ceiving 2 antipsychotic					
		receiving Risperdal 2			On 4/25/18, the minimum data		
		nouth daily (started on			nurse contacted the nurse prac		
		5 mgs intramuscular (IM)			(NP) and clarified the physician	order for	
		ed 2/13/18) and Seroquel 25			Resident #39's Seroquel.		
	mgs by mouth daily (started 1/11/18).					
		ation notes for Desident #00			On 4/25/18, the NP discontinue		
	i ne psychiatric evalu	ation notes for Resident #39			#39's order for Seroquel. The M	/IDS nurse	

Facility ID: 923021

If continuation sheet Page 120 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/30/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345293	B. WING				C /26/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEAL THCARE	AND REHABILITATION CENTE		HI	GHWAY 177 S BOX 1489		
				H.	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page	e 120	F	756			
		notes did not indicate that			transcribed the discontinued Seroque order to the medication administration record (MAR). There was no change		
	The Medication Admin for Resident #39 were	nistration Records (MARs) e reviewed.			that time for Resident #39's Risperdal orders.		
	The January 2018 M/ was not listed as one medications.	AR revealed that Seroquel of the resident's			On 4/25/18, the nurse facility consulta contacted the pharmacy provider and pharmacy verified the pharmacy had norder for Resident #39 to have Seroque	the าo	
		arch 2018 MARs revealed d received Seroquel the ary and March			On 4/26/18, the new pharmacy consu was made aware that the previous	ltant	
		revealed that Resident #39			pharmacy consultant failed to identify to report a drug irregularity to the	and	
	-	el from April 1- 25, 2018.			physician for Resident #39.		
		imen review notes were as no mention of Seroquel.			The procedure for implementing the acceptable plan of correction for the specific deficiency cited		
	On 4/25/18 at 12:45 F	-					
	Resident #39. Nurse was on Seroquel 25 r that she could not find	ted that she was assigned to #8 stated that Resident #39 ngs daily. Nurse #8 verified d an order for Seroquel in			On 5/21/18 through 5/23/18, the direc of nursing (DON), quality improvemen (QI) nurse, staff facilitator (SF) nurse, charge nurse, and staff nurses compa	it ired	
	the resident's medica				April MARs to May MARs to ensure n drug irregularities were noted to prote	ct	
	was interviewed. She	M, the Medical Record clerk e verified that she could not quel on Resident #39's thin			residents in similar situations. The aud result: no additional drug irregularities were identified, including administration two antipsychotic medications	5	
		M, the Nurse Consultant was			concurrently without a physician's ord	er.	
	interviewed. She stat pharmacy and the ph was no order for the S	ted that she had called the armacy indicated that there Seroquel, it was an error on			By 5/24/18, the SF nurse and QI nurs re-educate all licensed nurses, includi part-time (PT), as needed (PRN) nurs	ng es,	
	incorrectly.	roquel was transcribed			and agency nurses on: 1) the process notify pharmacy of new orders includi faxing to pharmacy, 2) medications m	ng	

Facility ID: 923021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/ FORM APF OMB NO. 093	PROVED
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURV COMPLETED	
		345293	B. WING		C 04/26/20	118
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/20/20	/10
RICHMON	RICHMOND 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CON	(X5) IPLETION DATE
F 756	On 4/26/18 at 4:31 P was interviewed. She the facility as Pharma was in March 2018 at 2018. She indicated called her about the S and she had reviewer notes and there was She revealed that the overlooked the Seroo On 4/26/18 at 7:20 P interviewed. She sta	M, the Pharmacy Consultant e stated that she was new to acy Consultant. Her first visit nd she came 1 day in April that the facility had already Seroquel for Resident #39 d the drug regimen review no mention of Seroquel. e previous Pharmacist had quel. M, the Administrator was ted that her expectation was nsultant to address drug	F 7	 be verified that they are correct delivery by the nurse receiving t medication, 3) the process of our medications not available. Any sin-serviced by 5/24/18 will not b to work until the re-education is completed. This re-education wo of the orientation for newly hired nurses, including PT, PRN, and nurses. Beginning 5/24/18, the SF nurse nurse, DON, charge nurse, and nurses will ensure residents are significant medication errors, ind administration of an antipsychot mediation to a resident without a physician/provider's order. To presidents in similar situations, the nurse, QI nurse, DON, charge nurse the upcoming month's medication records to the current MARs/TARs and a paper copy of the physician order from the physical/hard chart. The syst requirement to review the paper the physician orders from the physician's/provider's written or the new MARs/TARs without a physician's/provider's written or the physician's/provider's written or the problem will not recur. 	he btaining staff not e allowed vill be part l licensed agency e, QI staff free of cluding ic a protect he SF urse, monthly on and s (TARs) also the ers from stem copy of ure added to der so that	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 122 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/30/2018 RM APPROVED O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED C	
		345293	B. WING			04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page	e 122	F	756	requirements		
					The DON, SF, QI nurse, and/or minim data set (MDS) nurse will audit all new medication orders, including antipsych medication weekly x 12 weeks to ensu the order was transcribed correctly on the medication administration record (MAR) after verifying there is a physician's/provider's order in the hear record. This audit will be documented the MAR Audit Tool as verification the intervention of physician order review during MAR/TAR reconciliation is effect and solutions are sustained. The monthly QI committee will review results of the MAR Audit Tool monthly 3 months for identification of trends, actions taken, and to determine the ne for and/or frequency of continued monitoring of the facility's performance make sure the solutions are sustained addition, the QI committee will review status of pharmacy consultant visit da ensure there is continuity of pharmacy consultant coverage and identified/unidentified irregularities are reported to the physician. If the QI committee identifies any concerns, the DON will notify the pharmacy provider the resident's physician.	v notic ure to alth on ctive the for eed the te to f. In the te to / e and	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 123 of 171

	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		C	
		345293	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/26/2018	
				HIGHWAY 177 S BOX 1489		
RICHMON	ID 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 756	Continued From page	2 123	F 75	6		
				The title of the person respons implementing the acceptable p correction.		
				The DON is responsible for imp the acceptable plan of correction	on.	
F 757 SS=D		e from Unnecessary Drugs -(6)	F 75	7	5/24/18	
	-	ary Drugs-General. regimen must be free from An unnecessary drug is any				
	§483.45(d)(1) In exce duplicate drug therap	· · ·				
	§483.45(d)(2) For exc	essive duration; or				
	§483.45(d)(3) Withou	t adequate monitoring; or				
	§483.45(d)(4) Withou use; or	t adequate indications for its				
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be				
	stated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this				
	by:	is not met as evidenced		E 757		
	Based on observatio interviews and record monitor a resident's b	review, the facility failed to		F 757 The plan of correcting the spec	sific	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 124 of 171

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
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	TATEMENT OF DEFICIENCIES CY 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)	IOULD BE COMPLETIC
F 757	Continued From pag	e 124	F 757		
		ent #16) of 6 residents ssary medications. The		deficiency	
	findings included: Resident #16 was ac diagnosis of Diabetes			The position of Richmond Pines and Rehabilitation center regard process that led to the deficiency to monitor a resident's blood glue as ordered was failure to follow p	ing the y of failing cose level
	4/9/16 physician orde a blood glucose chec Monday morning. He (long-acting insulin) was prescribed a reg	#16's admission orders dated ers indicated he was to have ck via fingerstick every e was prescribed Lantus 14 units every morning. He jular diet with no . This was his current orders		following physician's orders. On 4/26/18, the nurse practitioner reviewed Resident #16's lab wor 4/24/18 and wrote orders to increa amount of the resident's daily ins ordered Resident #16's blood glu checked daily. On 4/26/18, the of improvement (QI) nurse ensured orders were transcribed onto the	k dated ease the sulin and ucose quality I the new
	indicated his Hemogl demonstrates average	ge blood glucose levels over was high at 7.9 with normal		medication administration record On 4/26/18, the administrator ma expectation known to the quality improvement (QI) nurse that Res #16's blood glucose level be che documented as ordered by the p	ade her sident ecked and
	electronic medical re	ation Record (MAR) and cord indicated there was no e that his blood glucose test		On 4/27/18 at approximately 6:0 third shift staff nurse verified Res #16's blood glucose level via fing and documented the result of "3" MAR. Insulin was given as orde physician and documented on the The staff nurse continued to doc	sident ger stick 18" on the red by the le MAR.
	and electronic medic no documented evide	#16's February 2018 MAR al record indicated there was ence that his blood glucose Monday 2/5/18, 2/18/18 or		The staff nurse continued to doc the MAR Resident #16's blood g level, as ordered, on 4/28/18, 4/2 4/30/18.	lucose

Facility ID: 923021

If continuation sheet Page 125 of 171

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	cc	OMPLETED
			5.14/11/0			С
		345293	B. WING			04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETIO
F 757	Continued From page	e 125	F 75	57		
		#16's care plan revised on was care plan for his		specific deficiency cited		
	diagnosis of Diabetes	s and his blood glucose		On 5/23/18, director of n	nursing (DON), QI	
		ompleted as ordered by the		nurse, staff facilitator (S		
	physician.			nurse, and staff nurses a residents with physician		
				glucose monitoring per f		
	Review of Resident #	#16's March 2018 MAR and		ensure last 7 days of res	-	
		cord indicated there was no		documented in the MAR		
		e that his blood glucose test		the audit was to identify		
	was completed Mono	day 3/5/18 or 3/19/18.		residents in the same sit		
				having documented bloc The audit result: 12 resi	-	
				missing documentation		
	Resident #16 quarter	rly Minimum Data Set dated		results on the MAR. The	-	
		had moderate cognitive		Resident #16's MAR had	d no blood	
	impairment and was days.	coded for insulin for 7 of 7		glucose results docume 5/7/18, 5/10/18, and 5/1		
				By 5/24/18, all licensed	-	
		#16's April 2018 MAR and		part time, as needed (PI		
		cord indicated there was no that his blood glucose test		will be re-educated rega deficiency of failing to m		
		day 4/2/18 or 4/23/18.		blood glucose level as o		
		, <u>, , , , , , , , , , , , , , , , , , </u>		follow policy for following		
				orders, and the importar	nce of following	
		ent #16 was conducted on		physician's orders so that		
		He stated he was a Diabetic		and other residents are		
		daily. He could not recall if is checked prior to his insulin		re-education was given and QI nurse and includ	-	
		as no observed food or		blood glucose monitoring		
	snacks at his bedside			as ordered per physiciar		
				documenting results on	-	
		#16's lab work dated 4/24/18		nurse will be allowed to	work after 5/24/18	
		lobin A1C was high at 11.3		until the in-service is cor		
	with normal ranges b	etween 5.0-6.1.		in-service will be part of		
				process for all newly hire including part time, PRN		
	Interview with Nurse				i, and agency.	

Facility ID: 923021

If continuation sheet Page 126 of 171

		ID HUMAN SERVICES			PRINTED: 05/30/2018 FORM APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	I		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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 757	Resident #16 on Mon stated she thought sh blood glucose level o Nurse #4 stated when completed, it was cha MAR. She stated Res have his blood glucos Interview with the Nu conducted on 4/26/18 reviewed Resident #1 and wrote orders to in units every morning a glucose checked dail consistent carbohydra carbohydrates at eac would expect Residen to be obtained and do Interview on 4/26/18 Administrator stated in Resident #16's blood	She stated she was assigned aday 4/23/18. Nurse #4 he obtained Resident #16's in 4/23/18 but was not sure. In a blood glucose level was arted on Resident #16's sident #16 did not refuse to se level checked. The Practitioner (NP) was a to 9:30 AM. She stated she 16's lab work dated 4/24/18 increase his Lantus to 20 and ordered his blood y. She also ordered a ate diet (same amount of h meal). NP stated she int #16's blood glucose level boumented as ordered.	F 75	 7 The monitoring procedure to ensure the plan of correction is effective a specific deficiency cited remains of and/or in compliance with the regurequirements The DON, SF nurse, QI nurse, mi data set (MDS) nurse, nurse super and/or charge nurse will monitor the nurses' performance with docume residents' blood glucose levels as by the physician for 6 months to make solutions are sustained. The SF nurse, QI nurse, MDS nurse, resure solutions are sustained. The SF nurse, QI nurse, MDS nurse, resure solutions are sustained. The SF nurse, QI nurse, MDS nurse, resure solutions are sustained. The SF nurse, and/or charge nurse weaks, and/or charge nurse weaks, and once monthly x 3 more ensure blood glucose monitoring via finget times weekly x 4 weeks, once we weeks, and once monthly x 3 more ensure blood glucose monitoring via funget times to the date on the MAR audit. The monthly QI committee will reverse of the MAR audit tool montimonths for identification of trends, taken, and to determine the need and/or frequency of continued mo and make recommendations for monitoring for continued compliant. The QI nurse and/or DON will prefindings and recommendations of monthly QI committee to the quart executive quality assurance (QA) committee for further recommendations of monthly QI committee to the quart executive quality. 	and that corrected ulatory inimum ervisor, he enting ordered nake e DON, hurse vill audit s for er stick 3 eekly x 8 hths to was audit will t tool. view the thly for 6 , actions for enitoring, hce. sent the the the the the the the the the the

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 127 of 171

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/30/2018 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING _				C 26/2018
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 757	Continued From page	127	F 7	757			
					The title of the person responsible for implementing the acceptable plan of correction.		
F 750	Free form three Dev				The director of nursing is responsible for implementing the acceptable plan of correction.	or	5/04/40
F 758 SS=E		chotropic Meds/PRN Use e)(1)-(5)	F 7	'58			5/24/18
	affects brain activities	notropic drug is any drug that associated with mental ior. These drugs include,					
	Based on a comprehe resident, the facility m	ensive assessment of a ust ensure that					
	psychotropic drugs ar unless the medication	nts who have not used e not given these drugs i is necessary to treat a liagnosed and documented					
	drugs receive gradual behavioral interventio						

If continuation sheet Page 128 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	l	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HGHWAY 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 SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	§483.45(e)(3) Reside psychotropic drugs p unless that medicatio diagnosed specific co in the clinical record; §483.45(e)(4) PRN o are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he o rationale in the reside indicate the duration §483.45(e)(5) PRN o drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev Practitioner and staff administered an antip resident without a ph #39) and failed to ens psychotropic medicat duration for 6 of 6 sai unnecessary medicat #38, #22, #39 and #5 1a. Resident #39 was 12/7/17 with multiple psychosis. The quar (MDS) assessment d Resident #39 had mo	ents do not receive ursuant to a PRN order in is necessary to treat a pondition that is documented and rders for psychotropic drugs as. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced iew and Pharmacists, Nurse interviews, the facility osychotic medication to a ysician's order (Resident sure that as needed (PRN) tions are time limited in mpled residents reviewed for tions (Residents #13, #58, i2). Findings included:	F 758	F 758 The plan of correcting the specific deficiency The position of Richmond Pines Nursi and Rehabilitation center regarding th process that led to this deficiency – administered an antipsychotic medica without a physician's order and failed ensure that as needed (PRN) psychotropic medications are time lim – was licensed nurse knowledge defic On 4/25/18, the order for Seroquel wa clarified (discontinued) with nurse practitioner (NP) for Resident #39 by t	e tion to ited it. s

Facility ID: 923021

If continuation sheet Page 129 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF PI	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 CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 758	Continued From page	e 129	F 758	3	
	during the assessme			director of nursing (DON).	
	revealed that Resider antipsychotic medica Risperdal 2 milligram (started on 12/8/17), intramuscular (IM) ev 2/13/18) and Seroque (started 1/11/18). Th for the Seroquel foun records. The psychiatric evalu through April 2018 for reviewed. The notes resident was on Sero The initial psychiatric 1/11/18. The notes in current psychiatric more mgs by mouth (po) da every 12 hours PRN.	rery 2 weeks (started el 25 mgs by mouth daily ere was no telephone order d in the resident's medical nation notes from January r Resident #39 were did not indicate that the equel. evaluation was dated ndicated that the resident's edications were Risperdal 2 aily, and Ativan 0.5 mgs The recommendation was ntidepressant drug) 25 mgs		 On 4/25/18, Seroquel was discomfor Resident #39 by the NP. Orde transcribed to medication administrecord (MAR) by the DON. On 4/25/18, the DON obtained an for Resident #39's as needed (PF Ativan (the medication was discort On 4/25/18, the DON obtained an for Resident # 52's PRN Ativan (the medication was discontinued). On 4/25/18, the DON obtained an for Resident # 58's PRN Ativan (the mediation was discontinued). On 4/25/18, the DON obtained an for Resident # 13's PRN Ativan (the medication was discontinued). On 4/25/18, the DON obtained an for Resident # 13's PRN Ativan (the medication was discontinued). On 4/25/18, the DON obtained an for Resident # 13's PRN Ativan (the medication was discontinued). On 4/25/18, the DON obtained an for Resident # 38's PRN Ativan (the medication was discontinued). 	r was stration order RN) ntinued). order he order he order he
	resident's current me mgs po daily, Ativan 25 mgs po daily. The initiate Risperdal Con weeks for mood labili The psychiatric notes had recommendation mgs po daily and Ris	a dated 2/20/18 and 4/17/18 is to continue Risperdal 2 perdal 25 mgs IM every 2		On 4/25/18, the DON obtained an for Resident # 22's PRN Ativan (the medication was discontinued). The procedure for implementing the acceptable plan of correction for the specific deficiency cited	he he
	weeks, Ativan 0.5 mg mgs po daily.	s BID PRN and Zoloft 25		On 5/21/18 through 5/23/18, the E quality improvement (QI) nurse, s facilitator (SF) nurse, charge nurs	taff

Facility ID: 923021

If continuation sheet Page 130 of 171

		MEDICAID SERVICES				D. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	SURVEY
			A. BUILDING	<u> </u>		С
		345293	B. WING			
	ROVIDER OR SUPPLIER	343233		STREET ADDRESS, CITY, STATE, Z		/26/2018
	ROVIDER OR SUFFLIER			HIGHWAY 177 S BOX 1489	IF CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETIC
F 758	Continued From page	e 130	F 75	58		
		nistration Records (MARs)		staff nurses compared t	he April MARs to	
	for Resident #39 wer	. ,		May MARs to ensure no		
				were noted to protect re		
		AR revealed that Seroquel		situations. The audit res		
	was not listed as one	of the resident's		irregularities were identi	-	
	medications.			administration of an anti medication without an o		
	The February and M	arch 2018 MARs revealed		psychotropic medication		
		d received Seroquel the		limited.		
	whole month of Febru	•				
		,		By 5/24/18, the SF nurs	e and QI nurse will	
	The April 2018 MAR	revealed that Resident #39		re-educate all licensed r		
	had received Seroque	el from April 1- 25, 2018.		part-time (PT), as neede		
				and agency nurses on:		
	On 4/25/18 at 12:45 I			notify pharmacy of new	-	
		ted that she was assigned to #8 stated that Resident #39		faxing to pharmacy, 2) r be verified that they are		
		mgs daily. Nurse #8 verified		delivery by the nurse re	-	
		d an order for Seroquel in		medication, 3) the proce		
	the resident's medica	•		medications not availab		
				in-serviced by 5/24/18 w	vill not be allowed	
		M, the Medical Record clerk		to work until the re-educ		
		e verified that she could not		completed. This re-edu		
	find an order for Serc	oquel on Resident #39's thin		of the orientation for nev nurses, including PT, PI	-	
				nurses.	art, and agonoy	
	On 4/25/18 at 3:48 P	M, the Nurse Consultant was				
	interviewed. She sta	ted that she had called the		Beginning 5/24/18, the S		
		armacy indicated that there		nurse, DON, charge nur		
		Seroquel, it was an error on		nurses will ensure resid		
	-	roquel was transcribed		unnecessary psychotrop		
	sheet for February 20	ummarized monthly order		including administration psychotropic mediation		
	Silection replicaty 20			limitations. To protect re		
	On 4/26/18 at 9:55 A	M, interview with the		situations, the SF nurse		
	Psychiatric Nurse Pra			charge nurse, and/or sta		
	-	cated that she was following		compare monthly the up		
	-	medication and behavior		medication administration		
	management. She s	tated that she did not		to the current MARs and	d also the new	

Facility ID: 923021

If continuation sheet Page 131 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/20 FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		IGHWAY 177 S BOX 1489		
	-	-	Н	AMLET, NC 28345	1	
(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 SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO	
F 758	Continued From page	e 131	F 758			
	recommend the Sero NP indicated that it w double antipsychotic she would increase th antipsychotic medica	quel for the resident. The as not her practice to order medications and if needed, ne dose of the current tion. She added that she esident #39 was receiving 2		physician orders for completeness include time limits. The system requirement to review MARs and physician orders at the end of the will help ensure the problem of unnecessary psychotropic medications/PRN use will not recu	new month	
	was interviewed. She the facility as Pharma was in March 2018 a 2018. She indicated called her about the S and she had reviewe notes and there was She revealed that the overlooked the Seroc			The monitoring procedure to ensu- the plan of correction is effective a specific deficiency cited remains of and/or in compliance with the regu- requirements The DON, SF, QI nurse, and/or m data set (MDS) nurse will audit all medication orders, including psyc- medication weekly x 12 weeks to	and that corrected ulatory inimum new hotropic ensure	
	was interviewed. He was entered incorrec doctor's order and the summarized monthly Administration Recor	M, the Pharmacy Pharmacist stated that the Seroquel tly into the system without a en it appeared on the orders and Medication ds (MARs) for February the incident was under part.		there is a complete and not duplic physician's/provider's order for psychotropic medication in the he record. This audit will be documen the MAR Audit Tool as verification intervention of physician order rev during MAR reconciliation is effect solutions are sustained.	alth nted on the riew	
	interviewed. She sta for the staff to ensure administered had doo	ctor's orders.		The monthly QI committee will rev results of the MAR Audit Tool mor 3 months for identification of trend actions taken, and to determine th for and/or frequency of continued monitoring of the facility's perform	hthly for ds, he need nance to	
	12/7/17 with multiple psychosis. The quar (MDS) assessment d	s admitted to the facility on diagnoses including terly Minimum Data Set ated 2/28/18 revealed that oderate cognitive impairment	711 Ea	make sure the solutions are susta The QI nurse or DON will present findings and recommendations of monthly QI committee to the quar	the the	

Facility ID: 923021

If continuation sheet Page 132 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345293	B. WING _				C / 26/2018
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		н	IREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	and he had not receiv medication during the Review of the current that Resident #39 had Ativan (antianxiety m day PRN and Ativan PRN. Review of the Medica (MARs) for March an PRN Ativan injectable used. On 4/25/18 at 5:26 PL Assurance/Infection O interviewed. She stat psychotropic medicat for 14 days including On 4/26/18 at 9:27 At was interviewed. She of the rule for PRN psy which was 14 days bur rule for all residents of condition/behaviors. Review of the physici revealed no document the PRN Ativan beyon On 4/26/18 at 4:31 PL was interviewed. She the facility as Pharmat was in March 2018 at 2018. She indicated identified some issue medications including	 ved an antianxiety e assessment period. t physician's orders revealed d orders dated 2/11/18 for edication) 1 mgs IM twice a 1 mgs by mouth twice a day ation Administration Records d April 2018 revealed that e and tablet had not been M, the Quality Control Nurse was ted that all PRN tions should only be ordered hospice residents. M, the Nurse Practitioner e stated that she was aware sychotropic medications ut she was not following that depending on their medical an's progress notes thed rationale for the use of nd 14 days. M, the Pharmacy Consultant e stated that she was new to acy Consultant. Her first visit nd she came 1 day in April that she had already 	F	758	executive quality assurance (QA) committee for further recommendation and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implement the acceptable plan of correction.		

Facility ID: 923021

If continuation sheet Page 133 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345293	B. WING _				C 26/2018
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	9 133	F 7	58			
	interviewed. She stat	M, the Administrator was ed that she expected all edications to have a stop					
	6/10/15 with multiple	ors. The quarterly Minimum ssment dated 4/15/18					
	for Ativan (antianxiety	octor's order dated 11/30/17 medication) 0.5 milligrams 8 hours as needed (PRN) inations.					
	On 4/25/18 at 5:26 PM Assurance/Infection C interviewed. She stat psychotropic medicati for 14 days including	Control Nurse was ed that all PRN ions should only be ordered					
	was interviewed. She of the rule for PRN ps which was 14 days bu	M, the Nurse Practitioner e stated that she was aware cychotropic medications ut she was not following that epending on their medical					
	Review of the physicia revealed no documen the PRN Ativan beyor	ted rationale for the use of					

Facility ID: 923021

If continuation sheet Page 134 of 171

	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE	
	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION NAME OF PROVIDER OR SUPPLIER B. WING				C 26/2018		
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE					
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	On 4/26/18 at 4:31 Pl was interviewed. She the facility as Pharma was in March 2018 at 2018. She indicated identified some issue medications including had started to address the physician. On 4/26/18 at 7:20 Pl interviewed. She stat PRN psychotropic me date of 14 days. 3. Resident #58 was 2/22/18 and readmitte that included vascula disturbance and Park A physician ' s order of Ativan (antianxiety me intramuscular (IM) ev (PRN) for Resident #1 for this PRN order. A physician ' s order of Ativan gel equal to 2 agitation for Resident date for this PRN ord The significant chang dated 4/12/18 indicate rarely/never understo understands. He had memory problems an making. Resident #5	M, the Pharmacy Consultant e stated that she was new to acy Consultant. Her first visit nd she came 1 day in April that she had already s with psychotropic g the PRN orders and she is some of the issues with M, the Administrator was ted that she expected all edications to have a stop admitted to the facility on ed on 3/9/18 with diagnoses r dementia with behavioral tinson ' s. dated 3/29/18 indicated edication) 1 milligrams (mg) ery 12 hours as needed 58. There was no stop date dated 3/29/18 indicated mg twice daily PRN for t #58. There was no stop er.	F7	758			

If continuation sheet Page 135 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
		345293	B. WING				26/2018
NAME OF P	ROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	A review of Resident # 4/1/18 through 4/24/1 were Ativan 1mg and continued to be active An interview was com Assurance (QA) Nurs She stated that all PF should only be ordered hospice residents. An interview was com Practitioner on 4/26/1 she was aware of the medications which was residents depending of condition/behaviors. An interview was com Consultant on 4/26/18 she was new to the fa Consultant. Her first she came 1 day in Ap had already identified psychotropic medication orders with no stop dat address some of thes An interview was com Administrator on 4/26 she expected all PRN to have a stop date of 4. Resident #13 was a 4/28/17 and most recomposite with multiple diagnose	 #58 's April 2018 MAR from 8 indicated the PRN orders Ativan gel (equal to 2 mg) e orders. ducted with the Quality e on 4/25/18 at 5:26 PM. RN psychotropic medications ed for 14 days including ducted with the Nurse 8 at 9:27 AM. She stated rule for PRN psychotropic as a time limited duration of not following that rule for all on their medical ducted with the Pharmacy 8 at 4:31 PM. She stated acility as Pharmacy visit was in March 2018 and ril 2018. She indicated she some issues with ions, including the PRN ate, and she had started to e issues with the physician. ducted with the /18 at 7:20 PM. She stated psychotropic medications 	F	758			

Facility ID: 923021

If continuation sheet Page 136 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345293	B. WING				C / 26/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, 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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	The quarterly Minimul assessment dated 1/7 #13 was rarely/never understands. Her sho memory were impaired impaired decision ma administered no antia MDS assessment per A physician 's order of (antianxiety medication hours as needed (PR was no stop date for the A review of Resident a 4/9/18 through 4/24/1 for Ativan 1mg contine There were no admin for Resident #13. An interview was con- Assurance (QA) Nurs She stated that all PF should only be ordered hospice residents. An interview was con- Practitioner on 4/26/1 she was aware of the medications which was residents depending of condition/behaviors. An interview was con- Consultant on 4/26/18 she was new to the fac Consultant. Her first	m Data Set (MDS) 15/18 indicated Resident understood and rarely never ort-term and long-term ed and she had severely king. Resident #13 was anxiety medication during the riod. dated 4/9/18 indicated Ativan on) 1 milligram (mg) every 4 N) for Resident #13. There this PRN order. #13 ' s April 2018 MAR from 8 indicated the PRN order ued to be an active order. istrations of this PRN Ativan ducted with the Quality se on 4/25/18 at 5:26 PM. RN psychotropic medications ed for 14 days including ducted with the Nurse 8 at 9:27 AM. She stated rule for PRN psychotropic as a time limited duration of not following that rule for all on their medical ducted with the Pharmacy 8 at 4:31 PM. She stated	F	758			

Facility ID: 923021

If continuation sheet Page 137 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		ECONSTRUCTION	(X3) DATE	
			A. BUILDI	NG _			C
		345293	B. WING			04/	26/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HGHWAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	orders with no stop da address some of thes An interview was com Administrator on 4/26 that she expected all medications to have a 5. Resident #38 was 1/26/11 and readmitte that included major da psychosis and agitation A physician ' s order of (antipsychotic medicat three times daily PRN Resident #38. There PRN order. The quarterly Minimu 2/23/18 indicated Res understood and usual communication. He v cognition. Resident #3 anti-psychotic medicat period. The antipsych received as a routine A review of Resident 4 Administration Record 2018 and April 2018 i Haldol 5 milligrams co	some issues with ions, including the PRN ate, and she had started to be issues with the physician. ducted with the /18 at 7:20 PM. She stated PRN psychotropic a stop date of 14 days. admitted to the facility on ed on 4/9/18 with diagnoses epressive disorder, on. dated 1/5/18 indicated Haldol tion) 5 milligrams by mouth I (as needed) agitation for was no stop date for this m Data Set (MDS) dated sident #38 was usually lly understands vas severely impaired in 38 received seven days of tion during the assessment notic medication was medication. #38 's Medication ds for February 2018, March ndicated the PRN order for portinued to be active orders.	F	758			
	Administration Record 2018 and April 2018 i Haldol 5 milligrams co An interview was con-	ds for February 2018, March ndicated the PRN order for					

Facility ID: 923021

If continuation sheet Page 138 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	
		345293	B. WING				26/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	should only be ordered An interview was com Practitioner on 4/26/1 she was aware of the medications which was 14 days, but she was residents depending of condition/behaviors. An interview was com Consultant on 4/26/18 she was new to the fa Consultant. Her first she came 1 day in Ap had already identified psychotropic medicat orders with no stop da address some of thes An interview was com Administrator on 4/26 she expected all PRN to have a stop date of 6. Resident #22 was 5/12/16 with diagnose psychosis not due to physiological condition disorder and unspecif The quarterly Minimu 1/30/18 indicated Res impaired in cognition. antipsychotic, antiany medication during the	RN psychotropic medications ed for 14 days. ducted with the Nurse 8 at 9:27 AM. She stated rule for PRN psychotropic as a time limited duration of not following that rule for all on their medical ducted with the Pharmacy 8 at 4:31 PM. She stated acility as Pharmacy visit was in March 2018 and oril 2018. She indicated she I some issues with ions, including the PRN ate, and she had started to se issues with the physician. ducted with the 5/18 at 7:20 PM. She stated I psychotropic medications f 14 days. admitted to the facility es that included unspecified a substance of known in, anxiety, major depressive fied mood affective disorder. m Data Set (MDS) dated sident #22 was moderately . Resident #38 received tiety and antidepressant e assessment period.	F 7	58			
	A physician 's order of	dated 3/20/18 indicated					

If continuation sheet Page 139 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 05/30/201 RM APPROVE IO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		TE SURVEY MPLETED
		345293	B. WING		0	C 4/26/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COI		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 758 F 760 SS=E	Ativan 0.25 milligram needed (PRN). Ther PRN order. An interview was con Assurance (QA) Nurs She stated that all PF should only be ordered An interview was con Practitioner on 4/26/1 she was aware of the medications which was residents depending condition/behaviors. An interview was con Consultant on 4/26/1 she was new to the fa Consultant. Her first she came 1 day in Ap had already identified psychotropic medicat orders with no stop d address some of thes An interview was con Consultant. Her first she came 1 day in Ap had already identified psychotropic medicat orders with no stop d address some of thes An interview was con Administrator on 4/26 she expected all PRN to have a stop date o Residents are Free o CFR(s): 483.45(f)(2)	s daily and q12 hours as e was no stop date for the aducted with the Quality se on 4/25/18 at 5:26 PM. RN psychotropic medications ed for 14 days. aducted with the Nurse 18 at 9:27 AM. She stated e rule for PRN psychotropic as a time limited duration of a not following that rule for all on their medical aducted with the Pharmacy 8 at 4:31 PM. She stated acility as Pharmacy visit was in March 2018 and oril 2018. She indicated she d some issues with tions, including the PRN ate, and she had started to se issues with the physician. aducted with the 5/18 at 7:20 PM. She stated N psychotropic medications if 14 days. f Significant Med Errors	F 758			5/24/18

Facility ID: 923021

If continuation sheet Page 140 of 171

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345293	B. WING			0	C 4/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			WAY 177 S BOX 1489 LET, 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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	Continued From page	e 140	F	760			
		actitioner and staff / administered an tion to a resident for almost		Т	760 he plan of correcting the specific eficiency		
	sampled residents re	hysician's order for 1 of 6 viewed for unnecessary nt #39). Findings included:		a p	he position of Richmond Pines Nur nd Rehabilitation Center regarding rocess that led to the deficiency of dministering an antipsychotic medi-	the	
	12/7/17 with multiple psychosis. The quar	admitted to the facility on diagnoses including terly Minimum Data Set ated 2/28/18 revealed that		w p	b a resident without a physician ord as the staff failure to follow policy a rocedure.	and	
	and he had received during the assessme			n (1	On 4/25/18, the minimum data set (I urse contacted the nurse practition NP) and clarified the physician orde Resident #39's Seroquel.	er	
	Resident #39 was red medications. He was milligrams (mgs) by r 12/8/17), Risperdal 2	ian's orders revealed that ceiving 2 antipsychotic s receiving Risperdal 2 nouth daily (started on 5 mgs intramuscular (IM) ed 2/13/18) and Seroquel 25 started 1/11/18).		# tr	On 4/25/18, the NP discontinued Re 39's order for Seroquel. The MDS is canscribed the discontinued Seroque rder to the medication administration ecord (MAR).	nurse Iel	
		ation notes for Resident #39 notes did not indicate that Seroquel.		a	he procedure for implementing the cceptable plan of correction for the pecific deficiency cited		
	for Resident #39 wer			0	on 5/21/18 through 5/23/18, the dire f nursing (DON), quality improveme QI) nurse, staff facilitator (SF) nurse	ent	
	The January 2018 M. was not listed as one medications.	AR revealed that Seroquel of the resident's		e p	harge nurse, and staff nurses will ompare April MARs to May MARs t nsure no drug irregularities were no rotect residents in similar situations	oted to	
		arch 2018 MARs revealed d received Seroquel the			udit result: no additional drug regularities were identified, includir	ng	

Facility ID: 923021

If continuation sheet Page 141 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05 FORM AP OMB NO. 09	PROVE
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
		345293	B. WING		C 04/26/2	018
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CO THE APPROPRIATE	(X5) MPLETION DATE
F 760	Continued From page	e 141	F 76	50		
	whole month of Febr		170	administration of an antips	sychotic	
				medication without a physi		
	The April 2018 MAR	revealed that Resident #39				
	had received Seroqu	el from April 1- 25, 2018.		By 5/24/18, the SF nurse a		
	On 1/25/19 at 12:45			re-educate all licensed nur part-time (PT), as needed		
	On 4/25/18 at 12:45 l	ted that she was assigned to		and agency nurses on: 1)		
		#8 stated that Resident #39		notify pharmacy of new or	-	
	was on Seroquel 25 i	mgs daily. Nurse #8 verified		faxing to pharmacy, 2) me	-	
		d an order for Seroquel in		be verified that they are co		
	the resident's medica	I records.		delivery by the nurse recei		
	On 1/25/18 at 1.50 D	M, the Medical Record clerk		medication, 3) the process medications not available.		
		e verified that she could not		in-serviced by 5/24/18 will		
		oquel on Resident #39's thin		to work until the re-educat		
	records.			completed. This re-educa of the orientation for newly		
		M, the Nurse Consultant was		nurses, including PT, PRN	I, and agency	
		ted that she had called the		nurses.		
		armacy indicated that there Seroquel, it was an error on		Beginning 5/24/18, the SF		
		roquel was transcribed		nurse, DON, charge nurse		
	incorrectly.			nurses will ensure residen		
	,			significant medication erro		
	On 4/26/18 at 9:55 A	-		administration of an antips	-	
	Psychiatric Nurse Pra			mediation to a resident wit		
		cated that she was following nedication and behavior		physician/provider's order residents in similar situatio	-	
	management. She s			nurse, QI nurse, DON, cha		
	-	quel for the resident. The		and/or staff nurses will cor		
	NP indicated that it w	as not her practice to order		the upcoming month's me	dication	
		and if needed, she would		administration records (MA	-	
		the current antipsychotic		treatment administration re		
		led that she was not aware is receiving 2 antipsychotic		to the current MARs/TARs paper copy of the physicia		
	medications.	o receiving 2 antipoyonotic		the physical/hard chart. T		
				requirement to review the	-	
		M, the Pharmacy Consultant		the physician orders from	the	
	was interviewed. She	e stated that she was new to		physical/hard chart will hel	lp ensure	

Facility ID: 923021

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTID	LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
					с
		345293	B. WING		04/26/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
Nonimon	DTINEOTIEAETTIOARE			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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETIO
F 760	Continued From pag	le 142	F 76	0	
	the facility as Pharmacy Consultant. Her first v was in March 2018 and she came 1 day in Apri 2018. She indicated that the facility had alread called her about the Seroquel for Resident #39 and she had reviewed the drug regimen review notes and there was no mention of Seroquel.			medications/treatments are no the new MARs/TARs without a physician's/provider's written o the problem will not recur.	order so that
She revealed that the previou overlooked the Seroquel. She were some residents who nee medications but the physician rationale for the duplicate use	quel. She stated that there s who needed 2 antipsychotic physician had to specify the		The monitoring procedure to e the plan of correction is effecti specific deficiency cited remain and/or in compliance with the requirements	ve and that ns corrected	
	was interviewed. He was entered incorrect doctor's order. He si under investigation of On 4/26/18 at 7:20 F interviewed. She sta for the staff to ensure	On 4/26/18 at 4:56 PM, the Pharmacy Pharmacist vas interviewed. He stated that the Seroquel vas entered incorrectly into the system without octor's order. He stated that the incident was nder investigation on their part. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that her expectation was or the staff to ensure that medications dministered had doctor's orders.		The DON, SF, QI nurse, and/o data set (MDS) nurse will audi medication orders, including a medication weekly x 12 weeks the order was transcribed corr the medication administration (MAR) after verifying there is a physician's/provider's order in record. This audit will be docu the MAR Audit Tool as verifical intervention of physician order during MAR/TAR reconciliation and solutions are sustained.	t all new ntipsychotic to ensure ectly onto record the health mented on tion the review n is effective
				The monthly QI committee will results of the MAR Audit Tool r 3 months for identification of tr actions taken, and to determin for and/or frequency of continu monitoring of the facility's performance make sure the solutions are su	nonthly for ends, e the need ied ormance to

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 143 of 171

-	OT OR MEDIOARE &	MEDICAID SERVICES				0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		345293	B. WING			C 26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From page	e 143	F 760	and oversight.		
				The title of the person re implementing the accept correction.		
F 004		<i></i>	5.00	The DON is responsible the acceptable plan of co		
F 801 SS=E	Qualified Dietary Stat CFR(s): 483.60(a)(1)		F 80 ⁻	1		5/24/18
	appropriate competer out the functions of th taking into considerat individual plans of ca	-				
	full-time, part-time, or qualified dietitian or o nutrition professional (i) Holds a bachelor's	rition professional either on a consultant basis. A ther clinically qualified				
	United States (or an e with completion of the a program in nutrition an appropriate nation recognized for this pu (ii) Has completed at supervised dietetics p	equivalent foreign degree) e academic requirements of or dietetics accredited by al accreditation organization urpose. least 900 hours of				

Facility ID: 923021

If continuation sheet Page 144 of 171
	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/30/2018 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPI	ETED
		345293	B. WING		_		<i>,</i> 26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 801	services are performed provide for licensure of will be deemed to have or she is recognized at the Commission on D successor organization requirements of parage this section. (iv) For dietitians hired November 28, 2016, in no later than 5 years at as required by state lat §483.60(a)(2) If a quation clinically qualified nut employed full-time, th person to serve as the nutrition services who (i) For designations p meets the following re years after November after November 28, 21 (A) A certified dietary (B) A certified dietary (B) A certified food set (C) Has similar nation service management certifying body; or D) Has an associate's service management course study includes management, from a higher learning; and (ii) In States that have	ified as a dietitian or by the State in which the ed. In a State that does not or certification, the individual we met this requirement if he as a "registered dietitian" by itetetic Registration or its on, or meets the graphs (a)(1)(i) and (ii) of d or contracted with prior to meets these requirements after November 28, 2016 or aw. affied dietitian or other rition professional is not e facility must designate a e director of food and b- orior to November 28, 2016, equirements no later than 5 28, 2016, or no later than 1 28, 2016 for designations 016, is: manager; or tryice manager; or and certification for food and safety from a national as or higher degree in food	F 80				

Facility ID: 923021

If continuation sheet Page 145 of 171

	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	<u>938-03</u> 9
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/20/	2010
				HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE C	(X5) OMPLETIO DATE
F 801	Continued From pag	e 145	F 801			
	-	nents for food service	1 001			
	managers or dietary					
		ntly scheduled consultations				
		tian or other clinically				
	qualified nutrition pro					
		T is not met as evidenced				
f. N r f	by:					
		view and staff interviews, the		F801		
		oy a Certified Dietary				
	-	mpetencies and skills		The plan of correcting the specific		
		food and nutrition services		deficiency		
		and continuing at the time of				
		oril 23-April 26, 2018. The		The position of Richmond Pines		
	findings included:			Healthcare and Rehabilitation cent regarding the process that led to the		
	An initial tour of the l	kitchen was conducted on		deficiency of failing to employ a ce		
		The Assistant Dietary		dietary manager with the competer		
		was also acting as the		and skills to carry out food and nut		
		ager at present. She stated		services was an unfilled vacancy in		
		n for two weeks and, when		certified dietary manager position.		
		or Assistant Dietary Manager				
	had left.			On 4/23/18, the administrator verif	ied the	
				facility failed to employ a certified of		
		AM, an interview was		manager (CDM) from March 8, 20		
		ssistant Dietary Manager		the CDM resigned without notice a		
		ietary Consultant. They		assistant dietary manager began a		
		Dietary Manager left March 8,		with CDM tasks with support from	line	
		t been a Certified Dietary tion since that time. The		corporate dietary consultant.		
		onsultant stated they		On 4/23/18, the administrator also	verified	
		on but did not have any		the facility was advertising for the		
		istant Dietary Manager stated		of a certified dietary manager. The		
		st shift cook until 4/13/18.		administrator contacted the corpor		
		en on vacation for 2 weeks		office for assistance with filling the		
	and came back on 4	/13/18 because the facility		certified dietary manager position.		
	had called her and s	tated the Assistant Dietary				
	-	he stated she was not serve		Beginning on 4/23/18, the assistan		
		ould not be able to take the		dietary manager and dietary depar	tment	
	class for certification	until September. She also		received on-site support from the		

Facility ID: 923021

If continuation sheet Page 146 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/30/2018 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345293	B. WING		C 04/26/2018	
	ROVIDER OR SUPPLIER D 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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 801	but had worked for set On 4/25/18 at 10:45 / conducted with the Ad had been at the facilit Assistant Dietary Man never showed up for she was aware that th Manager was not cer The Administrator stat current Assistant Diet phone or email if the Consultant was not in indicated the facility h	t taken any nutrition courses everal years as cook. AM, an interview was dministrator. She stated she ty 2 weeks. At that time the nager had already leftjust work. The Administrator said ne current Assistant Dietary tified as Dietary Manager. ted the only supervision the tary Manager was via by	F 80	Corporate dietary consultant and sister-facility CDM. As of 5/24/7 facility will continue to receive of support from a CDM until the fu CDM is employed at the facility. On 5/11/18, the administrator his qualified CDM for the dietary man position in effort to correct the d of failing to employ a CDM with competencies and skills require out food and nutrition services. the results of the pre-employment background checks, the CDM with the dietary manager role and be at the facility during the week of	18, the In-site III-time ired a anager leficiency the ed to carry Pending ent vill begin in e working	
	Dietary Consultant re on 3/7/18, 3/22/18, 4/ 4/25/18. On 4/26/18 at 7:21 Pl conducted with the Ad facility would have to	ard for the Corporate vealed she was in the facility /3/18, 4/23/18, 4/24/18 and M, a second interview was dministrator who stated the find someone qualified to be full time Dietary Manager		The procedure for implementing acceptable plan of correction for specific deficiency cited On 5/11/18, the administrator his certified dietary manager. The qualified CDM will be working a facility in the role of dietary mar during the week of 5/28/18, pen results of the pre-employment background checks. To prevent the deficiency from r any future vacancies in the CDM manager role will be promptly (v hours) reported by the payroll c administrator to the regional vic president of operations, the corr dietary consultant and/or corpor	r the ired a new, t the hager hding recurring, M/dietary within 24 lerk and te porate	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 147 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/30/2018 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	
		345293	B. WING				26/2018
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 801	Continued From page			801	 consultant, and the corporate human resources department vacancy of the certified dietary manager position. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The payroll clerk and/or administrator or validate every two weeks for 3 months employment of a certified dietary mana (CDM) in the kitchen. The validation we be accomplished through review of pay submission and supporting CDM credentials. The monthly QI committee will review of status of the CDM position monthly for months for the need of continued monitoring and make recommendations. The administrator will present the finding and recommendations of the monthly Committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversigh. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction. 	hat cted Ty will the ager rill yroll the 3 s. ngs QI	E/04/40
F 812 SS=E	Food Procurement,St CFR(s): 483.60(i)(1)(ore/Prepare/Serve-Sanitary 2)	F	812			5/24/18
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: SXJZ	 1	Fa	Litity ID: 923021 If continuat	ion sheet F	Page 148 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.20.2010
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		IGHWAY 177 S BOX 1489 IAMLET, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 812	Continued From page	e 148	F 812		
	§483.60(i) Food safe The facility must -	ty requirements.			
	state or local authorit (i) This may include f from local producers, and local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observation facility failed to have	red satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent produce grown in facility ompliance with applicable d-handling practices. es not preclude residents ls not procured by the facility. prepare, distribute and ance with professional ervice safety. T is not met as evidenced on and staff interviews, the proper dish sanitation, failed ened food items and failed to		F812 The plan of correcting the specific deficiency	
	dishwashing machine Corporate Dietary Co dishwashing machine machine and the was temperature of 150 d rinse cycle should be Observations were co AM and 9:45 AM. Th	e was a high temperature sh cycle should be at a egrees Fahrenheit and the e at 180 degrees Fahrenheit. onducted at 9:35 AM, 9:40 he wash cycle was at 142 and the rinse cycle was at		The position of Richmond Pines Healthcare and Rehabilitation Center regarding the process that led to the deficiency of failing to have proper of sanitation, failing to label and date of food items and failing to discard exp food items was lack of education and knowledge of the dietary staff. On 4/23/18, the assistant dietary ma and corporate dietary consultant discarded unlabeled items including	e dish open oired nd anager

Facility ID: 923021

If continuation sheet Page 149 of 171

		MEDICAID SERVICES					<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		345293	B. WING			C 04/26/2018	
AME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 04	20/2010
					GHWAY 177 S BOX 1489		
	ID PINES HEALTHCARE	AND REHABILITATION CENTE			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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 812	Continued From pag	e 149	F 8'	12			
	observations.		10	12	cartons of thawed chocolate mighty		
					shakes and 8 cartons of thawed sugar	r	
	On 4/25/18 at 9.45 Δ	M, the Corporate Dietary			free vanilla mighty shakes from the wa		
	Consultant stopped t	he dishwasher. She stated,			in cooler.		
	although the dishwas	sher was a high temperature					
	machine, there had b				On 4/23/18, the assistant dietary man	ager	
		grees Fahrenheit needed for			and corporate dietary consultant		
	the rinse cycle so the				discarded undated and unlabeled item		
		was used in the rinse cycle to			including an opened package of raisin		
	make sure everythin	g was sanitized.			cookie dough, 1 bag of chicken breast		
	On $\frac{1}{25}/18$ around 0	47 AM a tolophono			and 1/5 bag of chicken tenders from the freezer.	ie	
	On 4/25/18 around 9	nducted with the lead			neezer.		
		She stated there had been			On 4/23/28, the assistant dietary man	ager	
		taining the rinse temperature			and corporate dietary consultant	ago.	
	-	ere was a second rinse with			discarded expired items from the walk	in	
		ing the rinse cycle to make			cooler including 1 box of eggs (97) an	d 5	
	sure the dishes were	sanitized. When asked			flats of eggs (150).		
		emperature at 142 degrees					
		ed that was not acceptable			The procedure for implementing the		
	-	t down the dishwashing			acceptable plan of correction for the		
	machine.				specific deficiency cited		
	On 4/25/18 at 10:15	AM, an observation of the			On 4/23/18 and 4/24/18, the assistant		
		tures was conducted with the			dietary manager and corporate dietary		
	Maintenance directo				consultant audited all nourishment roc	oms,	
	temperature of the w	-			the freezer and the walk in cooler to		
		and it read 147 degrees			ensure there were no expired, undate		
		inse cycle was at 162			and/or unlabeled items. The audit results a source items noted as expired or	litea	
	-	He stated the entire system ter lines so he could not turn			in several items noted as expired or damaged and were immediately		
		re up to attain the 180			discarded.		
	degrees Fahrenheit						
	-	ater for the entire building.			On 5/23/18, the maintenance assistar	t	
	-	get someone to come and			had received confirmation a new		
	check the machine.				dishwashing machine was ordered,		
					awaiting arrival and installation. Until t	he	
		PM, an observation of the			dishwashing machine is installed and		
	dishwashing maching	e was conducted with the			properly working, the facility will utilize	•	

Facility ID: 923021

If continuation sheet Page 150 of 171

		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	1 Y	TE SURVEY MPLETED
		345293	B. WING			C 04/26/2018	
	ROVIDER OR SUPPLIER	040200			IREET ADDRESS, CITY, STATE, ZIP CODE	1 0	4/26/2018
					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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 812	Continued From page	o 150		10			
FOIZ	1.5		F 81	12	dispessible mession in a mesh sets (als	atia	
		nel who had arrived to check			disposable meal serving products (pla	SUC	
	-	hine. He stated he had			tableware, Styrofoam plates/bowls).		
		ts up for wash and rinse.			Starting the date of use of the new		
	and the rinse cycle w	t 158 degrees Fahrenheit			dishwashing machine, wash and rinse temperatures will be audited by the		
		d he was unable to get the			assistant dietary manager, interim diet	arv	
	rinse cycle any highe	5			manager, CDM dietary manager,	ul y	
	Fahrenheit.				maintenance assistant, and/or corpora	ate	
					dietary consultant. The wash and the		
	On 4/25/18 at 5:20 P	M, an observation of the			temperatures will be documented on t		
		with the Corporate Dietary			dishwasher water temperature sheets		
	company that mainta	ined the chlorine used in the			Starting the date of use of the new		
	rinse cycle. He state	d the chlorine was not			dishwasher, the CDM dietary manage	r,	
		servicing the dish machine			assistant dietary manager, dietary sta		
	•	was used to check the			maintenance assistant, and/or corpora		
		n the rinse cycle and tested			consultant will audit the wash and rins		
		s per million (ppm). The			temperatures twice a day to ensure th	е	
		onsultant stated they had			wash temperature is at 150 degrees		
		w heaters and three new			Fahrenheit and the rinse temperature	is at	
	fuses for the current	dish machine.			180 degrees Fahrenheit.		
					By 5/24/18, the assistant dietary mana	ager	
	2. a. On 4/23/18 at 9:	:30 AM, an initial tour of the			in-serviced all dietary staff related to the		
	kitchen was conducte	ed with the Assistant Dietary			labeling and dating of food items inclu	ding	
	•	ation of the walk-in cooler			dating mighty shakes according to		
		10 cartons of chocolate			manufacturing guidelines. After 5/24/1		
		ments and eight sugar free			no dietary staff member will be allowed		
		s. All the mighty shakes			work until receiving this in-service. Thi		
		not have a date on any of			in-service will be part of the orientation	ו	
		hen the mighty shakes had			process for all newly hired dietary		
		ctions on the carton stated			employees and maintenance staff.		
		n should be used within			Dy 5/24/19 the interim CDM accietan	+	
	-	Assistant Dietary Manager			By 5/24/18, the interim CDM, assistan		
		he stock expiration date and			dietary manager, and/or corporate die		
	after thawed.	as a 14-day discard date			consultant will complete the in-service		
	anei maweu.				with all dietary staff on the correct temperatures for the dish machine wa	eh	
				- 1	temperatures for the distributine wa	311	

Facility ID: 923021

If continuation sheet Page 151 of 171

	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TIF		CONSTRUCTION	1	O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
			7. 20122110				С
		345293	B. WING			04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
		AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489				
	D FINES HEALTHCARE			HA	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 812	Continued From page	e 151	F 81	12			
	was conducted with t				include actions to take when temperat	ure	
		on revealed the following: an			is not within acceptable range. After		
		hat appeared to be raisin			5/24/18, no dietary staff member can	work	
		ackage was not labeled or			until receiving this in-service. This		
oj 1/ ui Ti trj a jo	-	1 bag of chicken breasts			in-service will be part of the orientation	ו	
	1/5 bag of chicken te	ed or dated when opened;			process for all newly hired dietary employees and maintenance staff.		
	undated.				employees and maintenance stair.		
					To ensure the deficiency of Food		
	The Assistant Dietary	Manager stated she was			Procurement,		
		one in the kitchen but it was			Store/Prepare/Serve-Sanitary does no		
	a challenge with havi			recur, the administrator has hired a CI	DM		
		nad just given an in-service and dating things. She			to manage and direct the dietary department. On 5/11/18, the CDM wa	•	
		one while she was on			hired and, pending the results of the	5	
		beling and dating. Her			pre-employment background checks, t	the	
		Ill opened food items to be			CDM will be working in the facility the		
	labeled and dated wh				week of 5/28/18. The job duties of the	;	
					CDM include monitoring inventory,		
		0 AM, a tour of the walk-in			expiration dates, proper food storage,		
		d with the Assistant Dietary			ensuring proper functioning equipmen	t.	
	-	on revealed one box of eggs before; sell by 2/9/18 and 5					
		date on best by/ sell by			The monitoring procedure to ensure the	nat	
		t Dietary Manager said the			the plan of correction is effective and t		
		sh eggs anymore. She was			specific deficiency cited remains corre		
	unaware of the dates	on the boxes of eggs.			and/or in compliance with the regulato	ry	
					requirements		
					The assistant dietary manager, certifie	ed	
					dietary manager, corporate consultant		
					and/or administrator will audit the walk		
					cooler and freezer weekly (on varying		
					days and shifts to include 7 days a we	ek)	
					for 12 weeks to ensure there are no	d	
					expired, undated and/or unlabeled foo items. The audit will include noting if	u	
					thawed mighty shakes are dated and		
					stored according to manufactures		

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 152 of 171

	MENT OF HEALTH AN S FOR MEDICARE & I				PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 812		a 152	F 812	 guidelines. These audits will be documented on the Dietary Audit tool. The CDM, administrator, maintenance assistant, and/or corporate consultant audit the wash and rinse temperatures twice daily (on varying days, five days weekly, including weekends) for 12 weeks. This will be documented on the Dishwasher Temperature log. The monthly QI committee will review results of the Dietary Audit tool and Dishwasher Temperature log monthly 3 months for identification of trends, actions taken, and to determine if corrective actions are effective and solutions sustained. The CDM and/or administrator will pret the findings and recommendations of monthly quality improvement (QI) committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversig The title of the person responsible for implementing the acceptable plan of correction. The dietary manager is responsible for implementing the acceptable plan of correction. 	e will s s s s s s s s s s s s s s s s s s
F 849 SS=D	CFR(s): 483.70(o)(1)-	-(4)	F 849		5/24/18
	§483.70(o) Hospice s	ervices.			

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 153 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 04/26/2018		
	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 849	§483.70(o)(1) A long- do either of the follow (i) Arrange for the pro- through an agreement Medicare-certified ho (ii) Not arrange for the services at the facility a Medicare-certified h resident in transferrin arrange for the provis when a resident requivant §483.70(o)(2) If hosp LTC facility through a paragraph (o)(1)(i) of the LTC facility must requirements: (i) Ensure that the ho professional standard to individuals providint to the timeliness of the (ii) Have a written age that is signed by an a the hospice and an a the LTC facility before any resident. The wr at least the following: (A) The services the provide based on ead (D) A communication communication will be LTC facility and the h	eterm care (LTC) facility may ving: ovision of hospice services at with one or more spices. e provision of hospice r through an agreement with hospice and assist the g to a facility that will sion of hospice services ests a transfer. ice care is furnished in an n agreement as specified in this section with a hospice, meet the following spice services meet ds and principles that apply ng services in the facility, and us services. reement with the hospice outhorized representative of uthorized representative of e hospice care is furnished to itten agreement must set out hospice will provide. ponsibilities for determining ce plan of care as specified a chapter. LTC facility will continue to ch resident's plan of care. process, including how the e documented between the ospice provider, to ensure resident are addressed and	F 84	49			

If continuation sheet Page 154 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/201 FORM APPROVEI OMB NO. 0938-039		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 04/26/2018		
	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 849	 (E) A provision that the notifies the hospice at (1) A significant chan mental, social, or em (2) Clinical complicat alter the plan of care. (3) A need to transfer for any condition. (4) The resident's deater (F) A provision stating responsibility for determination to char provided. (G) An agreement the resided nursing needs in coor representative, and e provided is appropriative approvided is appropriative (H) A delineation of the including but not limited direction and manage counseling (including bereavement); social supplies, durable me necessary for the pal associated with the termined appropriation of the provision that with the termined appropriation of the pal associated with the termined appropriation of the provision that with the termined appropriation of the part of the	the LTC facility immediately about the following: ge in the resident's physical, otional status. ions that suggest a need to the resident from the facility ath. g that the hospice assumes ermining the appropriate re, including the nge the level of services at it is the LTC facility's sh 24-hour room and board ent's personal care and rdination with the hospice ensure that the level of care tely based on the individual the hospice's responsibilities, ted to, providing medical ement of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs liation of pain and symptoms erminal illness and related her hospice services that are te of the resident's terminal anditions.	F 84	19			

Facility ID: 923021

If continuation sheet Page 155 of 171

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 0. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345293	B. WING		C 04/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP COE	DE	
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 PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 849	Continued From page	e 155	F 849			
		state law and as specified by				
	-	g that the LTC facility must ations involving				
	mistreatment, neglec	t, or verbal, mental, sexual,				
		ncluding injuries of unknown opriation of patient property				
	by hospice personne	I, to the hospice				
	administrator immedi becomes aware of th	ately when the LTC facility				
		he responsibilities of the				
	hospice and the LTC	•				
	bereavement service	s to LTC facility staff.				
		TC facility arranging for the				
	provision of hospice	care under a written gnate a member of the				
	-	ary team who is responsible				
		vice representatives to				
		e resident provided by the				
	LTC facility staff and	hospice staff. The I member must have a				
		unction within their State				
	-	, and have the ability to				
		or have access to someone				
	that has the skills and resident.	d capabilities to assess the				
		disciplinary team member is				
	responsible for the fo					
	•	hospice representatives				
	-	c facility staff participation in				
	residents receiving the	nning process for those				
		ith hospice representatives				
		providers participating in the				
	•	he terminal illness, related				
		conditions, to ensure quality				
	of care for the patient	t and family.				

Facility ID: 923021

If continuation sheet Page 156 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG			C
		345293	B. WING	26/2018			
NAME OF PI	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	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 849	with the hospice med attending physician, a participating in the pro- as needed to coordina medical care provided (iv) Obtaining the follo hospice: (A) The most recent to each patient. (B) Hospice election (C) Physician certific the terminal illness sp (D) Names and conta personnel involved in patient. (E) Instructions on ho 24-hour on-call system (F) Hospice medicati each patient. (G) Hospice physicia any) orders specific to (v) Ensuring that the orientation in the polio facility, including patie and record keeping re furnishing care to LTC §483.70(o)(4) Each L care under a written a each resident's writte the most recent hospid description of the serv facility to attain or ma practicable physical, n well-being, as require This REQUIREMENT by:	 LTC facility communicates ical director, the patient's and other practitioners ovision of care to the patient ate the hospice care with the d by other physicians. Dwing information from the hospice plan of care specific form. ation and recertification of patient. act information for hospice hospice care of each bow to access the hospice's m. bow no adtending physician (if peach patient. LTC facility staff provides cies and procedures of the ent rights, appropriate forms, equirements, to hospice staff C residents. TC facility providing hospice agreement must ensure that n plan of care and a vices furnished by the LTC intain the resident's highest mental, and psychosocial 	F	349	F 849		

Facility ID: 923021

If continuation sheet Page 157 of 171

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 09 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETE	
					с	
		345293	B. WING		04/26/2	018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
RICHWON	D FINES HEALTHCARE	AND REPABILITATION 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COM	(X5) MPLETIO DATE
F 849	Continued From page	e 157	F 84	9		
		cility failed to coordinate care				
		vider for 1 of 1 residents		The plan of correcting the specific		
		wed for hospice care. The		deficiency		
	findings included:			The position of Richmond Pines Nu		
				and Rehabilitation center regarding		
		mitted to the facility on		process that led to this deficiency w	as the	
		cently readmitted on 4/9/18		staff failure to coordinate care with hospice and obtain hospice		
		es that included Alzheimer ' behavioral disturbance,		documentation.		
		se, Diabetes Mellitus, and				
	muscle weakness.	,,		On 4/25/18, the facility received pro	gress	
				notes and the hospice current plan		
	A review of Resident			for Resident #13 via fax. By 5/22/18		
		der the care of hospice		documents were uploaded in Resid	ent	
	since her readmission	n to the facility on 4/9/18.		#13's electronic medical record.		
	The significant chang	ge Minimum Data Set (MDS)				
		12/18 indicated Resident		The procedure for implementing the		
		understood and rarely never		acceptable plan of correction for the	e	
		ort-term and long-term		specific deficiency cited.		
	impaired decision ma	ed and she had severely		On 5/18/18, the minimum data set (
	-	e prior to her readmission to		nurse and MDS coordinator began		
	-	this MDS review period		audit to protect other residents from		
	while at the facility.	, I		deficiency of not having documente		
	-			coordinated care between the facilit		
	-	of care included the focus		the hospice provider. The audit cov		
		This area was initiated on		each hospice resident's hard chart		
	4/19/18.			electronic medical record to ensure hospice documentation, including		
	The medical record w	vas reviewed and revealed		progress notes and current plan of	care	
		lan of care and the hospice		were present. The 100% audit of ho		
		not in Resident #13 ' s		residents' charts for hospice		
	medical record.			documentation, progress notes, and		
				current plan of care was completed		
		ducted with Resident #13 's		5/23/18. The audit result: document		
		15 PM. She confirmed		and updates were needed for multip	ble	
		en receiving hospice care n to the facility on 4/9/18.		residents.		

Facility ID: 923021

If continuation sheet Page 158 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				1 APPROV . 0938-03
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE COMPI	LETED
		345293	B. WING		04/2	, 26/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 849	Continued From pag	le 158	F 84	9		
				On 5/18/18, the quality impro	ovement (QI)	
	On 4/25/18 at 11:00	AM the hospice		nurse in-serviced the admini		
		esident #13 providing		nurses and social worker rel		
	evidence of the coor requested from the A			coordinating care with hospi obtaining resident's current p and progress notes.		
	On 4/25/18 at 2.00 F	PM the MDS Coordinator		and progress notes.		
		ogress notes and the hospice		On 5/18/18, the QI nurse in-	serviced	
		for Resident #13. These		medical records related to pl	lacing hospice	
		icated to have been faxed to		documentation in the resider	nt's medical	
		8 at 1:17 PM. The MDS		record.		
		ed what staff member was		As of 5/24/18, the social wor	-	
		dinating care with the hospice		the hospice service provider		
	was not her.	I she was not sure, but that it		meeting dates and times. O director of nursing met with a		
	was not net.			representative. The facility h		
	The Director of Nurs	ing (DON) was unavailable		expectation with the hospice		
	for interview.			provider that a hospice repre	esentative	
				(nurse, social worker, and/or	-	
		nducted with the Quality		assistant) will attend care pla	-	
		se on 4/25/18 at 3:24 PM.		of residents receiving hospic		
		asked what staff member was		of 5/24/18. This new proces	-	
		dinating care with the hospice ited it was DON who was		will serve to protect Residen other hospice residents at th		
		dination of care with the		ensuring continuity and coor		
	•	e QA Nurse stated she		care.		
		e documentation to be				
		ty as required per the		The monitoring procedure to		
	regulations.			the plan of correction is effect specific deficiency cited rem	ains corrected	
		nducted with the 6/18 at 7:20 PM. She stated b be coordinated with the		and/or in compliance with the requirements	e regulatory	
	-	he indicated she expected		On 5/18/18, the MDS nurse	and MDS	
		ntation to be available at the		coordinator began auditing h		
	facility as required po			residents to ensure the facili		
				coordinating the resident pla		
				hospice using the Hospice A		
				audit will be completed for a	II hospice	

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 159 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	
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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 849 F 865 SS=E	CFR(s): 483.75(a)(2)	closure/Good Faith Attmpt (h)(i)	F 84	 residents weekly x 4 weeks the every-other week x 8 weeks be administrative nurse. The MDS nurse or director of (DON) will present the findings Hospice Audit Tool at the mon committee. The monthly QI cc will review the results of the H Audit Tool monthly for 3 month identification of trends, actions to determine the need for and, frequency of continued monitor make recommendations for m continued compliance. The MDS coordinator and/or I present the findings and recommendations of the month committee to the quarterly exequality assurance (QA) comm further recommendations and related to coordination of care hospice services. The title of the person responsion implementing the acceptable plan of correction. 	y an nursing s from the thly QI committee ospice ns for s taken, and /or oring, and onitoring for DON will hly QI ecutive ittee for oversight with sible for plan of plementing

Facility ID: 923021

If continuation sheet Page 160 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/20 FORM APPROV OMB NO. 0938-03
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		04/26/2018
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
	D PINES REALI ICARE	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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
E 005		100			
F 865	Continued From page		F 8	65	
		it its QAPI plan to the State			
	, , ,	er than 1 year after the			
	promulgation of this r	egulation;			
	\$492 75(b) Disalasur	a of information			
	§483.75(h) Disclosure A State or the Secret				
		ords of such committee			
		ich disclosure is related to			
		ch committee with the			
	requirements of this s				
	§483.75(i) Sanctions.				
		by the committee to identify			
		ficiencies will not be used as			
	a basis for sanctions.				
		is not met as evidenced			
	by: Based on record rev	iow chaonyotion			n/Plan
		Practitioner and staff and		F 865 QAPI/QAA Program	n/Plan
	resident interviews, th			The plan of correcting the	specific
		urance (QAA) committee		deficiency	speeme
		lemented procedure and to			
	· ·	ntions that the committee		The position of Richmond	Pines Nursing
		ng the 10/12/17 complaint		and Rehabilitation Center	•
		and 6/9/17 recertification		process that led to this def	c
	survey. This was for	the thirteen (13) recited		failure to follow establishe	-
	deficiencies (Coordin	ation of Preadmission		related to QAPI.	
		ent Review (PASRR),			
		ty, Choices, Minimum Data			
		Comprehensive care plan,		The procedure for implement	
		lan, Quality of Life, Activity of		acceptable plan of correct	ion for the
		e, Accident, Unnecessary		specific deficiency cited	
		, and Drug regimen review)		$D_{\rm M} = 5/24/10$ the comparate	facility
	which were cited on 1	•		By 5/24/18, the corporate	-
		and 6/9/17 recertification rrent recertification survey of		consultant will in-service the administrator, director of n	
	-	ed failure of the facility		nurse, admissions, activiti	-
			1		
		ral surveys of record show a		maintenance director, diet	

Facility ID: 923021

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/20 MAPPROVE 0. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		· ,		CONSTRUCTION		E SURVEY	
		345293	B. WING			04	C I/26/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	Continued From page	e 161	F	365			
	effective QAA progra				housekeeping supervisor related to th	ne	
					appropriate functioning of the QAPI		
	Findings included:				Committee and the purpose of the		
	This tag is cross refe	rred to:			committee to include identify issues a correct repeat deficiencies related F6	00,	
	1 E 600 - Neglect - B	ased on observation, record			F550, F561, F641, F644, F656, F657 F675, F677, F689, F757/758, F883, a		
	-	s with staff, police, and the			By 5/24/18 the administrator will facili		
		P), the facility neglected to			a quarterly quality assurance and		
	provide adequate sur	pervision for a cognitively			performance improvement (QAPI)/QA	λA	
	-	nt (Resident #45) with			Executive Committee meeting to revie	ew	
		ehaviors and a history of			the purpose and function of the QAA		
		e behaviors. Resident #45			committee and review on-going		
		a cognitively impaired female			compliance issues. The Medical Direct		
		or, and exposed his genital			Administrator, DON, MDS nurse, Diet	-	
	residents reviewed for	 This was for 1 of 1 			Manager, maintenance director, med records, and housekeeping superviso		
		i negleet.			attend QAPI Committee Meetings on		
	During the complaint	investigation survey of			ongoing basis and will assign addition		
		was cited F 600 for failure to			team members as appropriate.		
	protect a resident from	m harm.			The facility QAPI committee will meet	a	
					minimum of monthly and Executive Q	API	
		ased on record review,			committee meeting a minimum of		
		interview, the facility failed			quarterly to identify issues related to		
		feeding resident while wet			quality assessment and assurance	I	
	for dignity (Resident a	sampled residents reviewed			activities as needed and will develop implement appropriate plans of action		
		#09).			identified facility concerns.	1101	
	During the recertification	tion survey of 6/8/17, the			The Executive QAPI committee, inclu	dina	
		0 for not providing showers			the medical director, will review quart	-	
	to residents.				compiled QAPI report information, rev	-	
	3 E 561 Chainan	Based on record roviow			trends, and review corrective actions	ho	
		Based on record review, d staff interviews, the facility			taken and the dates of completion. T Executive QAPI committee will valida		
		dent's choice to receive			the facility s progress in correction o		
		ice for showers over bed			deficient practices or identify concern		
	baths for two of eight				The administrator will be responsible		
	(Resident #11 and #6	-			ensuring QAPI committee concerns a		
					addressed through further training or		

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 162 of 171

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/2 FORM APPRO OMB NO. 0938-0
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		04/26/2018
NAME OF PF	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COD	
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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
F 865	Continued From page	e 162	F 865	5	
	During the recertificat	tion survey of 6/9/17, the for not honoring the family		other interventions.	
	 4. F 641 - MDS accur review, observation a failed to promote digr wet and soiled for 1 of reviewed for dignity (I During the recertificat facility was cited F 64 assessments accurat and diagnoses. 5. F644 - Coordinatio record review and stat to make a referral for significant change in residents (Resident # Preadmission Screen II status. During the complaint 10/12/17, the facility of 	tion survey of 6/9/17, the 11 for not coding the MDS rely in the areas of dental an of PASRR - Based on aff interview, the facility failed re-evaluation after a condition, for 1 of 1 sampled 58) reviewed for hing Resident Review Level t investigation survey of was cited F644 for failure to		As of 5/24/18, after the facility in-service, the facility QAPI C begin identifying other areas of concern through the QI review for example: review of rounds review of work orders, review Click Care (Electronic Medica review of resident council min of resident concern logs, revie pharmacy reports, review of a to the plan of correction and r regional facility consultant recommendations. The Facility QAPI Committee a minimum of monthly and Ex QAPI committee meeting a m quarterly to identify issues rel quality assessment and assur activities as needed and will of implementing appropriate plan for identified facility concerns.	ommittee will of quality w process, s tools, of Point al Record), nutes, review ew of audits related review of will meet at kecutive inimum of ated to rance develop and ns of action
	6. F 656 - Develop ar	dent with PASRR level 11. nd Implement Care Plan - ew and staff interview, the ment the plan of care		Corrective action has been ta identified concerns related to deficiencies.	
	#34, and #58) review During the recertificat facility was cited F65	tion survey of 6/9/17, the 6 for failure to complete a		The monitoring procedure to a the plan of correction is effect specific deficiency cited rema and/or in compliance with the requirements	tive and that ins corrected
	comprehensive and li	ndividualized care plan.		The executive QAPI committe	e will

Facility ID: 923021

If continuation sheet Page 163 of 171

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/30/2018 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345293	B. WING			04	C / 26/2018
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		HIG	REET ADDRESS, CITY, STATE, ZIP CODE SHWAY 177 S BOX 1489 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	record review and stat to review and revise p current status of the r (Residents #13 and # During the recertificat facility was cited F 65 care plan for wanderi involve alert and orier planning process. 8. F675 - Quality of L resident interviews an failed to provide psyco ordered for 1 (Reside reviewed for unneces During the recertificat facility was cited F 67 psychiatric consult as 9. F 677 - ADL care - observation and staff to provide incontinem nail care (Resident # residents reviewed for (ADL). During the recertificat facility failed to provid 10. F689 - Accident - record reviews, and ip police, and the Nurse failed to implement fa Resident #13 for two sustained a nasal fract	vise Care Plan - Based on aff interview, the facility failed plans of care to reflect the resident for 2 of 25 residents (58) reviewed. tion survey of 6/9/17, the 57 for failure to revise the ing and falls and for failure to inted residents in the care Life - Based on staff and ind record review, the facility chological services as ent #68) of 6 residents asary medications. tion survey of 6/9/17, the 75 for failure to obtain as ordered. Based on record review, interview, the facility failed t care (Resident #69) and	F 84		continue to meet at a minimum of Quarterly, and QAPI committee mont with oversight by a corporate staff member. The Executive QAPI Committee, inclu- the Medical Director, will review quar compiled QAPI report information, re- trends, and review corrective actions taken and the dates of completion. T Executive QAPI Committee will valida the facility s progress in correction of deficient practices or identify concern The administrator will be responsible ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable pla correction.	uding terly view he ate of s. for	

If continuation sheet Page 164 of 171

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 26/2018
NAME OF PI	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489		
				1	HAMLET, NC 28345		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
TAG F 865	Continued From page impaired male resider him from exposing his cognitively impaired fe #13). The facility add Resident #16's wand monitor exit seeking b impaired residents) an analyze falls to deterr implement appropriate further falls (Resident was for 6 of 7 residen During the recertificat facility failed to preven resident from exiting to 11. F 757/758 - Unner Based on record revie Practitioner and staff administered an antip resident without a phy #39) and failed to ensy psychotropic medicat duration for 6 of 6 sar unnecessary medicat #38, #22, #39 and #55 During the recertificat facility was cited F757 administer medication	e 164 th (Resident #45) to prevent a genital region to a emale resident (Resident itionally failed to monitor der guard (a device used to behaviors for cognitively nd failed to thoroughly nine causative factors and e interventions to prevent s #22, #50, and #69). This ts reviewed for accidents. ion survey of 6/9/17, the nt cognitively impaired the facility unsupervised. cessary medications - ew and Pharmacists, Nurse interviews, the facility sychotic medication to a visician 's order (Resident sure that as needed (PRN) ions are time limited in npled residents reviewed for ions (Residents #13, #58, 2). ion sur vey of 6/9/17, the 7/758 for failure to as as ordered, failure to plood pressure, and failure		865	DEFICIENCY)	ΔTE	DATE
	interview, the facility f regarding the benefits of the influenza immu	and Pneumococcal ed on record review and staff ailed to provide education and potential side effects nization before offering the cumentation in the resident '					

Facility ID: 923021

If continuation sheet Page 165 of 171

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/30/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345293		B. WING		C 04/26/2018	
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP C 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 865	s medical records (Re offer the influenza im influenza season (Oc for 2 of 5 sampled res During the recertifica facility was cited F 88 pneumococcal vaccir 13. F 756 - Drug Reg record review and Pr interview, the Pharma identify and to report physician for 1 of 6 s for unnecessary med During the recertifica facility was cited F 75 AIMS assessment for medication. On 4/26/18 at 7:25 P interviewed regarding program. The Admin had a QAA program department heads in Director of Nursing al indicated that the cor She revealed that she Administrator and she deficiencies from the Administrator stated f repeat deficiencies w system in place and f monitoring the impler	esident # 37) and failed to munization during the tober-March) (Resident #52) sidents reviewed. tion survey of 6/9/17, the 33 for failure to administer he as ordered timen Review - Based on harmacy Consultant and staff acy Consultant failed to drug irregularities to the ampled residents reviewed lications (Residents #39). tion survey of 6/9/17, the 56 for failure to request an r a resident on antipsychotic M, the Administrator was g the facility ' s QAA istrator stated that the facility	F 86	5	
F 883	place. Influenza and Pneum	nococcal Immunizations	F 88	3	5/24/18

Facility ID: 923021

If continuation sheet Page 166 of 171

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 26/2018
NAME OF P	ROVIDER OR SUPPLIER		- I	STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HWAY 177 S BOX 1489 MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	383 Continued From page 166		F 8	83			
	policies and procedur (i) Before offering the each resident or the r receives education re potential side effects (ii) Each resident is or immunization Octobe annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident was provided educati and potential side effect immunization; and (B) That the resident immunization or did n immunization due to r refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization; and potential immunization;	za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically resident has already been a time period; e resident's representative or feuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza nedical contraindications or ococccal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal					

Facility ID: 923021

If continuation sheet Page 167 of 171

	-	ND HUMAN SERVICES			PRINTED: 05/30/2 FORM APPRO OMB NO. 0938-0:
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		04/26/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
RICHINION	D FINES 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETI E APPROPRIATE DATE
F 883	Continued From page	<u>- 167</u>	F 88	83	
1 000		ated or the resident has	1.00		
	already been immuni				
	•	ie resident's representative			
		o refuse immunization; and			
	(iv)The resident's me	dical record includes			
		ndicates, at a minimum, the			
	following:	or regidently representative			
		or resident's representative ion regarding the benefits			
		ects of pneumococcal			
	immunization; and				
	(B) That the resident	either received the			
		nization or did not receive			
	-	munization due to medical			
	contraindication or re	iusal.			
	by:	is not met as evidenced			
		iew and staff interview, the		F883 Influenza	
		le education regarding the			
	benefits and potentia	I side effects of the influenza		The plan of correcting the sp	ecific
		cumentation in the medical		deficiency	
	records before offerin	• · · · · · · · · · ·			
	. ,	ailed to offer the influenza		The position of Richmond Pil	-
	immunization during (October-March) (Re			and Rehabilitation center reg process that led to this defici	-
		viewed. Findings included:		staff failure to follow establis	-
				and procedure related immu	
	The facility's policy/pi	rocedure on immunization		include documenting and/or	
	dated 10/18/17 was r			education and offering the in	
	indicated that before	-		vaccine during the influenza	season.
		sident or resident's legal			wamant
	representative will be			On 5/18/18, the quality impro (QI)/Infection Control nurse p	
	reagraina the heretite				
	regarding the benefits			Resident #37 education incl	udina risk
	of the immunization v	vith documentation in the		Resident #37 education, incl versus benefits related to the	5
	of the immunization v	vith documentation in the policy also indicated that		Resident #37 education, incl versus benefits related to the vaccine, for the influenza vac	e influenza
	of the immunization v medical record. The residents will be offer	vith documentation in the policy also indicated that		versus benefits related to the	e influenza

Facility ID: 923021

If continuation sheet Page 168 of 171

		ND HUMAN SERVICES				05/30/201 PPROVEI
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		345293	B. WING		C 04/26	6/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
DICUMON				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES REALTINGARE	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 883	Continued From pag	e 168	F 88	3		
	Continued i rom pag		1 00	influenza vaccine due to the	flu season	
	1. Resident #37 was	admitted to the facility on		ended at the end of March, p		
		le diagnoses including		Centers of Disease Control (
		oulmonary disease (COPD).		guidelines.	,	
	The annual Minimum	n Data Set (MDS)				
		/9/18 indicated that Resident				
	# 37's cognition was	intact.		The procedure for implement		
	Resident #37's immu	inization record was		acceptable plan of correction	for the	
		dis revealed that Resident		specific deficiency cited		
		luenza immunization on		On 5/18/18, the QI nurse beg	nan auditing	
		ds did not indicate that		100% of resident records to		
	education was provid	ded to Resident #37		received education related to	•	
		ts and the potential side		vaccine, if the resident was r		
	effects of the influen:	za immunization.		facility during the flu season		
	0 4/00/40 40.00			the vaccine. The QI nurse in	2	
	On 4/26/18 at 6:20 F	-		addressed any questions or	concerns with	
		Control(QA/IC) Nurse was ated that she mailed the		the resident and/or resident representative. The audit wa	s 100%	
		the benefits and potential		completed by 5/24/18. Four i		
		fluenza immunization to the		were found without education		
		ative (RP) but did not		documented in the electronic		
	-	so indicated that she could		record. The QI nurse contact	ted the	
	not find documentati	on that the education was		resident representative and e		
	provided to Resident	t #37.		provided then documented ir	n the	
	0- 40040 17 00 5			electronic health record.		
		PM, the Administrator was		Depidents not offered the infl	00070	
		ated that she expected the esident's legal representative		Residents not offered the infl vaccine during the 2017-201		
		education regarding the		will not be offered the vaccin		
		al side effects prior to offering		flu season ended at the end		
	•	ization and to document in		2018, per the CDC guideline		
	the resident's medica	al records that education was				
	provided.			On 5/18/18, the QI and SF n		
				in-servicing all registered nui		
	0 Desident #50			and licensed practical nurses		
		admitted to the facility on		including part time (PT), as r (PRN), and agency. To prote		
I	G(1)(1) = G(1)(1)	diagnoses including				

Facility ID: 923021

If continuation sheet Page 169 of 171

		MEDICAID SERVICES				<u>IO. 0938-03</u>	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 4/26/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		4/20/2010	
				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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 883	Continued From page	e 169	F 88	3			
	Continued From page 169 Data Set (MDS) assessment dated 4/15/18 indicated that Resident #52 had memory and decision making problems. Resident #52's immunization record was reviewed. The records indicated that Resident #52 did not receive influenza immunization during the immunization season (October - March). On 4/26/18 at 6:20 PM, the Quality Assurance/Infection Control (QA/IC) Nurse was interviewed. She stated that she could not find documentation in the medical records that Resident #52 was offered influenza immunization during the immunization season. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that her expectation was for the influenza immunization to be offered to all residents during the immunization season and to document in the resident's medical records the administration or the refusal.		 F 883 in-service covers the facility's policy/procedure related to immunizat to include providing and documenting education related to risk versus benefin prior to offering the influenza vaccine. The in-service will be completed by 5/24/18. After 5/24/18, no licensed nuincluding PT, PRN, and agency will be allowed to work without completing the in-service. This in-service will be adde the orientation for all newly hired nurse including PT, PRN, and agency. On 5/18/18, the QI and SF nurses begin-servicing all RN's and LPN's, including PT, PRN, and agency, related to offering the influenza vaccine during fiseason (October-March) per the CDO guidelines. The in-service will be completed by 5/24/18. After 5/24/18, licensed nurse, including PT, PRN, and agency. The monitoring procedure to ensure to the plan of correction is effective and specific deficiency cited remains correction is compliance with the regulator requirements. 			ions ians its rse, e e ed to es gan ling b u u no id t the es e so to t the es e so to to es to to es to to es to to es to to es to to es to to es to to to to to to to to to to to to to	
				if the resident receives a vaca education was provided and a in the resident electronic heal This audit will aide in protection in similar situations. The aud	locumented th record. ng residents		

Event ID: SXJZ11

Facility ID: 923021

If continuation sheet Page 170 of 171

STATEMENT OF DEFICIENCIES (N) PROVIDER OR STRUCTION (N) DATE BURCH (N) DATE BURC			ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 05/30/2013 FORM APPROVEI MB NO. 0938-039	
345293 B. WIND Odd/28/2018 NAME OF PROVIDER OR SUPPLIER STREET AUDRESS, CITY, STATE, ZP CODE HIGHWAY 177 S BOX 1485 RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE IPO PROVIDER SPLAN OF CORRECTION HIGHWAY 177 S BOX 1485 Deproceed/Deproc	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	· · /			3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS.CUTY, STATE.21P CODE RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE Itelefanor (Complete) IMAMAY 177 8 B0X 1489 MALLET, NO 28345 (CA) ID PREFIX ISUMMARY SIMULATION OF DERICIPACIES (EACH DEPRICIPEO YOR LSC DENTIFYING INFORMATION) ID PREFIX (EACH DEPRICIPEO YOR LSC DENTIFYING INFORMATION) ID PREFIX (TAG) ID PREFIX (TAG) ID PREFIX (EACH DEPRICIPEO YOR LSC DENTIFYING INFORMATION) ID PREFIX (EACH DEPRICIPEO YOR LSC DENTIFYING IN			345293	B. WING				
PREFIX TAG REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Contencement and the properties of the precedence of the preced	NAME OF PROVIDER OR SUPPLIER			HIGHWAY 177 S BOX 1489			04/20/2016	
documented on the Vaccine Audit Tool. 5 resident records will be audited weekly x 4 weeks, the biweekly x 8 weeks to monitor and ensure the system remains in place and the problem does not recur. The QI nurse will present findings from the Vaccine Audit at the monthly QI committee. The monthly QI committee will review the results of the Vaccine Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The QI nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH COR	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	COMPLETION	
	F 883	Continued From page	∋ 170	F 8	 documented on resident records weeks, the biwe and ensure the s and the problem The QI nurse wi the Vaccine Aud committee. The will review the retorn of trends, action the need for and continued monit recommendation continued comp The QI nurse wi recommendation continued comp The title of the p implementing the correction. The director of m implementing the correction of the content of the con	 will be audited weekly x ekly x 8 weeks to monitor system remains in place does not recur. Il present findings from it at the monthly QI monthly QI committee esults of the Vaccine Audi 3 months for identification s taken, and to determine for frequency of oring, and make ns for monitoring for liance. Il present the findings and ns of the monthly QI e quarterly executive e (QA) committee for e acceptable plan of 	4 r it in e	

Facility ID: 923021

If continuation sheet Page 171 of 171