PRINTED: 11/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C <b>10/18/2018</b>
	ROVIDER OR SUPPLIER  D PINES HEALTHCARI	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, S HIGHWAY 177 S BOX 148 HAMLET, NC 28345		
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F 558 SS=D	S483.10(e)(3) The riservices in the facility accommodation of right preferences except endanger the health other residents. This REQUIREMEN by:  Based on observatificatility failed to make accommodations of residents investigate (Resident #68).  The findings included Resident #68 was on 4/16/16 and was 10/10/18. The resident included: Diabetes, legs and both arms)  A review was complied revealed a quarterly Assessment Reference The resident was concept assistance mobility. The resident totally dependent or following Activities of dressing, eating, toil bathing.  A review was complied to the review was complied to the review was complied to the resident was concept as a sistance was assistance was assistance which was sistance which was most of the review was complied to the review was complied	ight to reside and receive by with reasonable esident needs and when to do so would for safety of the resident or a safety of the resident or and staff interviews the ereasonable needs for one of four ed for functional call lights add:  riginally admitted to the facility most recently readmitted on tent's cumulative diagnoses quadriplegia (paralysis of both and, anxiety, and heart failure.  eted of Resident #68's most that Set (MDS). The review assessment with an ance Date (ARD) of 9/29/18. And a shaving required the of two people for bed that was coded as having been and one to two people for the form of the form of the second of	F 5	Richmond Pines Rehabilitation Ce receipt of the Stat and proposes this the extent that the factually correct a compliance with a provisions of qual The Plan of Corre written allegation Richmond Pines Rehabilitation Ce Statement of Defi denote agreemen Deficiencies nor o admission that an Further, Richmon Rehabilitation Ce refute any of the o Statement of Defi Informal Dispute o appeal procedure administrative or  F 558  How corrective ac accomplished for	nter acknowledges tement of Deficiencies s Plan of Correction to e summary of findings and in order to maintai applicable rules and lity of care of residents ection is submitted as of compliance. Healthcare and inter's response to this iciencies does not at with the Statement of does it constitute an inter reserves the right deficiencies on this iciencies through Resolution, formal e and/or any other legal proceedings.  ction will be those residents found	is n s. a of tte. nd t to
BORATORY	NIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	L F	TITLE	 E	(X6) DATE

11/08/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE				
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T. O. I. III O. I.	DI INCOTICACITICANE	AND REMADIEMATION SERVE		HAN	MLET, NC 28345				
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F 558	F 558 Continued From page 1		F 5	558					
		related to the resident		_   ı	have been affected by the deficient				
	having been a quadriplegic and requiring total				practice				
	care including: Bathin			'	praedice				
		sferring (such as from the			On 10/17/18, the maintenance director				
		mobility, and toileting.			ordered a soft touch call pad for Reside				
	bod to a Wilcolonany,	mosmity, and tonothing.			#68's use. On 10/18/18, the maintenal				
	Review of Resident #	68's Care Guide, which was			director received the soft touch call page				
		/18, revealed the listed			and installed it in Resident #68's room				
		two people, feed resident,			On 10/18/18, Resident #68 was able to				
	and encourage to cal		(	demonstrate use of the soft touch call pad.					
	An interview was con	ducted in conjunction with		'					
		sident #68 and Resident							
	#68's call light was co	onducted on 10/15/18 at							
	12:20 PM. The obser				How the facility will identify other reside	ents			
	resident's standard by	utton call light was on the		having the potential to be affected		ne			
	night stand and the re	esident was resting in the		;	same deficient practice				
	bed. The resident sta	ated he could not use his							
	hands, but he could n	nove his hands. The		(	On 11/9/18, the minimum data set (MD	S)			
	resident stated he wa	s unable to use the call light		1	nurse and director of nursing (DON)				
	button. The resident	further stated when he		1	reviewed resident care plans to identify	1			
	needed the nurse he	would either wait for the		1	residents requiring reasonable				
	nurse to come to the	room or call out for the		6	accommodations relating to call lights a	and			
	nurse.			1	the type of call light needed. On 11/9/1	8,			
					the DON instructed the nurse unit				
		sident #68 and Resident			manager and the maintenance director	to			
	_	onducted on 10/15/18 at 3:50			audit the rooms of residents requiring				
		revealed the resident's			alternative call lights and ensure: 1) th				
		ght was on the night stand			correct call light type was in the room a				
		resting in the bed. The call			accessible and 2) the alternative style	call			
	_	be out of reach of the			light was in working order. The audit				
	resident.				revealed residents identified as needin	g			
					an alternate style call light had the				
		sident #68's call light was			preferred call light in place and it was i	n			
	_	ound on 10/16/18 at 3:16		'	working order.				
		standard button call light was			0 44/0/40 !!				
	_	e resident's night stand out			On 11/9/18, the interdisciplinary team				
	of the resident's reacl	1.			(IDT) began identifying other residents requiring reasonable accommodations				

Facility ID: 923021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
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DICUMON	ID DINIES HEALTHCADE	AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489			
KICHWION	ID PINES REALITICARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
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F 558	F 558 Continued From page 2		F 5	558			
	An observation of Reconducted during a real AM. Resident #68's observed sitting on the of the resident's reach An observation of Reconducted in conjunct Nursing Assistant (N. AM. Resident #68's observed sitting on the of the resident's reach taken care of Resident im. The NA stated from his call light and the NA then stated the relight button but used tap bell. The NA was	esident #68's call light was ound on 10/17/18 at 9:59 standard button call light was ne resident's night stand out		needs for functional call lights assessing new admissions/ re-admissions. The IDT consideration administrator, DON, nursing use manager, MDS nurse, social sedirector, activities worker, their representative, and/or admissed director. The completion of the Admission and Re-Entry Evaluatilized to document identified accommodation of needs for readmitted/ re-admitted resident use of an alternative call light.  What measures will be put into systemic changes made to enthe deficient practice will not re-	ists of the init services rapy ions e Nursing uation will be reasonable newly ts, including		
	and tap bell to the left of the resident.  An interview was conducted with Nurse #1 on 10/17/18 at 10:38 AM. The nurse stated Resident #68 needed a padded call light, such as a soft touch call light. The nurse stated he thought he had had a soft touch call light in the past. The nurse stated she was going to see about getting the resident a soft touch call light for the resident to use.  An interview was conducted with NA #6 on 10/17/18 at 10:41 AM. The NA stated Resident #68 had had a padded/soft touch call light in the past and he could use his are or elbow to ring the call light.  An interview was conducted with the Director of Nursing (DON) on 10/17/18 at 10:44 AM. The DON stated Resident #68 normally would call out			On 10/17/18, the administrator the maintenance director to or additional soft touch call lights there are extra in stock to mediate needs for reasonable accommendation. The administrator and maintendirector agreed there should be soft touch call light for resident touch call lights and an extrastical light in case there is a new use of a soft touch call light by resident (current, new admissing re-admission).  On 11/9/18, the administrator, nursing unit managers, social director, admissions director, weekend manager on duty be reporting to the IDT any resident.	rder s to ensure et resident nodations. nance be a back-up its using soft soft touch of need for y another ion, or  DON, services and/or gan		

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ысниои	D DINES HEAT THOADE	AND REHABILITATION CENTE		HI	GHWAY 177 S BOX 1489		
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F 558	Continued From page when he had wanted he needed something resident had had a so The DON explained to discharged to the hos hospital another resident also needed a so The DON stated soft been removed from Figiven to the new residexplained when Residenthe hospital there wellights for him to use. expectation for a resimechanism which we independently notify to A round and observation conjunction with an in Maintenance Director PM. Resident #68 we standard button call light button resident and it was so overnight delivery on he was not aware Refrom the hospital and touch call lights availareturned from the hospi	to let the facility staff know g. The DON stated the off touch call light button, he resident had been spital and while at the dent had been admitted who off touch call light button, touch call light button had Resident #68's room and dent. The DON further dent #68 had returned from are no more soft touch call. The DON stated it was her dent to have a call light ould allow the resident to the nurse.  Ition was conducted in a soft of the cheduled to arrive via a soft of the cheduled to arrive via 10/18/18. The MD stated is sident #68 had returned there were no more soft able in the facility when he spital.  Inducted with the stated with the soft at 9:16 AM. The stated as a soft touch call when a soft touch call is such as a soft touch call		558	use the standard call light button as not during administrative rounds. Upon notification, the DON and/or MDS nurse will assess the resident, update the resident's care plan, and offer an alternative style call light to accommodate individual resident's call light needs.  On 11/9/18, the admissions director, DON, nursing unit manager, and/or soc services director will begin notification of the need for alternative style (other that standard push button) call lights to the maintenance director during the mornin IDT meeting. The notification will include the specific alternate style required. The maintenance director will ensure alternative style call light is installed promptly and give report at the afternoon IDT meeting.  How the facility plans to monitor its performance to make sure that solution are sustained  On 11/9/18, the nursing unit manager began weekly monitoring of the availabe of extra call lights and alternative style lights. The unit manager will report the monitoring results to the DON weekly. The DON will determine if current inventories are sufficient and if not, the DON will ensure additional call lights and alternative inventories are sufficient and if not, the DON will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure additional call lights and alternative and the poon will ensure	ted e ate cial of n ng de ne on	
	with the MD on 10/18	nterview were conducted 1/18 at 11:10 AM. The MD call light had been delivered			ordered to meet the reasonable accommodations of resident needs.  On 11/9/18, the administrator and/or		

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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
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F 561 F 561 SS=D	promote and facilitate through support of renot limited to the right (1) through (11) of thi §483.10(f)(1) The resactivities, schedules (waking times), health care services consist assessments, and plaapplicable provisions §483.10(f)(2) The reschoices about aspect facility that are significable support of the community activities facility.  §483.10(f)(8) The resparticipate in other activities in other a	mination. right to and the facility must resident self-determination sident choice, including but its specified in paragraphs (f) is section.  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 is 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 stivities, including social,	F 561		11/15/18
	interfere with the righ facility. This REQUIREMENT by: Based on record rev interviews, and reside failed to provide show	rity activities that do not ts of other residents in the is not met as evidenced iew, observations, staff ent interview, the facility vers as scheduled for 1 of 2 or choices (Resident #54).		F 561 Self-Determination  How corrective action will be accomplished for those residents found have been affected by the deficient practice	d to

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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			
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F 561	Continued From page	e 6	F 56	31			
	diagnoses of urinary quadriplegia.  The quarterly Minimu revealed the resident other behavior which week. The resident rassistance of 2 staff f (ADL) except locomo active diagnoses wern and retention of urine.  A review of the reside 8/1/18 to date timefra periods out of the fac approximately 8 days received 5 showers a or partial bed baths o	or all activities of daily living tion was one staff. The e neurogenic bladder, UTI,  ent's shower sheets from me, which included two		On 10/16/18, the nursing assistal interviewed Resident #54 regard bathing preferences. On 10/16/1 unit manager scheduled Resider shower days for days chosen by resident, Wednesdays and Fridatirst shift.  On 10/16/18, the minimum datase (MDS) nurse verified Resident #8 care plan reflected the resident preferences in order to promote self-determination through choice bathing preferences.  On Tuesday 10/16/18 during first nursing assistant (NA) assisted F#54 with a shower, as requested resident that day. On Friday, 10/10/10/10/10/10/10/10/10/10/10/10/10/1	ing 18, the 18, the 18 the 19		
	A review of a grievance form dated 8/22/18 revealed the resident filed a concern that he wanted his shower. The resident was interviewed by the Director of Nursing (DON). Actions documented were the resident was showered (evening shift).  A review of a documented facility concern form dated 8/23/18 by social work (SW) who was informed by the resident that he had not had a shower for 2 weeks.  Nurses' note dated 8/31/18 resident requested a shower and was offered a shower after lunch; the resident was not happy with the delay.			How the facility will identify other having the potential to be affecte same deficient practice  By 11/12/18, the social worker, n and unit managers completed int with all current residents with a E (Brief Interview for Mental Status higher for shower preferences ar scheduled the residents per their individual shower preferences.  Beginning 11/14/18, the admission	residents d by the urses, terviews BIMS e) of 9 or		

Facility ID: 923021

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				HIGHWAY 177 S BOX 1			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
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F 561	Continued From page	e 7	F 5	61			
	The care plan dated interventions for ADL (refused care/shower encourage), toileting, ineffective coping, ur	9/13/18 revealed goals and		services directo admission resid representative r including prefer	g unit manager, or social or will interview new lents or the resident segarding bathing choice the bathing type, days, ensure the resident is ordingly.		
	resident was done, a The resident was in h hair appeared shiny. On 10/15/18 at 12:48 conducted with the re	in 10/15/18 at 12:48 pm an interview was sonducted with the resident who stated he had not received his showers as scheduled; he had ceived bed baths. The resident just returned om the hospital after being treated for a UTI and as still receiving antibiotics. The resident stated at he had a bed bath today. The resident's pain as under control with current pain medication. The resident stated that he preferred a shower and had made the staff aware of his preference		systemic chang the deficient pra On 11/7/18, the	s will be put into place o les made to ensure that actice will not recur DON initiated a		
	received bed baths. from the hospital afte was still receiving and that he had a bed bad was under control wit The resident stated the			shower schedul completed show the process of r showers to the resident prior to 11/14/18, no NA re-education is 11/14/18, newly	r the NAs on: 1) the le, 2) documentation of wers and refusals, and 3 reporting completion of nurse responsible for the the end of the shift. Affa will work until the completed. After a hired NAs, nurses, and nurses will receive thi	B)  ne ter	
	resident revealed he for morning care which strong or unusual odd.  On 10/16/18 at 9:50 at conducted with the remot ready to get up at assistant (NA).  On 10/16/18 at 10:15 conducted to check to assigned Nurse #1 w	am an observation of the was sleeping and not ready ch was accommodated. No or at this time was identified.  am an interview was esident who stated he was not had informed the nursing am an interview was eack with the resident 's who stated NA #1 went in to resident was ready to get		on 11/14/18, the showers provided The NA will not showers, resident needing complete resident refuses confirm the refused resident then do	g orientation to the faciline NAs will document ed and resident refusals ify the nurse of complete ent refusals, and shower etion on the next shift. It is a shower, the nurse we usal by interviewing the ocument the resident seident selectronic hear	ity. s. ed rs f a	

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F 561	Continued From page	e 8	F 5	561			
F 501	Solution of Seed Seed Seed Seed Seed Seed Seed See		F 5	661	How the facility plans to monitor its performance to make sure that solution are sustained  Beginning 11/14/18, the nursing unit manager, wound nurse, MDS nurse, DON, weekend supervisor, and/or corporate consultant will begin daily monitoring of bathing. The monitoring include: 1) review of documentation for the completion of showers, 2) documentation of resident refusals, and interviews with residents/resident representatives. The nursing unit manager, wound nurse, MDS nurse, DON, and/or weekend supervisor will immediately address concerns if bathin is not documented or if a resident is refusing bathing. The monitoring process will continue for a minimum of 12 weekend supervisor will begin audits of	will r d 3) ng ess	
	NA #1 also commented that the resident did rescheduled. The NA versident sometimes parternoon when he had on 10/17/18 at 12:00	d rarely refused his shower. ed that she was not aware not receive his shower when was also aware that the costponed his shower to the ad pain in the morning.  pm an observation was who received a full bed bath			bathing documentation 3 times a week 4 weeks, then weekly for 8 weeks. The nursing unit manager or desk nurse wil communicate the results of the audit to the DON. The nursing unit manager and/or DON will present the findings of the audits to the interdisciplinary team (IDT) for recommendations and correct actions.	  -  -	
	by NAs #1, #2, and #	3. NAs #1 and #3 provided ng of the resident 's stiff legs ed the bed bath. No			The nursing unit manager and/or DON present IDT corrective actions and resident grievance corrective actions to the monthly quality improvement (QI) committee for review, identification of		

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F 561 F 571 SS=B	unless refused. If a s was expected to infor	om an interview was ON who stated she vide scheduled showers shower was refused, the NA rm the assigned nurse.		5571	trends, additional corrective actions, ar recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensur continued compliance in the area of self-Determination related to providing bathing assistance as preferred by the resident or resident representative.	e	11/15/18
33-B	§483.10(f)(11) The facharge against the performent of any item or service under Medicaid or Medicaid or Medicaid eductible. The facility may charge services that are more excess of covered see §489.32 of this chapter prohibition on facility services for which Meg §447.15 of this chapter in the Medicaid progras payment in full, Medeductible, coinsurant by the plan to be paid (i) Services included payment. During the Medicare or Medicaid charge a resident for items and services:	acility must not impose a personal funds of a resident e for which payment is made edicare (except for and coinsurance amounts). If the resident for requested e expensive than or in excess in accordance with er. (This does not affect the charges for items and edicaid has paid. See er, which limits participation am to providers who accept, edicaid payment plus any lice, or copayment required to by the individual.) in Medicare or Medicaid					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 571	§483.60. (C) An activities prog §483.24(c). (D) Room/bed mainte (E) Routine personal as required to meet the including, but not limit comb, brush, bath so specialized cleansing treat special skin prol razor, shaving cream denture adhesive, de moisturizing lotion, tis swabs, deodorant, in supplies, sanitary nay towels, washcloths, ho counter drugs, hair are bathing assistance, a (F) Medically-related at §483.40(d). (G) Hospice services paid for under the Medically paid for by Medicaid (ii) Items and services residents' funds. Para (L) of this section are examples of items and may charge to reside requested by a reside achieve the goals staplan, if the facility info	ram as required at  ram as required.  hygiene items and services, ap, disinfecting soaps or a agents when indicated to blems or to fight infection, toothbrush, toothpaste, nture cleaner, dental floss, asues, cotton balls, cotton continence care and bkins and related supplies, rospital gowns, over the and nail hygiene services, and basic personal laundry, social services as required  relected by the resident and adicare Hospice Benefit or under a state plan.  Is that may be charged to agraphs (f)(11)(ii)(A) through general categories and d services that the facility ants' funds if they are ent, if they are not required to ted in the resident's care forms the resident that there if payment is not made by	F5	571			
	electronic device for	personal computer or other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 571	(D) Cosmetic and groexcess of those for with Medicaid or Medicare (E) Personal clothing. (F) Personal reading (F) Gifts purchased of (H) Flowers and plant (I) Cost to participate entertainment outside program, provided un (J) Non-covered specificately hired nurses (K) Private room, excrequired (for example control). (L) Except as provide of this section, special food requested instead generally prepared by §483.60. (1) The facility may not and meals, including supplements, ordered physician assistant, in nurse specialist, as the §483.60. (2) In accordance with when preparing foods take into consideration preferences and the comake-up of the facility (iii) Requests for item (A) The facility can or non-covered item or service is specifically (B) The facility must reference in the facility must reference in the facility of the facility must reference in the	d novelties, and confections. oming items and services in hich payment is made under an atter. In behalf of a resident. Its. In social events and the scope of the activities der §483.24(c). Italicare services such as for aides. Item therapeutically the injuries of the food and meals the facility, as required by the facility, as required by the resident's physician, urse practitioner, or clinical these are included per the \$483.60(c) through (f), and meals, a facility must in residents' needs and overall cultural and religious of spopulation. In §483.60(c) through (f), and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in social events and services. In social events and services in	F	571			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 571	the resident reques which a charge will charge for the item charge will be. This REQUIREMEN by: Based on record restaff interview, the f Medicaid resident whair trimming for 1 of (Resident #77).  The findings include Resident #77 was in on 9/19/12 and most 10/5/18. Resident # was Medicaid.  The quarterly Minimassessment dated 8 #77 's cognition was	ued stay. It inform, orally and in writing, It inform, orally and information will be a or service and what the  IT is not met as evidenced  Eview, resident interview, and It information interview, and It is not met as evidenced  Eview, resident interview, and It is not met as evide	F 57'	· ·	ctor 77 7 8 of
	indicated under the Resident #77 asked free for the resident An interview was con 10/15/18 at 4:00 PN asked about haircut Resident Council mbrought this up at the hers had informed high per month free at he stated that she had	cil minutes dated 9/27/18 "New Business" section that I if one haircut per month was s.  Inducted with Resident #77 on I. She confirmed she had Is at the September 2018 I eeting. She stated she I me meeting because a friend of I ner that she gets one haircut I facility. Resident #77 I been residing at this facility I did that she was charged for		How the facility will identify other resid having the potential to be affected by t same deficient practice  On 10/25/18, the DON in-serviced the nursing staff (licensed nurses, nursing assistants, geriatric care assistants, ar agency staff) that nursing staff will prohair trimming and hair care services frof charge. The staff facilitator will provide education to newly hired nursing a	nd vide ee ide

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	343233	B: Willo	STREET ADDRESS, CITY, STATE, ZIP CODE	10/18/2018
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RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345	
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F 571	Worker (SW) on 10/10 Resident Council min to Resident #77 's ind reviewed with the SW spoken with Resident	ducted with the Social 6/18 at 2:28 PM. The utes dated 9/27/18 related quiry about haircuts was 7. The SW stated she had #77 and told her that the	F 57	agency staff during orientation to the facility.  On 11/6/18, the social services directo mailed written notification to resident representatives. The written notification informed the resident representatives they can have nursing staff trim or do it.	ons that hair
	facility had not provided revealed she was under trimming was consider that was covered by Market that was covered by Market that was considered that was considered that was covered by Market that was covered b	ed free haircuts. She then aware that routine hair gred a basic hygiene service Medicaid with no charge to ducted with the Director of 1/16/18 at 4:00 PM. The as unaware that routine hair gred a basic hygiene service Medicaid with no charge to infirmed that this service was all Medicaid residents. She		care for a resident without charge to the resident.  On 11/14/18, the social services direct provided information to the resident council. The social services director educated the residents that they can he nursing staff trim or do hair care, if requested, without charge to the residents without charge to the residents.	or ave ent.
	acknowledged that Re was Medicaid and that not being provided to stated that she expect	esident #77 ' s payor source at routine hair trimming was her at no charge. The DON ted the regulation to be was going to inform the		systemic changes made to ensure that the deficient practice will not recur  On 11/14/18, the social services direct began informing newly admitted residents/resident representatives that nursing staff will, if requested, provide trimming and hair care services free of charge. The social services director w also inform new admissions of other routine hair services provided at the center.  On 11/14/18, the social services direct and/or administrator began monitoring resident grievances for issues related Medicaid residents being charged for routine hair trimming or hair care services	t or hair f vill

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE,	, ZIP CODE	10/18/2018
				HAMLET, NC 28345		
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F 571	Continued From pag	e 14	F 5	71  How the facility plans t	to monitor its	
				performance to make are sustained	sure that solution	
				On 11/14/18, the social began quarterly monitor residents to ensure residents to ensure residents for routine has newly admitted resident representatives are awastaff will, if requested, trimming and hair care charge. The social ser complete the monitoring The social services diridentified issues to the administrator.	oring of Medicaid sidents are not ir trimming and nts/resident vare that nursing provide hair e services free of vices director will report a sector will report a	I
				The social services dir will present any issues residents being charge trimming to the monthl improvement (QI) comidentification of trends corrective actions, and The social services dir will present trends and recommendations to the assurance and perform (QAPI) committee for a recommendations, and need for continued mocontinued compliance Limitations on Charges related to routine hair testing the social services directly and the services directly and the social services directly and the social services directly and the services directly and the services directly and the services directly and the services directly and t	s related to Medic ed for routine hair ly quality mittee for review , additional d recommendation rector and/or DOI d QI committee the quarterly quality mance improvement review, additionated to determine the positioning to ensure in the area of s to Personal Fur	caid f f f f f f f f f f f f f f f f f f f

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		ATE SURVEY DMPLETED
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F 584 SS=B	CFR(s): 483.10(i)(1)- §483.10(i) Safe Envi The resident has a ri comfortable and hor but not limited to rec- supports for daily livi The facility must prov §483.10(i)(1) A safe, homelike environment use his or her persor possible. (i) This includes ensureceive care and ser physical layout of the independence and d (ii) The facility shall of the protection of the or theft.  §483.10(i)(2) Housel services necessary trand comfortable inte §483.10(i)(3) Clean transition in good condition; §483.10(i)(4) Private resident room, as sp §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial	ronment. ght to a safe, clean, nelike environment, including eiving treatment and ng safely.  vide- clean, comfortable, and nt, allowing the resident to nal belongings to the extent  uring that the resident can vices safely and that the e facility maximizes resident oes not pose a safety risk. exercise reasonable care for resident's property from loss  keeping and maintenance o maintain a sanitary, orderly,	F 58			11/15/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		10/10/2010
				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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 584	Continued From page	e 16	F 5	84		
	sound levels. This REQUIREMENT by: Based on observatio	maintenance of comfortable  is not met as evidenced  ns and staff interviews, the		F 584		
	environment as evideresident cabinetry for 403, 405, 406, 407, a sheetrock for four of t405, and 407), cover two of nine rooms (Roof two medication room), and	d keep bathroom exhaust ld up in three of nine rooms		Safe/Clean/Comfortable/H Environment  How corrective action will be accomplished for those resider have been affected by the defic practice  On 11/9/18, the maintenance d repaired the cabinetry in rooms #405, #406, #407, and #408.  On 11/9/18, the maintenance d repaired the sheetrock in rooms #403, #405, and #407.	nts found cient lirector s #403,	to
	10/15/18, which starts following rooms had president closet cabine wooden framework: 4  Observations conduct 10/16/18, which starts following rooms had president closet cabine wooden framework: 4  Observations conduct 10/17/18, which starts following rooms had president closet cabine resident closet clo	ducted during a round on ed at 10:24 AM, revealed the beeling laminate from the etry which exposed the 103, 405, 407, and 408.  Ited during a round on ed at 3:16 PM, revealed the beeling laminate from the etry which exposed the 103, 405, 407, and 408.  Ited during a round on ed at 9:59 AM, revealed the beeling laminate from the etry which exposed the 103, 405, 407, and 408.		On 11/9/18, the maintenance of replaced the cover for the fluor lighting in rooms #406 and #42  On 11/9/18, the maintenance of repaired the light fixtures in the unit medication room.  On 11/9/18, the maintenance of cleaned the bathroom exhaust rooms #302, #406, and #408.  How the facility will identify other having the potential to be affect.	escent tu  11.  lirector dementia  lirector vents in	a
	An interview was con	ducted with Nurse #1 on		same deficient practice		

NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584  Continued From page 17  10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD) along with observations of rooms 403, 405, 406,	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584  Continued From page 17  10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  SUMMARY STATEMENT OF CENTED  HIGHWAY 177 S BOX 1489  HAMLET, NC 28345   D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERIOR TO THE APPROPRIATE DEFICIENCY)  F 584  On 11/9/18, to protect other residents, the Maintenance Director performed an observation audit of the 55 remaining rooms for needed cabinetry repairs, sheetrock repairs, lighting repairs, and vent cleaning. The results of the audit revealed 13 rooms needing laminate repairs, 25 room needing laminate repairs, 25 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	8/2018
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	0/2010
CX4) ID   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TO 1/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.    A round was conducted in conjunction with an interview with the Maintenance Director (MD)   PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EAC	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584  Continued From page 17  10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584  On 11/9/18, to protect other residents, the Maintenance Director performed an observation audit of the 55 remaining rooms for needed cabinetry repairs, sheetrock repairs, lighting repairs, and vent cleaning. The results of the audit revealed 13 rooms needing light cover repairs, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	
F 584  Continued From page 17  10/17/18 at 10:10 AM. The nurse stated she had written work orders for various issues needing attention such as a call bell that did not work, a wheel off an over the bed table, or a broken over the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  F 584  On 11/9/18, to protect other residents, the Maintenance Director performed an observation audit of the 55 remaining rooms for needed cabinetry repairs, sheetrock repairs, lighting repairs, and vent cleaning. The results of the audit revealed 13 rooms needing laminate repairs, 25 room needing minor sheetrock repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air  Conditioning vent cleaning. The light	
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the bed table. The nurse further stated the staff at the facility documented work orders in the computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  sheetrock repairs, lighting repairs, and vent cleaning. The results of the audit revealed 13 rooms needing laminate repairs, 25 room needing minor sheetrock repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	
at the facility documented work orders in the computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  vent cleaning. The results of the audit revealed 13 rooms needing laminate repairs, 25 room needing minor sheetrock repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	
computer into a software program which managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  revealed 13 rooms needing laminate repairs, 25 room needing minor sheetrock repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	
managed work orders.  A round was conducted in conjunction with an interview with the Maintenance Director (MD)  repairs, 25 room needing minor sheetrock repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	
A round was conducted in conjunction with an interview with the Maintenance Director (MD)  repair, 17 rooms needing light cover repairs, and 55 rooms requiring Air Conditioning vent cleaning. The light	
interview with the Maintenance Director (MD)  Conditioning vent cleaning. The light	
, , ,	
along with observations of rooms 403, 405, 406, cover repairs were completed on	
407, and 408, on 10/17/18 at 4:18 PM. 11/15/18.	
Observations were made of the resident cabinetry	
in the rooms revealed peeling laminate which What measures will be put into place or	
exposed the wooden framework. The MD stated systemic changes made to ensure that	
the cabinets were delaminating and the the deficient practice will not recur	
delaminating had needed to be addressed. He	
stated cabinets in some other resident rooms had  On 11/1/18, the director of nursing	
been repaired/replaced but he did not have a initiated an in-service with licensed	
schedule for repair/replacement of the cabinets in nurses, nursing assistants, geriatric care	
the rooms observed.  assistants, and agency staff. The	
in-service reviewed the process for	
At the completion of the round conducted on completing and submitting work orders for 10/17/18 at 4:18 PM the MD demonstrated how repairs to include furniture, light fixtures.	
1	
the work orders were categorized and and vents. The in-service was completed	
documented in the work order software program.  A review of recent work orders was completed,  A review of recent work orders was completed,  11/14/18. After 11/14/18, no licensed nurse, nursing assistant, geriatric care	
back to August 1, 2018. The review revealed no assistant, or agency staff will work until	
submitted work orders documenting the peeling the re-education is completed. After	
laminate of the resident cabinetry.  11/14/18, the staff facilitator will educate	
all newly hired licensed nurse, nursing	
An interview was conducted with the assistant, geriatric care assistant, and	
administrator on 10/18/18 at 9:16 AM. The agency staff on the work order process,	
Administrator stated it was his expectation for the during orientation to the facility.	
resident cabinetry to have been intact. In	
addition, the Administrator stated it was his  On 11/13/18 the maintenance director	
expectation if maintenance issues were formulated a prioritized repair calendar.	
discovered by a staff member, a work order for On 11/13/18, the maintenance director	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION		E SURVEY IPLETED
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RICHMON	ID PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
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F 584	Continued From p	page 18	F 5	584		
	the maintenance	department would be		and maintenance assistants	s began	
		maintenance being made		completing the repairs and	-	
	1	tified maintenance issue through		tasks in order of priority. TI		
	the work order, th	e maintenance department		repairs were completed 11/		
	would be able to	complete the necessary repairs.				
	2. Observations	conducted during a round on				
		tarted at 10:24 AM, revealed the		How the facility plans to mo	onitor its	
		212 had an approximate 12 inch		performance to make sure		
	by 12 inch scuffed	d area on the wall to the left of		are sustained		
	the resident's bed	where the sheetrock paper had				
	been scraped off	exposing unpainted sheetrock;		On 11/14/18, the department	nt heads	
	Room 403 had sh	eetrock where the paper had		(administrator, director of n	ursing, unit	
	bubbled and had	come loose from the sheetrock		managers, social services of	director,	
	above the televisi	on next to the resident cabinetry		activities director, bookkeep	oers, payroll,	
	on the ceiling; Ro	om 405 had peeling paint and		maintenance, environmenta	al services, and	
	exposed sheetroo	ck paper on the wall behind the		dietary manager) began we	ekly	
	vanity sink; Room	1 407 had torn sheetrock paper		compliance monitoring rour	nds to ensure a	
	and a hole in the	ceiling, approximately the size of		clean and functional enviro	nment. The	
	a nickel, above th	e television located between the		department heads will docu	ıment findings	
	resident cabinetry	<i>1</i> .		on the Compliance Monitor for 12 weeks. Identified issu		
	Observations con	ducted during a round on		immediately addressed by		
	10/16/18, which s	tarted at 3:16 PM, revealed the		head and reported to the ad	dministrator,	
	following: Room 2	212 had an approximate 12 inch		maintenance director, and/o	or	
	by 12 inch scuffed	d area on the wall to the left of		environmental services dire	ector.	
	the resident's bed	where the sheetrock paper had				
	been scraped off	exposing unpainted sheetrock;		The maintenance director a	ınd	
	Room 403 had sh	eetrock where the paper had		environment services direct	tor will present	
	bubbled and had	come loose from the sheetrock		any issues related to a safe	e, clean,	
	above the televisi	on next to the resident cabinetry		comfortable, and homelike		
	on the ceiling; Ro	om 405 had peeling paint and		the monthly quality improve	· · ·	
		ck paper on the wall behind the		committee for review, ident		
		1 407 had torn sheetrock paper		trends, additional corrective		
		ceiling above the television		recommendations. The ma	intenance	
	located between	the resident cabinetry.		director, environmental serv		
				and/or administrator will pre		
		ducted during a round on		and QI committee recomme		
	10/17/18, which s	tarted at 9:59 AM, revealed the		the quarterly quality assura	nce and	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C <b>0/18/2018</b>	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		0/10/2010	
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 OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 584	Continued From pag	e 19	F 5	84			
	following: Room 212 by 12 inch scuffed at the resident's bed who been scraped off expression and 403 had shee bubbled and had corrabove the television on the ceiling; Room exposed sheetrock provenity sink; Room 40 and a hole in the ceilocated between the an interview was considered between the an interview was considered by the facility documented winto a software progrorders. The nurse facility documented winto a software progrorders. The nurse stroom 407 had been the water leaks. The written a work order the torn sheetrock in the torn sheetrock in the facility documented with a work order the torn sheetrock in the water leaks. The written a work order the torn sheetrock in the wall to the left the sheetrock paper exposing unpainted sheetrock where the	had an approximate 12 inch rea on the wall to the left of here the sheetrock paper had posing unpainted sheetrock; trock where the paper had me loose from the sheetrock next to the resident cabinetry 405 had peeling paint and paper on the wall behind the 107 had torn sheetrock paper ling above the television resident cabinetry.  Inducted with Nurse #1 on M. The nurse stated she had for various issues needing a further stated the staff at the work orders in the computer fam which managed work tated the hole in the ceiling in there months and it was from the nurse stated she had not for the hole in the ceiling or room 407.  Ited in conjunction with an anintenance Director (MD) ons of rooms 212, 403, 405, at 4:18 PM. The following of the round: Room 212 had each by 12 inch scuffed area at of the resident's bed where had been scraped off sheetrock; Room 403 had paper had bubbled and had		performance improvement (committee for review, additive recommendations, and to do need for continued monitoric continued compliance in the facility maintaining a safe, or comfortable, and homelike of for the residents.	onal etermine the ng to ensure e area of the lean,		
	television next to the ceiling; Room 405 ha	sheetrock above the resident cabinetry on the ad peeling paint and exposed the wall behind the vanity					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 584	hole in the ceiling a between the resident the resident in room and he had not bee repair the drywall w the room. The MD sheetrock and the sto be addressed.  At the completion of 10/17/18 at 4:18 PN the work orders weld documented in the A review of recent w back to August 1, 2 submitted work orders weld administrator on 10. Administrator on 10. Administrator stated maintenance issues member, a work ordepartment would be maintenance being maintenance issue.	It torn sheetrock paper and a bove the television located in cabinetry. The MD stated in 212 often stayed in the bed in able to get into the room to then the resident was not in stated the damage to the sheetrock paper had needed if the round conducted on the MD demonstrated how re categorized and work order software program. Work orders was completed, in the review revealed no ers documenting the holes in ged sheetrock.	F 584		
	11:44 AM revealed lighting with no prot the over the bed light nearest the window	conducted on 10/15/18 at exposed florescent tube ective tubing or lens cover in the in room 406 for the bed.  There were two residents in 406 at the time of the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345293	B. WING _			C <b>10/18/2018</b>
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	10/16/18, which star following: Exposed protective tubing or light in room 406 for exposed florescent over the bed closes. There were two rest the time of the observation commedication room w 8:34 AM. The observations conducted by a lens.	ucted during a round on arted at 3:16 PM, revealed the florescent tube lighting with no a lens cover in the over the bed or the bed nearest the window; tube lighting in the ceiling light set to the door in room 421. Sidents residing in room 421 at ervation.  Inducted of the dementia unit as conducted on 10/17/18 at ervation revealed three of the less were exposed and were not cover or plastic tubing.  Inducted during a round on arted at 9:59 AM, revealed the florescent tube lighting with no arted the bed nearest the window; tube lighting in the ceiling light	F	584		
	An interview was consistent of the National American Around was conducted into a software programmer.  A round was conducted interview with the National American Around Washington	onducted with Nurse #1 on AM. The nurse stated she had for various issues needing se further stated the staff at the work orders in the computer gram which managed work octed in conjunction with an Maintenance Director (MD) tions of rooms 406 and 421 on M. Observations were made of cent tube lighting with not lens cover in the over the bed				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	(X3)	) DATE SURVEY COMPLETED
		345293	B. WING			C <b>10/18/2018</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ZIP CODE	10/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCEI	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 584	and the exposed florceiling light over the room 421. An addition of the ceiling lights in dementia unit. The of the four florescent tucover or protective to florescent tube lights cover or plastic tubin tubes.  At the completion of 10/17/18 at 4:18 PM the work orders were documented in the wA review of recent we back to August 1, 20 submitted work order laminate of the reside.  An interview was conadministrator on 10/1 Administrator stated fluorescent glass tub addition, the Adminis expectation if mainted discovered by a staff the maintenance depcompleted. Upon mainted work order, the minute work order work	the bed nearest the window escent tube lighting in the bed closest to the door in onal observation was made the medication of the observation revealed three of bes did not have a lens abing. The MD stated should have had a lens g over the florescent glass the round conducted on the MD demonstrated how exategorized and ork order software program. Ork orders was completed, 18. The review revealed notes documenting the peeling ent cabinetry.  Inducted with the 18/18 at 9:16 AM. The it was his expectation for ing to be protected. In trator stated it was his nance issues were member, a work order for partment would be anintenance being made d maintenance issue through the naintenance department inplete the necessary repairs.	F	584		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345293	B. WING		C 10/18/2	2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARI	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 10/10/2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CC	(X5) DMPLETION DATE
F 584	Continued From pag	je 23	F 58	4		
	AM revealed a dust in the bathroom of re	build up on the exhaust vent oom 406.				
		ducted on 10/15/18 at 12:20 build up on the exhaust vent oom 408.				
	10/16/18, which star following rooms had	cted during a round on ted at 3:16 PM, revealed the a dust build up on the resident bathrooms: 302, 406,				
	10/17/18, which star following rooms had	cted during a round on ted at 9:59 AM, revealed the a dust build up on the resident bathrooms: 302, 406,				
	interview with the Malong with an observom 406 on 10/17/observation revealed had a dust build up. maintenance depart ensure the bathroon The MD further state	d the bathroom exhaust vent The MD stated it was the ment's responsibility to n exhaust vents were clean. ed the exhaust vent in the 06 needed to be cleaned so it				
F 585 SS=C	Administrator stated resident bathroom e free of a dust build u Grievances	18/18 at 9:16 AM. The it was his expectation for the xhaust vents to have been ip.	F 58:	5	11/	15/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 10/18/2018	
NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE		E AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		1 10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 585	grievances to the fact that hears grievances reprisal and without reprisal. Such grievarespect to care and furnished as well as furnished, the behavesidents, and other facility stay.  §483.10(j)(2) The refacility must make puresolve grievances to accordance with this §483.10(j)(3) The fact on how to file a grievato the resident.  §483.10(j)(4) The fact grievance policy to expression of all grievances regulation contained in this part provider must give at to the resident. The include:  (i) Notifying resident postings in prominer facility of the right to (meaning spoken) of grievances anonymous of the grievance offician be filed, that is, address (mailing and	es. sident has the right to voice cility or other agency or entity is without discrimination or fear of discrimination or inces include those with treatment which has been that which has not been vior of staff and of other concerns regarding their LTC is sident has the right to and the rompt efforts by the facility to the resident may have, in	F 585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 0/18/2018	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		G. 16.2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 585	to obtain a written grievance; and the independent entitie be filed, that is, the Quality Improveme Agency and State program or protect (ii) Identifying a Gresponsible for overeceiving and track conclusions; leading by the facility; main information associexample, the ident grievances submit written grievances submit written grievances coordinating with senecessary in light (iii) As necessary, prevent further portight while the alleginvestigated; (iv) Consistent with reporting all allege abuse, including in and/or misapproprianyone furnishing provider, to the adas required by State (v) Ensuring that a include the date the summary statement the steps taken to summary of the peregarding the residuation of the	iew of the grievance; the right decision regarding his or her contact information of es with whom grievances may experiment State agency, ent Organization, State Survey Long-Term Care Ombudsmantion and advocacy system; ievance Official who is erseeing the grievance process, king grievances through to their ag any necessary investigations intaining the confidentiality of all eated with grievances, for ity of the resident for those ted anonymously, issuing decisions to the resident; and state and federal agencies as of specific allegations; taking immediate action to the ential violations of any resident ged violation is being in §483.12(c)(1), immediately diviolations involving neglect, siguries of unknown source, iation of resident property, by services on behalf of the ministrator of the provider; and	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 585	and the date the wr (vi) Taking appropriaccordance with State of the residents' right or if an outside entite the State Survey Agorganization, or loc confirms a violation rights within its area (vii) Maintaining eviresult of all grievand 3 years from the issidecision.  This REQUIREMENT by:  Based on record refacility failed to provisummary for one of grievances (Reside Findings include:  Resident #4 was or was most recently resident was dischatol/10/18 and did no resident's diagnose generalized weakned difficulty speaking.  Review of Resident Data Set (MDS) revivith an Assessment 7/3/18. The resident severe cognitive im	as a result of the grievance, itten decision was issued; atte corrective action in ate law if the alleged violation at is is confirmed by the facility y having jurisdiction, such as gency, Quality Improvement allaw enforcement agency for any of these residents' a of responsibility; and dence demonstrating the tes for a period of no less than uance of the grievance.  IT is not met as evidenced eview and staff interviews the ride a written grievance one resident reviewed for any admitted on 1/4/16 and the eadmitted on 5/23/18. The gried to the hospital on the treturn to the facility. The included: Dementia, ess, and difficulty swallowing,  #4's most recent Minimum the ealed a quarterly assessment at Reference Date (ARD) of the was coded as having had pairment. The resident was	F 58	F 585 Grievances  How corrective action will be accomplished for those residents for have been affected by the deficient practice  On 11/9/18, the social services direct mailed a written grievance summary. Resident #4 serident representate.  How the facility will identify other resident #4 serident to be affected be same deficient practice.  On 11/9-14/18, the administrator resident grievance concern log for composition of the resolution process. The	ctor y to ive. sidents y the viewed letion
	with an Assessmen 7/3/18. The residen severe cognitive im coded as having red	t Reference Date (ARD) of t was coded as having had		the grievance concern log for comp	ed e audit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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		345293	B. WING		1	0/18/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO			
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 585	Continued From p	age 27	F 58	35			
	Concern/Grievand 10/7/18 for Reside by a family memb Concern/Grievand investigation finding member voicing the review revealed the	the Form revealed the langs were reported to the family language on concern via phone. Further language had signed the language form as having been		closed with providing a writ summary follow-up to the resident/resident represents protect other residents havi potential to be affected, the provide a written grievance all residents.	ative. To ng the facility will		
	An interview was Worker (SW) on 1 the grievance filed Resident #4. The grievances, most communication. To grievances wa passing" and aski was OK. The SW the family membe a nursing matter a up for the grievances was of the grievances was of the family members and the family members and the grievances was of	conducted with the Social 0/17/18 at 11:26 AM regarding d by the family member of SW stated the follow up for of the time, was through verbal The SW further stated follow up s often completed "just in ng the filing party if everything stated the grievance filed by r of Resident #4 was related to and she had not provided follow ce filed by the family member of		What measures will be put systemic changes made to the deficient practice will not on or before 11/14/18, the consultant in-serviced the sidirector, director of nursing administrator on the Reside and Grievance Guidelines pin-service included the facil written response to the resi representative speaking on resident who file a grievance for a written response is no The written response will in the grievance was received	ensure that of recur  corporate cocial services and ent Concerns crocess. The ity will provide dent/resident behalf of the ee; a request t required. clude the date		
	Administrator and on 10/17/18 at 11 the DON stated sl conversations with Resident #4 inclus stated she had ve family member whother family meml grievance was file resident was discitled to the family member and provided to the family member was discitled to the family member was discitled to the family member was discitled to the family members was file resident was discitled to the family members was filed to the family members was filed to the family members with the family members with the provided to the prov	the Director of Nursing (DON) 33 AM. During the interview		description of the grievance description of findings of invany corrective action.  On 11/14/18, the social sen and/or the administrator be grievances during the morn interdisciplinary team (IDT) ensure resolutions and actibe communicated to the resincluding a written grievance.  On 11/14/18, the administrator	e, a brief vestigation and vices director gan reviewing ing meeting to ons taken will sident, e response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			1	C 1 <b>18/2018</b>
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010
DICUMON	D DINES HEALTHOADE	AND DELIABILITATION CENTE		н	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page	e 28	F 5	85			
	not the facility's policy response to provide a regarding the filed gri	written grievance decision			reviewing the grievance concern log weekly and will ensure all grievances completed include written responses to the resident/resident representative.	)	
	both the Administrato	ON on 10/17/18 at 5:55 PM, r and the DON stated it was					
	grievances.	ollow the regulation for			How the facility plans to monitor its performance to make sure that solutior are sustained	IS	
					Beginning on 11/14/18, the social servi director and/or administrator will present any issues related resident grievances the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, ar recommendations. The social services director and/or administrator will present trends and QI committee recommendations to the quarterly qual assurance and performance improvem (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensur continued compliance in the area of the grievances.	nt to and s nt ity ent I e	
F 600 SS=E	Free from Abuse and CFR(s): 483.12(a)(1)	-	F 6	000			11/15/18
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to					

			(X3) DATE COMP	SURVEY LETED			
		345293	B. WING _			l	C 18/2018
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page		F 6	800			
	treat the resident's mo	edical symptoms.					
	§483.12(a) The facilit	y must-					
	physical abuse, corporinvoluntary seclusion; This REQUIREMENT by: Based on record revision and to make the provision and	is not met as evidenced  iew, observation, and staff neglected to provide anage the physical ely impaired residents for 2 ents #10 and #56) reviewed are resulted in Resident #10 reations with 5 cognitively lesidents #8, #18, #26, #74, ent #56 slapping a esident (Resident #18) twice eriod.			How corrective action will be accomplished for those residents found have been affected by the deficient practice The resident # 10 has had decreased episodes of agitation with increased supervision and continued routine psychiatric consults, most recently on 10/26/2018. The Resident #56 has had decreased episodes of agitation with increased supervision and continued routine psychiatric consults, most recently on 10/26/2018.	I to	
		ses that included dementia sturbance, psychosis, mood			How the facility will identify other reside having the potential to be affected by the same deficient practice Beginning 10/18 through 10/22/2018	ie	
	#10 had short-term and problems and severed. She had no behaviors period. Resident #10 assistance of 1 for the supervision of 1 for the walking in corridor, and Resident #10 was not	17/18 indicated Resident			Minimum Data Set (MDS) Nurse, Direct of Nursing, Unit Managers and Desk Nurse audited 100% of current resident progress notes for unreported evidence abuse or neglect for the previous 30 day without negative findings. What measure will be put into place or systemic changemade to ensure that the deficient practic will not recur. The Nursing staff on the dementia unit were in-serviced by the DON on 10/18/on supervision of residents to prevent	t□s e of nys res des	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245202	B. WING			С	
		345293	B. WING _			0/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
RICHMON	D PINES HEALTHCA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
Talon IIII On	DI INCO NEAEINOA	NE AND REMADIEMATION SERVE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From p	age 30	F 6	00			
	-	ment with range of motion and					
	she utilized a whe			reoccurrence, including non-pharmacological interver	ations for		
	Sile utilized a wrie	eichail.		behavior management. The r			
	The plan of care for	or Resident #10 included the		Nursing staff will be re-educa	-		
		ematic manner in which		DON or the Unit Managers b	-		
		acterized by ineffective coping;		supervision of residents to pr			
		reness related to: dementia.		occurrences related to behave			
		ff and has period of crying.		non-pharmacological interver	•		
		story] of hitting others, grabbing		hires and agency staff will red			
	others, and accus	ing others of 'running around'		education during orientation	to the facility.		
	with her husband.	This focus area was initiated		Facility staff will receive annu	al training on		
	on 12/22/17. The	interventions for Resident #10		Abuse, Neglect, Misappropria	ation of		
		peing careful not to invade her		Property that includes superv			
		nitiated on 12/22/17), behavior		residents and management of			
		chiatric consultation as needed		behaviors of cognitively impa			
	·	/17 and revised on 2/1/18), and		residents. Training will be pro	-		
	_	item or task in an attempt to		Staff Development Coordinat	or or the		
	distract (initiated c	011 4/27/18).		Director of Nursing.	ivo hohavioro		
	The plan of care for	or Resident #10 also included		Residents exhibiting aggress will be discussed in the next	ive periaviors		
		roblematic manner in which		Interdisciplinary Team (IDT)	meeting after		
		acterized by ineffective coping;		the occurrence. Discussion w	•		
		gression and combativeness		notification of Medical Directo			
		of dementia. Resident has		Representative and whether			
		nysically and verbally abusive to		implemented are effective.			
		idents". This focus area was		How the facility plans to mon	itor its		
	initiated on 12/27/	17. The interventions for		performance to make sure th	at solutions		
	Resident #10 inclu	uded, in part, allow resident to		are sustained			
	pace where she ca	an be observed (initiated on		The DON will review the IDT			
		sed on 1/25/18) and be		behaviors for trending and tra	-		
	_	vading her personal space		residents repeat behaviors or	n a weekly		
	(initiated on 2/1/18	3).		basis for 12 weeks.			
				The DON and/or nursing unit	Ū		
		oort dated 4/29/18 completed by		present IDT corrective action			
		d Nursing Assistant (NA) #6		reported abuse/neglect action			
		heard residents arguing and		monthly quality improvement committee for review, identification			
		room she observed Resident		trends, additional corrective a			
		#74 hitting each other. observed to slap Resident #74		recommendations. The adm			
	i i logiaciil # 10 Was	UDUGU YOU IU SIAD INCSIUCIII #14	1	i recommendations. The autil	แมงแฉเบเ	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 10/18/2018	
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COI HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10, 10, 20 10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	and Resident #74 w was noted with a bri arms. Resident #74 #74's 4/1/18 annual her cognition was set. A nursing note date #2 indicated that Rewere separated and after the physical all noted with purple colleft forearm and a neforearm.  A written statement NA #6 indicated she Resident #74 grabb Resident #74 grabb Resident #74 two tir head. NA #6 indicated #10 to Nurse #2 and An interview was conditionally and the resident #10 had a included physical be residents. She report ambulatory and she of her unit, in the conformation of resident rooms. So to prevent any phys #10 and other resident whereabouts and reareas or the nurses.	de of her head. Resident #10 vere separated. Resident #10 uise on her right and left lower had no injuries. (Resident MDS assessment indicated	F 60	and/or DON will present tren committee recommendations quarterly quality assurance a performance improvement (C committee for review, addition recommendations, and to deneed for continued monitorin continued compliance in the Abuse/Neglect.	s to the and QAPI) onal termine the g to ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 0/18/2018	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO. HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	stated she was unal information about the An interview was con 10/17/18 at 3:00 PM familiar with Resided Resident #10 was at the hours while she down the hall and in confirmed she was of the physical alternand Resident #74. It was the first time she #10 and she was un physical behaviors as she had been in and providing care when yelling at each other and observed Resident #74 in indicated the hitting get to the residents when she was able	and Resident #74. She be to recall any specific e incident.  Inducted with NA #6 on I. NA #6 stated she was nt #10. She stated that imbulatory and spent most of was awake walking up and it the common areas. She working on 4/29/18 at the time beation between Resident #10 NA #6 revealed that 4/29/18 is had worked with Resident leaware of her history of at that time. She stated that other resident's room in she heard two residents in the she had worked with Resident worked with the other resident's room in she heard two residents in the she had worked with the other resident #10. She occurred before she could to separate them. She stated to separate the residents she	F 60				
	indicated she had of a couple of times sing she did work with Reference on the resist where she was easing physical altercations.  On 4/30/18 the carefor Resident #10 relagitation/combative intervention, "Remowhen behavior is diswith resident in a low	plan (initiated on 12/22/17)					

	ATEMENT OF DEFICIENCIES O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 10/18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	<b>,</b>	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	5/1/18 indicated star continued to present agitation. Staff also become physically a residents.  A Nurse Practitioner indicated Resident altercation with another Resident #10 was in combativeness toward b.) An incident reponsurse #2 indicated #10 hit Resident #15 significant change in the state of the s	Practitioner (PNP) note dated ff reported that Resident #10 at with increased anxiety and anoted that Resident #10 had aggressive toward other r (NP) note dated 5/3/18 #10 was involved in an ther resident on her unit.	F 6			
	NA #7 indicated she	dated 5/9/18 completed by e observed the incident on sident #10 and Resident #18.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING_			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COL HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/16/2016	
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	station and saw Resic Resident #18's wheel Resident #10 to let go wouldn't. NA #7 indic go around the chair F Resident #18 on her walked off and went of the walked off and went of the working on 5/6/18 at altercation between F #18. She stated she specific information a A phone interview was 10/17/18 at 4:55 PM. currently worked at the as needed basis only familiar with Resident her a couple of times was ambulatory and sabout on her unit whill confirmed she was wof the physical altercation and Resident #18. She stated and Resident #10 holding wheelchair and was to indicated she asked Fresident #18's wheel complied. She stated around to the front of and get to her to release before she could do to the sident would be the could do to the forest would be the could be the could be the could do to the forest would be the could be th	dent #10 holding onto chair. NA #7 asked of the chair, but she cated that before she could desident #10 "popped" eft hand. Resident #10 then down the hall.  ducted with Nurse #2 on she confirmed she was the time of the physical desident #10 and Resident was unable to recall any bout the incident.  s conducted with NA #7 on NA #7 indicated she are facility infrequently on an she stated she was she was as a #10 and had worked with she reported Resident #10 she was normally walking are she was awake. NA #7 orking on 5/6/18 at the time ation between Resident #10 she reported she saw onto Resident #18's rying to push her. She Resident #10 to let go of chair, but she had not at that she started to walk Resident #10 to redirect her ase the wheelchair, but shat Resident #10 hit hand. NA #7 reported that 10 walked away from	F	600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C 10/18/2018	
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10, 10, 20 10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Nurse #3 indicated #10 had been in a panother resident (Rhit Resident #26 and back. (Resident #2 assessment indicated long-term memory pimpaired decision in A nursing note date #3 indicated NA #8 slapped Resident # #26 then slapped his residents were septionserved.  A written statement NA #8 indicated she (Resident #10 and and forth. She ther was coming from an hit Resident #10 bat indicated she was a and reported to the A phone interview won 10/18/18 at 9:29 not worked with Rehad on a few occas #10 was ambulator on her own. She st lying in bed one mit knew she was up a Nurse #3 confirmed at the time of the ph Resident #10 and Fesident #10 and	NA #8 informed her Resident ohysical altercation with desident #26). Resident #10 and then Resident #26 hit her 16 's 4/28/18 annual MDS ed she had short-term and problems and severely making).  Material of 5/13/18 completed by Nurse reported Resident #10 and Resident er back on the hand. The arrated, and no injuries were a dated 5/13/18 completed by the heard two residents Resident #26) arguing back an looked for where the arguing and she observed Resident #26 then arck on the hand. NA #8 able to separate the residents	F 6				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		345293	B. WING _			1 <b>0</b> /1	) 18/2018
	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	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	I	(X5) COMPLETION DATE
F 600	Resident #26 then in before NA #8 could so An interview was cor 10/17/18 at 3:43 PM. familiar with Resident Resident #10 had ph toward both staff and Resident #10 was very and the hall and into almost the whole time confirmed she was worded the physical alterorand Resident #26. So Resident #10 and Resident #26 hit indicated she then sereported the incident revealed it was very with Resident #10 as her at all times and masn't too close to an any physical altercation. On 5/14/18 the care for Resident #10 relating aggression was updaintervention, "Remove when behavior is diswith resident in a low decrease/eliminate uprovide diversional at An NP note dated 5/10.	sident #10 hit Resident #26. turn hit Resident #10 back reparate the residents.  Inducted with NA #8 on NA #8 stated she was t #10. She reported ysical behaviors directed It residents. She indicated rey active and she walked up other residents ' rooms re she was awake. NA #8 rorking on 5/13/18 at the time ration between Resident #10 she indicated she heard resident #26 arguing so she rothem. She stated that to the residents to separate hit Resident #26 on her hand her back on her hand. She reparated the residents and to Nurse #3. NA #8 challenging at times to work reyou had to keep an eye on reeded to make sure she red yother residents to avoid red to verbal/physical red to include the re resident from public area ruptive/unacceptable. Talk repitch, calm voice to ondesired behavior and	F6	600			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3	) DATE SURVEY COMPLETED
		345293	B. WING _			C <b>10/18/2018</b>
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP C HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ODE	10/10/2010
(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 HE APPROPRIATE	(X5) COMPLETION DATE
F 600	F 600 Continued From page 37		F 6	600		
	the unit. She was se Department (ED) on a evaluation, but the EI Resident #10 would be evaluation in the ED at to the facility.  A PNP note dated 5/2 continued with increas She was noted with pother residents. Medimade by the PNP.  d.) An incident report Nurse #4 indicated N Resident #10 walked (Resident #8) and be injuries were observed (Resident #8 's 4/6/1 assessment indicated long-term memory primpaired decision mather than the statement, at #9 indicated Resident #10 when	nt to the Emergency 5/13/18 for psychiatric D provider had not felt benefit from a psychiatric so she was transferred back  15/18 indicated Resident #10 sed anxiety and agitation. Shysical aggression toward cation adjustments were  dated 6/9/18 completed by A # 9 informed her that up to another resident gan to pull and hit him. No id to either resident. 8 quarterly MDS If he had short-term and oblems and severely				
	on 10/17/18 at 4:29 F be reached. (Nurse #	s attempted with Nurse #4 PM. Nurse #4 was unable to #4 completed the incident 6/9/18 physical altercation 0 and Resident #8.)				
		•				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 1 <b>0/18/2018</b>		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/16/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 600	#8.)  A PNP note dated 6. Resident #10 recent also reported increa and agitation. The F was irritable and angadjustments were m  A PNP note dated 8. had returned to her adjustments. She had returned for a days during the sident #10 require of 1 for bed mobility supervision of 1 for corridor, and locome #10 was not steady to stabilize without simpairment with ranga wheelchair.  e.) A nursing note day hollering "get out of entered Resident #3 the arm, and twisted Resident #10 was regroom. Resident #32 and complained of netered for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #32 and complained of many and twisted for the sident #33 and complained of many and twisted for the sident #33 and complained of many and twisted for the sident #34 and complained for the sident #35 and complained for many and twisted for the sident #35 and complained for the sident #35 and	Resident #10 and Resident  /13/18 indicated staff reported ly hit another resident. Staff sed confusion, restlessness, PNP indicated Resident #10 gry with staff. Medication ade by the PNP.  /29/18 indicated Resident #10 baseline following medication ad intermittent crying spells, ression or combative	F 6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _		C 		) 18/2018	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP O HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	CODE			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO ) DEFICIENCE	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE	
F 600	Continued From page 39		F 6	500				
	completed by NA up trays and hear Resident #10 had and grabbed her I twist.	#10 indicated she was setting d Resident #329 hollering. entered Resident #329's room hand and arm and started to  working day report for an						
	allegation of resident abuse related to the incident between Resident #10 and Resident #329 on 10/4/18 was reviewed. Resident #329 was in bed as NA # 10 provided care for her roommate. Resident #10 entered Resident #329's room and grabbed her on the wrist. NA #10 went over to intervene and tried to get Resident #10 to release Resident #329's wrist. Nurse #5 came into the room and assisted NA #10 with getting Resident #10 to release Resident #329's wrist. Resident #10 was then separated from Resident #329. A skin tear was noted to Resident #329's wrist. An x-ray was obtained of Resident #329's wrist and results were negative. Resident #329 was relocated to another hall way away from Resident #10. The allegation of resident abuse was substantiated.							
	at 10:15 AM indic	the Social Worker on 10/18/18 ated that she completed a Brief al Status (BIMS) for Resident and her cognition was severely						
	on 10/17/18 at 4:4 was familiar with I Resident #10 had toward other resid	was conducted with Nurse #5 H5 PM. Nurse #5 stated she Resident #10. She indicated physical behaviors directed Hents in the past. She reported make sure she wasn't too close						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345293	B. WING _			C 10/18/2018
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	member to keep the that it could be diffic Resident #10 in thei because she moved confirmed she was wof the physical alterdand Resident #329. yelling from Resident #3 room and was trying from Resident #329 #10 was able to be a #329's room. She rehad a skin tear on hordered to ensure not A phone interview when 4:15 PM. NA #10 income Resident #10. She active throughout threported Resident #	ts and for at least one staff ir eye on her. She indicated ult at times for staff to keep reyesight at all times about constantly. Nurse #5 working on 10/4/18 at the time cation between Resident #10 She stated she had heard at #329's room. She indicated in and she saw Resident #10 29's wrist. NA #10 was in the to separate Resident #10 Nurse #5 stated Resident emoved from Resident eported that Resident #329 er wrist and an x-ray was	F 6	,		
	She stated that Res behaviors directed a She indicated that s' #10 in their eyesight physical altercations resident. NA #10 exproviding care for or other NA on the unit monitored Resident were always at least revealed it was som at all times because constantly. NA #10 to 10/4/18 at the time to	dent #10 had physical t other residents in the past. taff tried to keep Resident at all times to ensure no occurred with any other uplained that if she was the of her residents that the or the nurse on the unit #10. She indicated there to the limit was the properties of the second that the limit was the properties of the limit was the past.  It				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 600	setting up her meal the room. She stat that Resident #10 h room and grabbed She reported she w #10 from Resident	in Resident #329's room I tray when she heard yelling in ted she looked over and saw had entered Resident #329 's her wrist and was twisting. went over to separate Resident #329 and at that time Nurse m to assist her with separating	F 600		
	PM ambulating with room of the facility's were present in the observation.  Resident #10 was of PM ambulating with of the facility's men	observed on 10/15/18 at 12:30 In a shuffled gait a common is memory care unit. Staff is common room during this observed on 10/17/18 at 2:00 In a shuffled gait in the hallway mory care unit. She was within			
	An interview was constraint (DON) on stated that she expurotected from the residents. She also provide adequate states	ing this observation.  onducted with the Director 10/18/18 at 3:35 PM. She elected residents to be physical behaviors of other to stated she expected staff to supervision and for behaviors brevent resident to resident as.			
	6/27/18 and most r with diagnoses that behavioral disturba The plan of care fo	as admitted to the facility on ecently readmitted on 9/28/18 t included dementia with ence and schizophrenia.  The Resident #56 included the ematic manner in which			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		ніс	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 177 S BOX 1489 AMLET, NC 28345	1 101	10/2010
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	verbal/physical aggrerelated to: cognitive in placement to [nursing reported [history] of hother residents." This 7/16/18. Intervention in part, provide one of sure you have the respeaking or touching slowly and from the final fractitioner (PNP) on indicated that staff rebeen aggressive vertices aggressive vertices aggressive vertices and rejection of care MDS review period. Extensive assistance locomotion on the unassistance of 2 or more Resident #56 was now was only able to stab He had no impairment he utilized a wheelch. An incident report dar Nurse #8 indicated Resident #18 reached around her of the stab He had no impairment he utilized a wheelch.	erized by ineffective coping; ession or combativeness impairment and recent gracility]. Resident has a ditting staff members and focus area was initiated on some for Resident #56 included, in one sitter as needed, be sident's attention before grand approach the resident front.  Evaluation for Resident #56 included with approach the resident front.  Evaluation for Resident #56 included with approach the resident front.  Evaluation for Resident #56 included with approach the resident #56 included with approach the resident #56 included with approach the resident #56 had believed by the ported Resident #56 had believed with approach the sessment dated 9/6/18 included with approach to 3 days during the resident #56 required the of 1 for bed mobility and with the required the extensive for staff with transfers. It steady on his feet and he will read the staff assistance with with range of motion and	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 10/18/2018		
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•	10/16/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 600	redness to her left of quarterly MDS asses short-term and long-severely impaired downward of the Murse #8 indicated a in the dining room who pushing Resident # reached around and side of her face". The by staff and new ord Nurse Practitioner (If the Emergency Deput A written statement NA #12 indicated Rewere in the dining roobserved Resident afface.  An incident report downward Resident #8 indicated asset of the incident which were separated and Resident #18's left is no injuries were not incident was noted to Emergency Medical Resident #56 to the	nt #18 was observed with heek. (Resident #18's 7/9/18 ssment indicated she had -term memory problems and	F 60					
	Nurse #8 indicated a "once again struck [	at 3:40 PM Resident #56 Resident #18]" on the left side vas passing him in her						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP C HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ODE	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICI	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	EMS arrived at 4:0 #56 to the ED for a form NA #11 indicated was seated in his self-propelling in his passing Resident her on the left side. The ED evaluation Resident #56 was aggressive behaving Resident #56 president #56 likeling her recommended with an antibiotic of #56 was discharged An inservice sign indicated the subjection indicated the subjection indicated the subjection indicated the subjection indicated include separate include includ	lents were separated by staff. 20 PM to transport Resident evaluation.  Is statement taken by Nurse #8 ated on 10/14/18 Resident #56 wheelchair. Resident #18 was er wheelchair and as she was #56 he reached out and struck to fher face.  In dated 10/14/18 indicated sent in for evaluation of ors and a medical screening. ented with normal vital signs, his appearance, and an dical exam. Resident #56 was in treated for a urinary tracting his hospitalization on 128/18. Resident #56 had been facility on 9/28/18 on an for 2 weeks. A urinalysis and and for Resident #56 on 10/14/18 when the ED physician indicated by had chronic colonization and discharge back to the facility or dered for one week. Resident and to the facility on 10/14/18.  In sheet, dated 10/15/18, extraction of residents to protect The sign in sheet indicated 27 the inservice provided by the	F6				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345293	B. WING _			10/	C 18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	E	, , , ,	
(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 COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 600	An observation of Re on 10/15/18 at 12:30 self-propelling in his hall of the facility's massigned staff memb supervision.  A phone interview wa on 10/18/18 at 9:15 familiar with Residen Resident #56 had pe physical and verbal be staff. Nurse #8 confi 10/14/18 when Resident #56 slaft ace. Nurse #8 state occurred when Resident #56 slaftace. Nurse #8 state Responsible Parties received an order to evaluation. She report Resident #56's unit to building to copy Resident #56's unit to building #56's unit to building #56's unit to building #56's unit to building #56's	18/18 indicated he was one supervision.  sident #56 was conducted PM. Resident #56 was wheelchair up and down the emory care unit. He had an er providing one to one  as conducted with Nurse #8 AM. Nurse #8 stated she was t #56. She indicated riods of agitation as well as behaviors directed toward rmed she was working on the the #56 slapped Resident occasions (3:00 PM and d that the first incident then #56 and Resident #18 pm. NA #12 reported to her apped Resident #18 in the d she notified the (RPs) and the NP and she send Resident #56 to ED for orted she had exited to go to the front of the dent #56's medical with him to the ED. She pier on Resident #56's unit #8 revealed that while she es building one of the NAs Resident #56 to the nurses' station waiting for EMS to arrive.	F	500			

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	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 600	Nurse #8 reported the done things differently was kept separated for the ED. She staken Resident #56 with documents, or she constaff's assistance.  An interview was constaff's assistance.  An interview	sident #18 a second time. at in hindsight she should've by to ensure Resident #56 from Resident #18 until he stated that she could 've with her while she copied the build've asked for another  aducted with NA #12 on She stated she was familiar She indicated Resident #56 from as well as physical and field toward staff. NA #12 forking on 10/14/18 when d Resident #18 on two 3:00 PM and 3:40 PM). She first incident, Resident #56 fre separated and Resident the nurses' station for arrived. She indicated that lif-propelled her wheelchair station and near Resident that before she or NA #11 for residents, Resident #56 8 again. NA #12 indicated as now on one to one	F6				
	physical behaviors of stated she expected supervision and for b prevent resident to re The DON spoke aboroccurred on 10/14/18	She stated that she be protected from the fother residents. She also staff to provide adequate behaviors to be managed to esident physical altercations. But the two incidents that I in which Resident #56 twice in a 40-minute time					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	١ , ,	E SURVEY MPLETED
		345293	B. WING _		1	C 0/18/2018
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	<u> </u>	0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607 SS=D	occurred, staff shou the two residents an staff member staying times until EMS arrivinitiated an inservice incidents. She reporthe process of being Develop/Implement CFR(s): 483.12(b)(1) Section 12(b)(1) The facili implement written possible with the process of being Develop/Implement CFR(s): 483.12(b)(1) The facili implement written possible with the process of t	hat after the first incident d've immediately separated d kept them separated with a g with Resident #56 at all yed. She indicated she had for staff related to these rted the inservice was still in given to all nurses and NAs. Abuse/Neglect Policies )-(3)  ity must develop and olicies and procedures that:  bit and prevent abuse, ation of residents and resident property,  lish policies and procedures and resident property,  lish policies and procedures are training as required at  T is not met as evidenced wiew, resident interview, and acility failed to implement its e in the area of reporting for appropriation of Property for 1 and (Resident #77).  d:	F 6	F 607 Develop/Implement Abus Policies How corrective action will be accomplished for those resident have been affected by the deficit practice Resident #77 was reimbursed for on 9/4/18. On 10/16/18, the adm	s found to ent or the doll ninistrator	11/15/18
	Misappropriation of dated 1/2009 and la	itled, "Abuse, Neglect, or Resident Property Policy", st revised on 3/10/17, Iministrator was responsible of investigations of		#2 notified the local law enforcer the allegation of misappropriatio property.  How the facility will identify other having the potential to be affected.	n of r residents	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345293	B. WING _			1	C <b>18/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010
					IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 607	Continued From page	e 48	F 6	607			
		roperty and for reporting the eappropriate agencies in			same deficient practice		
	_	e and federal regulations.			Other residents that allege		
					misappropriation of property, allegation	ıs	
		tially admitted to the facility			of abuse or neglect have the potential		
		recently readmitted on			be affected. Any allegations of abuse,		
	10/5/18.				be reported to law enforcement if there	: IS	
	The guarterly Minimu	ım Data Set (MDS)			reasonable suspicion of a crime. Administrator #2 completed a 100%		
	' '	13/18 indicated Resident			review of all allegations of abuse, negl	ect	
	#77's cognition was f				or misappropriation of property that we		
	Ŭ	•			reported since 9/4/18 to determine		
		evance form dated 8/21/18			notification of local law enforcement if		
		77 was missing a porcelain			reasonable suspicion of a crime was		
	doll.				reported. The results of the audit		
	The facility filed a 24	hour and E working day			determined that the center has not had		
	-	-hour and 5-working-day on of Misappropriation			any allegations with suspicion of a crim since 9/4/18.	ie	
		t #77's missing porcelain			31100 3/4/10.		
		ndicated Resident #77			What measures will be put into place of	r	
	_	ne stole the doll she had			systemic changes made to ensure that		
	bought for her grande	daughter for Christmas. The			the deficient practice will not recur		
		d the facility staff had					
		77's room and were unable			The administrator, DON, Social Worke	r	
	-	n doll. The investigation was			will be re-educated by the RN Facility		
	T	B by the facility's former			Consultant regarding the responsibilities process for allegations of	₽S,	
		llegation of misappropriation perty was substantiated by			misappropriation of property including		
		orking day report, completed			notification to law enforcement and		
		asonable suspicion of a			utilization of the Facility Investigative		
	crime had occurred, I				Checklist.		
	enforcement was not				Incidences are reviewed at morning		
					stand-up meetings by the interdisciplin	ary	
		ducted with Resident #77 on			team.		
		She confirmed she had a			Identification of neglect, abuse and		
		doll that went missing from			misappropriation will be completed by	ine	
		f months ago and she			interdisciplinary team and the law		
		ne stole it. She reported r with searching for the doll			enforcement contact will be initiated by the Director of Nursing or Administrato		
	Juli Hau assisted He	with scarcing for the doll			and pineotor or rearising or Authinistrato	f .	[

STATEMENT OF DEI AND PLAN OF CORI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(	(X3) DATE SURVEY COMPLETED
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NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	<u>l</u> DE	10/10/2010
				HIGHWAY 177 S BOX 1489		
RICHMOND PIN	IES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	
to edunal rein portof some rein portof some rein only miss sev sev sev sev sev sev sev sev sev s	ble to locate it. inbursed her \$39 celain doll plus a hipping the doll. Inder the porcelain declined and achbursement. Reviewed piece of personsing since she beral years ago.  Interview was cosing (DON) on 1 ed that the formed pleted the investigation gation was substorking day report cated reasonable urred, but that lousted to misappropowed and for located the investigation was reviewed the expectation ted to misappropowed and for located it, the allocated it, and it is she thought this gation was not represent. The Econtact local law gation wasn't represent its part of the property wasn't part of the property w	misplaced, but they were She indicated the facility .99 for the cost of the n additional \$7.99 for the cost The facility had offered to n doll for Resident #77, but deepted the financial sident #77 stated this was the real property that had gone egan residing at the facility and modern mo	F6	when there is a reasonable scrime.  The Administrator will utilize Investigative Checklist to ass following regulatory guideline Facility Investigative Checklis administrator and or the Dire Nursing on tasks to be compallegations of abuse, neglect misappropriation of property. The Administrator will share any reportable incidents with monthly to include the results investigation and notification enforcement if there was a resuspicion of a crime.  The QI committee will review for identification of trends, act and to determine the need for frequency of continued monimake recommendations for recontinued compliance.  How the facility plans to monperformance to make sure that are sustained  The facility Administrator will Executive QI committee the results of all allegations of at and misappropriation of propreport will The Administrator responsible for the implement acceptable plan of correction	the Facility sist in es. The st directs the st directs the ctor of eleted when the results of the QI teams of the of law easonable of the finding ctions taken or and/or toring, and monitoring for the state of the electrons that solutions the electrons that solutions the electrons that solutions the electron of the will be electron of the electron o	e  of n  s e e n ct

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10.102010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 607	allegation of misappi	e 50 2:27 PM. She confirmed the ropriation of property related rcelain doll was not reported	F 60	7	
F 641 SS=D	to local law enforcen Accuracy of Assessr CFR(s): 483.20(g)	nent.	F 64	.1	11/15/18
	resident's status. This REQUIREMEN' by: Based on record rev facility failed to code (MDS) assessments hospice care (Reside (Resident # 280), dia #11) and nutrition (R sampled residents w were reviewed.  Findings included:  1. Resident #44 was 12/21/15 with multipl Chronic Obstruction The quarterly MDS a indicated that Reside hospice care.  The care plan dated Resident #44 was re terminal illness.  The hospice notes d	st accurately reflect the  T is not met as evidenced  view and staff interview, the the Minimum Data Set accurately in the areas of ent #44), medications agnoses (Residents #280 & esident #30) for 4 of 20 those MDS assessments  admitted to the facility on e diagnoses including Pulmonary Disease (COPD).  assessment dated 8/27/18 ent #44 was not receiving  8/27/18 indicated that ceiving hospice care due to  ated 8/11/18 and 8/24/18 evealed that Resident #44		F641 Accuracy of Assessments How corrective action will be accomplished for those residents for have been affected by the deficient practice The Minimum Data Set (MDS) for residents #44, #280, #11 and #30 wc corrected by the MDS nurse and resubmitted on 10/19/18 by RN MDS nurse. How the facility will identify other res having the potential to be affected by same deficient practice Beginning on 11/7/18 the MDS (Mini Data Set) License Nurses will condu a 100% audit of the current residents most recent Omnibus Budget Reconciliation Act (OBRA) Minimum Set (MDS) submitted for accuracy re to Diagnosis, Hospice, Nutrition and Medications. current residents. The was completed on 11/8/18 and revea (nine) Assessments that have discrepancies will be that were corre and resubmitted per Resident Assessment Instrument (RAI) manual	ere S sidents y the mum octed s' Data elated audit aled 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(>	X3) DATE SURVEY COMPLETED
	345293	B. WING _			C <b>10/18/2018</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	10/10/2010
			HIGHWAY 177 S BOX 1489		
RICHMOND PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
interviewed. The MD Resident #44 was un and she missed to co quarterly MDS asses  On 10/18/18 at 3:40 M (DON) was interviewed she expected the MD accurately.  2. Resident #30 was 9/27/17 with multiple dysphagia.  The quarterly Minimulassessment dated 8/4 #30 was on therapeur feeding tube.  Resident #30 had a control to tube feeding at 50 min AM and on at 11 AM.  On 10/18/18 at 11:50 interviewed. She stan (DM) was responsible (nutritional status) on MDS Nurse stated the feeding and nothing to the control to the polymer.  On 10/18/18 at 11:52 interviewed. The DM was receiving tube feet therapeutic diet. She	PM, the MDS Nurse was PS Nurse verified that der hospice care since 2017 ode hospice care on the sment dated 8/27/18.  PM, the Director of Nursing ed. The DON stated that PS assessments to be coded admitted to the facility on diagnoses including and Data Set (MDS) 2/18 indicated that Resident tic diet and was not on doctor's order to receive a lililiter (ml) per hour - off at 7 and AM, the MDS Nurse was ted that the Dietary Manager is for completing section K the MDS assessment. The at Resident #30 was on tube by mouth (NPO).	F 6	the MDS Coordinator. What measures will be put i systemic changes made to the deficient practice will not the deficient practice and the deficient process and Interdisciplinary Team (IDT) re-educated regarding the ir accurate submission of MDS assessments by the MDS C. How the facility plans to more performance to make sure the are sustained. The Director of Nursing (DC perform a 10% audit for accurate and purition early there are sustained. The Director of Nursing (DC perform a 10% audit for accuracy of submitted assess the DON will share the result of the deficient process and Nutrition early weeks; then quarterly there accuracy of submitted assess. The DON and/or MDS RN we corrective actions to the more improvement (QI) committed identification of trends, addition corrective actions, and reconstructive actions, and reconstructive actions to the quarterly committee recommendations to the quarterly committee for review recommendations, and to define the deficient of the definition o	ensure that of recur  ompleted on and of will be were importance of Sconsultant. Initor its chat solutions  ON) will curacy in the dications, of week for 1 after on the ssments. In the series of MDS ary team (ID is will present ID on the series of MDS ary team (ID is will present ID on the series of MDS ary team (ID is will present ID on the series of MDS ary team (ID is will present ID on the series of mendations on will present in the improvement in a ditional etermine the ing to ensure	2 T) OT s. nt

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		345293	B. WING			C <b>10/18/2018</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STA HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	TE, ZIP CODE	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) COMPLETION DATE
F 641	(DON) was interviewd she expected the MD accurately.	e 52 PM, the Director of Nursing ed. The DON stated that S assessments to be coded	Fé	341		
	5/21/108 with multiple depressive disorder. Data Set (MDS) asse	e diagnoses including major The quarterly Minimum essment dated 8/27/18 nt # 280 had no diagnosis of				
		doctor's order dated 8/20/18 sant drug) 75 milligrams for major depressive				
	August, 2018 reveale	nistration Record (MAR) for d that Resident #280 had 3/21/18 through 8/27/18.				
	interviewed. She ver received Zoloft for de assessment period.	The MDS Nurse stated that tent dated 8/27/18 she epression under the				
	(DON) was interviewe	PM, the Director of Nursing ed. The DON stated that S assessments to be coded				
	5/21/108 with multiple	as admitted to the facility on e diagnoses including major The quarterly Minimum				

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F 641	Continued From pag	ge 53	F 6	41		
	indicated that Resid antidepressant drug period. Resident #280 had	essment dated 8/27/18 ent # 280 did not receive during the assessment a doctor's order dated 8/20/18 essant drug) 75 milligrams				
	(mgs) by mouth dail disorder.	y for major depressive				
	August, 2018 reveal	e Medication Administration Record (MAR) for gust, 2018 revealed that Resident #280 had eived Zoloft from 8/21/18 through 8/27/18.				
	interviewed. She ve received Zoloft during	_				
	(DON) was interview	PM, the Director of Nursing ved. The DON stated that DS assessments to be coded				
		s admitted to the facility on e diagnoses including age renal disease.				
	I .	lent's quarterly Minimum Data /2/18 revealed end stage ot coded.				
	revealed goals and including deep vein	lent's care plan dated 10/4/18 interventions for all diagnoses thrombosis to left upper, end stage renal disease,				

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	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	I	10/10/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656 SS=D	revealed the resident hemodialysis on Moreach week. The residiet and multivitamin for renal failure.  On 10/16/18 at 4:05 interviewed. The MEResident #11 was rethe assessment periodend stage renal diseadated 10/2/18.  On 10/18/18 at 3:40 (DON) was interviewed she expected the MERESIDE (DEVELOP) in the resident rights set for \$483.21(b)(1) The faimplement a compressident rights set for \$483.10(c)(3), that in objectives and timefrimedical, nursing, and	cian order dated 10/1/18 t was sent for outpatient day, Wednesday and Friday dent received a liberal renal s and nutritional supplement  PM, the MDS Nurse was DS Nurse verified that ceiving hemodialysis during od and she missed to code ase on the quarterly MDS  PM, the Director of Nursing ed. The DON stated that DS assessments to be coded Comprehensive Care Plan  ensive Care Plans cility must develop and thensive person-centered sident, consistent with the eth at §483.10(c)(2) and	F6			11/15/18
	describe the following (i) The services that or maintain the resident physical, mental, and	mprehensive care plan must g - are to be furnished to attain ent's highest practicable d psychosocial well-being as .24, §483.25 or §483.40; and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 656	under §483.24, §483 provided due to the under §483.10, inclu treatment under §48 (iii) Any specialized rehabilitative service provide as a result or recommendations. If findings of the PASA rationale in the resid (iv)In consultation wiresident's representa (A) The resident's godesired outcomes. (B) The resident's profuture discharge. Fawhether the resident community was asselocal contact agencie entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMEN by:  Based on record reinterviews, resident implement the reside and urinary catheter reviewed for care plate.  Findings included:  1. Resident #54 was	a would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights iding the right to refuse 3.10(c)(6).  Services or specialized is the nursing facility will if PASARR if a facility disagrees with the IRR, it must indicate its ent's medical record. If the resident and the ative(s)-bals for admission and reference and potential for cilities must document it's desire to return to the essed and any referrals to es and/or other appropriate ose. In the comprehensive care, in accordance with the thin paragraph (c) of this  T is not met as evidenced view, observations, and staff interview, the facility failed to ent's care plan for showers care for 1 of 2 residents	F 65	How corrective action will be accomplished for those residents fou have been affected by the deficient practice Resident #54 was provided with a sh on 10/16/2018 and catheter care as directed in the plan of care on 10/17/How the facility will identify other resi having the potential to be affected by same deficient practice Residents that have a catheter and expressed shower choices have the	ower 2018. dents

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X:	3) DATE SURVEY COMPLETED				
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		345293	B. WING _			10/18/2018				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE					
DICUMON	D DINES HEAT THOAS	DE AND DELIABILITATION CENTE		HIGHWAY 177 S BOX 1489						
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F 656	Continued From pa	age 56	F 6	56						
	-	num Data Set dated 9/12/18		potential to be affected.						
		ent had an intact cognition with		What measures will be put	into place or					
		ch occurred 1 to 3 days in the		systemic changes made to	•					
		it required extensive		the deficient practice will no						
		ff for all activities of daily living		Wound Nurse provided nur						
		notion was one staff. The		re-education on the showe	-					
		ere neurogenic bladder, UTI,		the Resident Care Guide to	o include					
	and retention of uri	ne.		providing urinary catheter of	care as					
				indicated on 10/17/2018 to						
		d 9/13/18 revealed goals and		include fulltime, part time a		TO PLATE  TO PLA				
		DLs, personal hygiene,		staff. For staff not inservice	-					
	, ·	vers at times, intervention to		11/15/2018 they will be in-s		5				
		y catheter management, y to ineffective coping, urinary		working on the floor. The entire included the importance of						
		urosepsis, chronic pain, and		Resident Care Guide to pro		Α/				
	at risk for skin brea			hires and agency staff will						
	at hor or or or or			education during orientatio						
	a. A review of the re	esident 's shower sheet		How the facility plans to mo	-					
	documentation from	n 8/1/18 to present revealed		performance to make sure						
	the resident had 5	showers and the remaining		are sustained						
	documentation was	s partial or full bed bath.		The wound care nurse will observation and/or intervie	•					
	On 10/15/18 at 12:4	48 pm an interview was		residents that have urinary	catheters and					
	conducted with the	resident who stated he had		expressed preferences for	showers. The					
		owers as scheduled; he had		audits will be performed 3						
		s. The resident stated that he		for 4 weeks, then weekly for	or 2 months					
		ay. The resident stated that he		then quarterly hereafter.						
	•	and had made the staff aware		The results of the audits wi						
	of his preference for	or months.		communicated to the DON						
	0= 10/17/10 =+ 10:	20 am an interview.		track and trend the results		•				
		30 am an interview was #1 who was assigned to the		or initiate counseling for nu indicated. The DON will sh						
		I the resident liked to have his		of audits with the interdisci						
		and rarely refused his shower.		(IDT) weekly for 12 weeks.	. ,					
		ented that she was not aware		The DON and/or nursing u		II				
		d not receive his shower when		present IDT corrective action		"				
		A was also aware that the		monthly quality improveme						
		s postponed his shower to the		committee for review, ident						
		had pain in the morning.		trends, additional corrective						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345293	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343293	B: Willia _	STREET ADDRESS, CITY, STATE, ZIP COL		10/18/2018
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RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From p	age 57	F 6	56		
	conducted with the she expected nurs showers as planned b. On 10/17/18 at	30 pm an interview was e Director of Nursing who stated sing staff to provide scheduled ed.  12:15 pm an observation was are for Resident #54. Nursing		recommendations. The adm and/or DON will present trend committee recommendations quarterly quality assurance a performance improvement (Committee for review, addition recommendations, and to deneed for continued monitoring continued compliance in the developing and implementing	ds and QI to the nd QAPI) nal termine the g to ensure area of	
	assistants (NAs) # completed bed ba present were obse to clean the insert	th. None of the three NAs erved to perform catheter care ion site of the urinary catheter ary catheter tubing.		comprehensive care plans.	3	
	who stated that the provided the urina day which include	:35 pm NA #2 was interviewed e treatment nurse (TN) ry catheter cleaning care each d changing the urinary catheter, eter and checking that the red.				
	conducted with the stated the NA who bath/shower or pe	:40 pm an interview was e treatment nurse (TN) who provided morning care to rsonal care was to perform the are cleaning and to empty the ag.				
	conducted with NA #54 received a be observe catheter of perform catheter of her role was to ho legs and had not of cleaned. NA #1 st	:10 am an interview was A #1 who stated when resident d bath yesterday she did not care cleaning and did not care. NA #1 commented that ld the resident 's contracted observed what was being tated that catheter care ected to be done with morning				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345293	B. WING _		C 10/18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 10/10/2010
(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 658 SS=E	care.  On 10/18/18 at 2:30 producted with the Dishe expected nursing care every day within Nursing stated the staresident 's plan of caservices Provided McCFR(s): 483.21(b)(3)  §483.21(b)(3) Composite Services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the commustical formula of the services provide as outlined by the community of the services provide as outlined by the services provide as outlined by the services provide as outlined by the serv	om an interview was irector of Nursing who stated a staff to provide catheter norning care. The Director of aff should be following the are.  Beet Professional Standards (i)  Behensive Care Plans dor arranged by the facility, mprehensive care plan,  Standards of quality.  The is not met as evidenced and record review, staff atric Nurse Practitioner failed to administer tion as ordered for 1 of 5 or unnecessary medications  Example 11 in the facility on 2/1/16 admitted on 6/26/17 with led psychotic disorder and loral disturbance.  Indicated 6/19/18 indicated of the medication) 0.5 es daily for 3 days then	F 6		lal 1mg to on of anager orders, 8, and
	The quarterly Minimu	•		Risperdal 1 mg by mouth every ar resident #8 on 8/29/18. The Direct	m for

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	0.10200		9.	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2018
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F 658	Continued From page	e 59	F 6	658			
	assessment dated 7/	6/18 indicated Resident #8			Nursing and Unit Manager visually		
	had short-term and lo	ong-term memory problems			observed the current MAR for		
	and moderately impa	ired decision-making skills.			documentation of the medication		
	He had no behaviors	and no rejection of care.			administration as ordered. The		
		I antipsychotic medication on			observation by the DON and nursing u	nit	
	7 of 7 days during the	e MDS review period.			manager revealed that resident was		
					receiving medication as ordered as		
		Practitioner (PNP) note dated			evidence by the documentation.		
		ecommendation to reduce					
	•	erdal 1 mg once daily to			How the facility will identify other reside		
	Risperdal 0.5 mg ond	ce daily.			having the potential to be affected by the	те	
	A physician 's order	dated 8/22/18 indicated a			same deficient practice		
		t #8 's Risperdal from 1 mg			On 11/7-8/18, the desk nurse complete	nd a	
	once daily to 0.5 mg				review of all residents with new	.u u	
					antipsychotic orders for the previous 3	)	
	A PNP note dated 8/2	29/18 indicated Resident #8			days. The review identified five resider		
	had an increase in be	ehaviors and aggression with			orders requiring further investigation.	Γhe	
	recent medications c	hanges. The PNP indicated			desk nurse and DON immediately		
		rse to give Resident #8			obtained clarification and took necessa	ıry	
		w for one dose due to			action, including notification of the		
		s/agitation and to increase			physician and resident/resident		
	Risperdal back to 1 n	ng once daily.			representative as appropriate.		
	_	8/29/18 indicated the PNP					
		I new orders were given to					
	change Risperdal to	1 mg once daily.			What measures will be put into place o		
					systemic changes made to ensure that		
		dated 8/29/18 indicated			the deficient practice will not recur		
		w one time and an increase			On 11/14/18 the DON completed		
	daily to 1 mg once da	sperdal from 0.5 mg once			On 11/14/18, the DON completed re-education of the nurse unit manager	·e	
	daily to 1 mg once da	any.			on reviewing all new physician orders f		
	A PNP note dated 9/	5/18 indicated Resident #8			antipsychotics prior to the next morning		
		Dose Reduction (GDR) of			interdisciplinary team (IDT) meeting. T		
		2018. Medications were			review of the orders will include the	-	
		ordered and staff noted an			complete processing of the order to		
	improvement in mood				include transcription to the medication		
					administration record (MAR).		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
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		345293	B. WING		1	0/18/2018
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DIGUMON	ID DINIEG LIEAL THO	DE AND DELIABILITATION OFNITE		HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE		HAMLET, NC 28345		
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F 658	Continued From p	page 60	F 65	58		
F 658	A review of the Order from 10/1/18 throw had the 8/29/18 p mg once daily ele. This order for Risp crossed out and roon the MAR. This receiving Risperdirather than the order than than the order than the	ctober 2018 hard copy MAR ugh 10/18/18 for Resident #8 hysician 's order for Risperdal 1 ctronically printed on the MAR. perdal 1 mg had the 1 mg eplaced with 0.5 mg handwritten is resulted in Resident #8 al 0.5 mg once daily for 18 days dered 1 mg once daily.  as conducted of Resident #8 in heelchair on 10/15/18 at 12:15 ho behavioral issues observed. Halert and oriented to self only.  as conducted of Resident #8 in hunit in his wheelchair on AM. There were no behavioral Resident #8 was alert and	F 65	The nurse unit manager will finding of the review to the I during the next morning IDT On 11/14/18, the DON impliparactice that the end-of-morchangeover of MARs will be two licensed nurses.  How the facility plans to mo performance to make sure that are sustained  On 11/14/18, the desk nurse auditing 10% of the residen administration records MAR changeover accuracy each weeks, then quarterly for 12. The DON will share the residen audits with the interdisciplinal weekly for 12 weeks.  The DON and/or nursing unpresent IDT corrective action monthly quality improvemer committee for review, identifications, additional corrective recommendations. The additional corrective recommendations and the committee recommendation quarterly quality assurance	emented the oth ereviewed by enitor its that solutions ewill begin t medication as for month for 12 months. Early team (IDT) enit manager will ons to the out (QI) effication of exactions, and ministrator onds and QI as to the	
	administered as o expectation was for administered as o	rdered. The DON stated her or medications to be		performance improvement ( committee for review, additi recommendations, and to d need for continued monitori continued compliance in the	(QAPI) ional etermine the ng to ensure	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345293	B. WING	<del> </del>	1	C / <b>18/2018</b>
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 658	physician 's orders of related to Resident # reviewed with the DC from 10/1/18 through the DON. The DON she observed the me confirmed Resident # of Risperdal once daidaily as ordered for a October 2018. The DC why the hard copy M Risperdal 1 mg once and she was unsure change. She stated September the facility residents who were efacilities due to weath She revealed that this admissions disrupted processes and she for not discovered as it's monthly changeover.  A phone interview was on 10/18/18 at 2:32 F Resident #8 had faile August 2018 and she order back to 1 mg or was unaware Reside once daily of Risperding once daily for 18	ated 8/22/18 and 8/29/18 8 's Risperdal were N. The October 2018 MAR 10/18/18 was reviewed with reviewed this information, dication cart, and she then 8 was administered 0.5 mg ly rather than 1 mg once period of 18 days in OON was unable to explain AR had been changed from daily to 0.5 mg once daily who had completed the that during the month of y admitted a total of 49 evacuated from other her related emergencies. Is high number of new the facility 's normal elt this was why the error was hould have been during the	F 65	professional standards.		
F 677 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid	or Dependent Residents ent who is unable to carry living receives the necessary	F 67	77		11/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CUIDDUED	343233	B. WING_	CTD	REET ADDRESS CITY STATE ZID CODE	10/	18/2018
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCA	RE AND REHABILITATION CENTE			HWAY 177 S BOX 1489		
				HA	MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From p	age 62	F 6	677			
	personal and oral	in good nutrition, grooming, and hygiene; ENT is not met as evidenced					
	by:	is not met as evidenced					
	'	ations, record review, and staff			F 677 ADL Care Provided for		
		lity failed to provide fingernail			Dependent Residents		
		dependent residents reviewed			How corrective action will be		
	for Activities of Da	ily Living (ADLs) (Resident #5).			accomplished for those residents found	d to	
					have been affected by the deficient		
The findings include		ded:			practice		
					The resident #5 was provided with nail		
		admitted to the facility on 4/8/16.			care immediately on 10/15/18 by staff		
		nulative diagnoses included: a, generalized weakness,		- 1	Certified Nursing Assistant (CNA). How the facility will identify other reside	onto	
		aresis (weakness of one side of		- 1	having the potential to be affected by the		
		and multiple sclerosis (MS).			same deficient practice		
	, , , , , , , , , , , , , , , , , , , ,	()		- 1	All residents that require assistance ha	ve	
	A review was com	pleted of Resident #5's most			the potential to be affected. The Unit		
	recent Minimum D	ata Set (MDS). The review			Managers observe resident grooming a	and	
		ly assessment with an			hygiene during the performance of the		
		rence Date (ARD) of 7/3/18.			Compliance Monitoring rounds to inclu-	de	
		coded as having been			nails being clean. New Compliance		
	,	The resident was also coded			Monitoring rounds were initiated on		
		d extensive assistance of one to		- 1	11/8/2018 by the Unit Managers (UM) a		
		following Activities of Daily		- 1	any issues with resident nails are resol	ved	
		d mobility, transfer (such as wheelchair), dressing, toilet		- 1	immediately. What measures will be put into place o	r	
		iene, and was totally dependent			systemic changes made to ensure that		
	for bathing.	ierie, and was totally dependent			the deficient practice will not recur		
	lor batimig.			- 1	All CNA's to include fulltime, part time a	and	
	A review of Reside	ent #5's care plan which was			agency staff will be re-educated regard		
		ewed on 10/4/18. The review			following the Resident Care Guide to		
		ent had a Focus area for			include nail care by the DON (Director	of	
		ce for personal hygiene			Nursing). For staff not inserviced by		
		he daily maintaining of			11/15/2018 they will be in-serviced prior	r to	
		d to: Stroke and generalized		- 1	working on the floor. New hires and		
	_	oal listed was for the resident to		- 1	agency staff will receive this education		
		d odor free through next review.			during orientation to the facility.		
	An intervention wa	as: Hygiene/grooming: Provide			The UM and assigned Department Hea	ads	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDII	_		Ι,	3
		345293	B. WING _				_ 18/2018
NAME OF P	ROVIDER OR SUPPLIER	•	,	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICUMON	D DINES HEATTHCAD	E AND DELIABILITATION CENTE		IGHWAY 177 S BOX 1489			
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F 677	needed. The reside care plans addressi weakness including Transferring, Mobilit Pain. In addition, the for MS. The goal list would remain free corelated to MS through intervention was: M damage to motor net paralysis, spasticity notify MD as appropriately appropriately motify MD as appropri	in with physical assistance as ent's care plan had several ing the resident's right-sided the Focus areas of: Eating, ity, Toileting, Risk for falls, and ite resident had a Focus area sted for MS was the resident of complications or discomforting in next review. A listed conitor for signs/symptoms of cerve tracts such as weakness, fatigue, and diploplia and criate.  #5's Care Guide, which was 1/4/18, revealed the listed of one person and the ided paralysis.  #5's fingers  #6'18 at 11:28 AM revealed the fit hand, the resident's ite and dark debris under the free in all five fingers.  #5's fingers  #6'18 at 3:48 PM revealed the fit hand, the resident's ite and dark debris under the free in all five fingers.  #5's fingers  #6'18 at 11:14 AM revealed the fit hand, the resident's ite and dark debris under the free in all five fingers.	F	677	will continue to perform Compliance Monitoring Rounds 3 (three) times per week. The rounds will be performed at random times, and days including weekends. How the facility plans to monitor its performance to make sure that solutior are sustained The UM will perform observation of 5 residents with daily audits 5 times a we for 1 week, then 3 times a week for 3 weeks then weekly thereafter for Activit of Daily Living (ADL) care to include na care. The results of the ADL observation aud will be shared with the DON. The Director of Nursing (DON) will trace and trend the results and re-educated of initiate counseling for nursing staff as indicated. The DON will share the resu of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager present Interdisciplinary Team (IDT) corrective actions to the monthly quality improvement (QI) committee for review identification of trends, additional corrective actions, and recommendation The administrator and/or DON will prese trends and QI committee recommendations to the quarterly qual assurance and performance improvem (QAPI) committee for review, additional recommendations, and to determine th need for continued monitoring to ensur continued compliance in the area of	eek ties till lits k tor lts will y ns. sent tity ent l	
	edge of each nail fo				_	e	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345293	B. WING			10/	18/2018
	D PINES HEALTHCARE	AND REHABILITATION CENTE		н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG				X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	her assignment. The care for her residents care for the residents week. The NA stated residents' nails daily, NA stated she had not Resident #5's nails ye yesterday, 10/17/18, assignment and had him. The NA stated she care because she had ladies doing nail care was told they would non her hall. Resident the dining room await of Resident #5's finger The observation reveleft hand, the resident dark debris under the all five fingers. NA #6 fingernails had debris the nail on the resident resident's nails needed cleaned.  An interview and observith the Director of National States o	nated Resident #5 was on NA stated she provided nail and she had provided nail on her assignment last she tried to check including Resident #5. The of checked residents' nails or et that day. The NA stated she had Resident #5 on her not provided nail care for she had not provided nail d been told there were two for all the residents and she nail care for all the residents #5 was observed to be in ing lunch. An observation ers was conducted by NA #6. aled the fingernails on the et's non-affected side, had free edge of each nail for of stated the resident's under the nail free edge of et's left hand and the et to be trimmed and ervation were conducted ursing (DON) on 10/18/18 at observed Resident #5's hail and stated the had dark debris under the on all five fingers on the left beded to have been trimmed	F	677			
F 689 SS=E	expectation for reside trimmed finger nails.	ON further stated it was her ents to have clean and ards/Supervision/Devices (2)	F	689			11/15/18
			1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		E SURVEY IPLETED
		345293	B. WING		10	C 0/18/2018
	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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 689 Continued From page 65  §483.25(d) Accidents.  The facility must ensure that -		F 68	39			
	§483.25(d)(1) The reast free of accident has	sident environment remains izards as is possible; and				
	supervision and assist accidents. This REQUIREMENT by: Based on record revinterview, the facility of cognitively impaire histories of combative #56, and #74) to previet other cognitively sampled residents reresident incidents. The secure one of two median (memory care unit).  The findings included 1. Resident #10 was 12/21/17 with diagnostic residents.	admitted to facility on ses that included dementia		F 689 Free of Accidents Hazards/Supervision/Devices How corrective action will be accomplished for those residents for have been affected by the deficient practice As of 11/14/18, the DON verified the progress note review, nursing staff and direct observation Resident # 1 had decreased episodes of agitatic correlated to medication monitoring increased supervision and continue routine psychiatric consults. As of 11/14/18, the DON verified the progress note review, nursing staff	t rough input, 10 has on g, ed rough input,	
	without behavioral dis disorder, and anxiety  The 14-day Minimum assessment dated 4/#10 had short-term a problems and severe She had no behavior period. Resident #10 assistance of 1 for the supervision of 1 for the walking in corridor, and	sturbance, psychosis, mood		and direct observation Resident #5 had decreased episodes of agitatic correlated to medication monitoring increased supervision and continue routine psychiatric consults. Resident # 74 was transferred to th hospital on 10/31/18 related to a ch in condition. How the facility will identify other re having the potential to be affected same deficient practice On 10/18/18, the DON immediately the medication storage room on the	66 has on g, ed ne nange esidents by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
						С	
		345293	B. WING _		<u> </u>	10/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
DICHMON	D DINES HEATTHCA	RE AND REHABILITATION CENTE		HIGHWAY 177 S BOX 14	<b>189</b>		
KICHWION	D PINES REALITICA	RE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		
F 689	Continued From p	age 66	F 6	89			
. 000	·	<del>-</del>			is unit. The DON also		
		ze without staff assistance.			ia unit. The DON also	,; <u>+</u>	
	she utilized a whe	rment with range of motion and			ed with the dementia un	ill	
	Sile utilized a wrie	eichail.			ant it is to provide sion of the residents to		
	The plan of care for	or Resident #10 included the			incidents/accidents.		
	•	ematic manner in which			will be put into place or		
		acterized by ineffective coping;			es made to ensure that		
		reness related to: dementia.		'	ctice will not recur		
	_	off and has period of crying.			DON and staff facilitate	or	
		story] of hitting others, grabbing			cing with licensed nurse		
	others, and accus	ing others of 'running around'			ts, and agency staff		
	with her husband.	" This focus area was initiated		working on the de	lementia unit. The		
	on 12/22/17. The	interventions for Resident #10		in-servicing inclu	ided supervision of		
	included, in part, b	peing careful not to invade her		residents to prev	ent recurrence, includin	ng	
	personal space (ir	nitiated on 12/22/17), behavior		non-pharmacolog	gical interventions for		
		chiatric consultation as needed		-	ement and the locking o	of	
		/17 and revised on 2/1/18), and		the medication ro			
	_	item or task in an attempt to			secured dementia unit		
	distract (initiated o	on 4/27/18).		_	was completed on		
	The alex of second	Did+ #40 -l ildd			ursing staff or agency	J: J	
		or Resident #10 also included		_	the dementia unit who o		
		roblematic manner in which acterized by ineffective coping;		1	e in-service by 11/14/18, the unit until they have	,	
		gression and combativeness			ine unit until they have le in-service provided by	,	
		of dementia. Resident has			or and/or DON. Newly	'	
		hysically and verbally abusive to			urses, nursing assistants	s.	
		idents". This focus area was		and agency staff	_	,	
		17. The interventions for			orientation to the facilit	tv.	
	Resident #10 inclu	uded, in part, allow resident to			DON and/or nurse unit		
		an be observed (initiated on			n discussing, in the next		
	·	sed on 1/25/18) and be		interdisciplinary t	team (IDT) team meetin	ıg,	
	cognizant of not ir	vading her personal space		residents exhibiti	ing aggressive behavior	rs.	
	(initiated on 2/1/18	3).			nclude: 1) monitoring fo		
					e attending physician, 2)		
		oort dated 4/29/18 completed by			e resident representative	е,	
		d Nursing Assistant (NA) #6			ate interventions are		
		heard residents arguing and			tional action is necessar	y.	
		room she observed Resident			plans to monitor its		
	⊦#10 and Resident	#74 hitting each other.		performance to n	make sure that solutions	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						(	С
		345293	B. WING _			10/	18/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIGUINON	D DINES HEALTHOAD	AND DELIABILITATION CENTS		Н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 689	89 Continued From page 67		F	389			
	Resident #10 was of	oserved to slap Resident #74			are sustained		
		e of her head. Resident #10			On 11/14/18, the DON, quality		
	_	ere separated. Resident #10			improvement nurse, nurse unit manage	er.	
		ise on her right and left lower			and corporate consultant began review		
		had no injuries. (Resident			of nurse progress notes, incident repor		
		MDS assessment indicated			assignment sheets, and/or nurse	,	
	her cognition was se	verely impaired.)			assistant behavior documentation to		
	•				ensure adequate supervision is provide	ed	
	A nursing note dated	4/29/18 completed by Nurse			to meet resident needs on the dementi-	а	
	#2 indicated that Res	sident #10 and Resident #74			unit. Any identified issues will be		
	were separated and	brought to the nurses' station			immediately reported to the assigned		
	after the physical alte	ercation. Resident #10 was			nurse on that shift and the DON for		
		ored bruises to her right and			prompt intervention and corrective action		
		il indentation on the left			The reviews will occur five times weekl	У	
	forearm.				for 12 weeks.		
					On 11/14/18, the DON, nursing unit		
		dated 4/29/18 completed by			managers and other assigned		
		saw Resident #10 and			Department Heads began Compliance		
	_	ng each other's arms.			Monitoring rounds in the dementia unit	to	
		"she was going to beat			ensure residents are adequately		
		then Resident #10 slapped			supervised, non-resident areas are	41-	
		nes on the right side of her			secured, and residents are provided wi	LT1	
		ed she then brought Resident			diversional activities. The compliance rounds are performed 3 times weekly a	.+	
	# 10 to Nuise #2 and	explained the incident.			various times, on various days to include		
	An interview was cor	nducted with Nurse #2 on			the weekends. The results of the	10	
		A. Nurse #2 stated she was			compliance rounds are reported to the		
		it #10. She indicated			DON and Administrator during morning		
		history of behaviors that			IDT meeting.		
		haviors directed at other			Beginning 11/14/18, the DON and or U	nit	
		ted Resident #10 was			Manager will share trending and tracking		
		walked up and down the hall			of the behaviors with the IDT on a week		
		nmon areas, and in and out			basis for 12 weeks.	,	
		she indicated that staff tried			The DON and/or nursing unit manager	will	
		cal altercations with Resident			present IDT corrective actions to the		
		nts by monitoring her			quality improvement (QI) committee for		
		directing her to the common			review, identification of trends, addition	al	
	areas or the nurses'	station where she was easily			corrective actions, and recommendatio	ns.	
	observed. Nurse #2	confirmed she was working			The administrator and/or DON will pres	ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING				
		343293	B. WING_			10/	18/2018
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489		
				HA	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pag	ge 68	F 6	889			
F 689	on 4/29/18 at the time between Resident # stated she was unabinformation about the An interview was con 10/17/18 at 3:00 PM familiar with Resider Resident #10 was at the hours while she down the hall and in confirmed she was word the physical altercand Resident #74. Now was the first time she #10 and she was un physical behaviors as she had been in and providing care when yelling at each other and observed Resident #74 in indicated the hitting get to the residents when she was able informed Nurse #2 condicated she had or a couple of times sin she did work with Reher eyes on the residents where she was easil physical altercations.  On 4/30/18 the care for Resident #10 relations.	the of the physical altercation and Resident #74. She oble to recall any specific e incident.  Inducted with NA #6 on Inducted with Inducted Hat Inducted In	F6	689	trends and QI committee recommendations to the quarterly qual assurance and performance improvem (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance with ensuring the facility is free of accidents/hazards, provides supervision, and has safe devices to protect the residents.	ent Il e e	
	intervention, "Remove when behavior is dis	ve resident from public area rruptive/unacceptable. Talk v pitch, calm voice to					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _				C 18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		HIG	EET ADDRESS, CITY, STATE, ZIP CODE HWAY 177 S BOX 1489 MLET, NC 28345	1 10	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 689	F 689 Continued From page 69 decrease/eliminate undesired behavior and		F	889			
	5/1/18 indicated staff continued to present agitation. Staff also become physically agresidents.	Practitioner (PNP) note dated reported that Resident #10 with increased anxiety and noted that Resident #10 had agressive toward other					
	indicated Resident # altercation with anoth	er resident on her unit. ted with agitation and					
	Nurse #2 indicated N #10 hit Resident #18 significant change MI	dated 5/6/18 completed by A #7 reported that Resident (Resident #18's 4/12/18 DS assessment indicated nd long-term memory ly impaired decision					
	#2 indicated Residen (Resident #18) on he	5/6/18 completed by Nurse t #10 hit another resident r forearm. The residents no injuries were noted to					
	Nurse #2 indicated N 5/6/18 that Resident residents were separ placed on 1 to 1 supe	undated, completed by A #7 reported to her on #10 hit Resident #18. The ated, and Resident #10 was ervision until she went to e observed to either resident.					
		ated 5/9/18 completed by observed the incident on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345293	B. WING _			C <b>10/18/2018</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COI HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		
F 689	NA #7 reported she was station and saw Resi Resident #18's whee Resident #10 to let g wouldn't. NA #7 inding of around the chair F. Resident #18 on her walked off and went walked off and went walked off and went working on 5/6/18 at altercation between F. #18. She stated she specific information at A phone interview was an edded basis only familiar with Resident was ambulatory and about on her unit which confirmed she was wof the physical altercand Resident #18. She stated and Resident #18. She stated around to the front of and get to her to releice before she could do Resident #18 on her	dent #10 and Resident #18.  valked up to the nurses' dent #10 holding onto lchair. NA #7 asked o of the chair, but she cated that before she could Resident #10 "popped" left hand. Resident #10 then down the hall.  ducted with Nurse #2 on M. She confirmed she was the time of the physical Resident #10 and Resident was unable to recall any about the incident.  as conducted with NA #7 on NA #7 indicated she he facility infrequently on an M. She stated she was t #10 and had worked with She was normally walking le she was awake. NA #7 forking on 5/6/18 at the time ation between Resident #10 she reported she saw y onto Resident #18's trying to push her. She Resident #10 to let go of lchair, but she had not d that she started to walk f Resident #10 to redirect her ase the wheelchair, but that Resident #10 hit hand. NA #7 reported that it10 walked away from	F	589		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345293	B. WING		10/18/2018		
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 689	c.) An incident report dated 5/13/18 completed by Nurse #3 indicated NA #8 informed her Resident #10 had been in a physical altercation with another resident (Resident #26). Resident #10 hit Resident #26 and then Resident #26 hit her back. (Resident #26 's 4/28/18 annual MDS assessment indicated she had short-term and long-term memory problems and severely impaired decision making).  A nursing note dated 5/13/18 completed by Nurse #3 indicated NA #8 reported Resident #10 slapped Resident #26 on the hand and Resident		F 689				
	observed.  A written statement NA #8 indicated she (Resident #10 and F and forth. She then was coming from ar hit Resident #26 on hit Resident #10 bar indicated she was a and reported to the  A phone interview won 10/18/18 at 9:29 not worked with Reshad on a few occasi #10 was ambulatory on her own. She straight ying in bed one mirknew she was up ar Nurse #3 confirmed at the time of the ph	dated 5/13/18 completed by heard two residents Resident #26) arguing back looked for where the arguing has he observed Resident #10 the hand. Resident #26 then ck on the hand. NA #8 ble to separate the residents nurse (Nurse #3).  Vas conducted with Nurse #3 AM. Nurse #3 stated she had sident #10 frequently, but she ions. She indicated Resident vand could get up and down ated Resident #10 could be nute and the next thing you and walking about again. She was working on 5/13/18 bysical altercation between tesident #26. She stated that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE	1	STREET ADDRESS, CITY, STATE, ZIP C HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	when NA #8 saw F Resident #26 then before NA #8 coul  An interview was of 10/17/18 at 3:43 F familiar with Resid Resident #10 had toward both staff a Resident #10 was and the hall and in almost the whole to confirmed she was of the physical alte and Resident #26. Resident #10 and started to walk ove before she could of them, Resident #1 and Resident #26 indicated she then reported the incide revealed it was ve with Resident #10 her at all times and wasn't too close to any physical altero On 5/14/18 the ca for Resident #10 in aggression was up intervention, "Rem when behavior is of with resident in a I decrease/eliminate provide diversional	Resident #10 hit Resident #26. In turn hit Resident #10 back d separate the residents.  Conducted with NA #8 on M. NA #8 stated she was ent #10. She reported physical behaviors directed and residents. She indicated very active and she walked up atto other residents' rooms ime she was awake. NA #8 s working on 5/13/18 at the time ercation between Resident #10 She indicated she heard Resident #26 arguing so she er to them. She stated that get to the residents to separate 0 hit Resident #26 on her hand hit her back on her hand. She separated the residents and ent to Nurse #3. NA #8 ry challenging at times to work as you had to keep an eye on d needed to make sure she of any other residents to avoid cations.  The plan (initiated on 12/27/17) the lated to verbal/physical bodated to include the love resident from public area disruptive/unacceptable. Talk ow pitch, calm voice to the undesired behavior and	F6	889			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			10/ <sup>-</sup>	) 18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
F 689	the unit. She was see Department (ED) on evaluation, but the EResident #10 would evaluation in the ED to the facility.  A PNP note dated 5/continued with increase She was noted with other residents. Med made by the PNP.  d.) An incident report Nurse #4 indicated Nesident #10 walked (Resident #8) and be injuries were observed (Resident #8 ' s 4/6/assessment indicate long-term memory primpaired decision made in the statement, #9 indicated Resident #10 to "pull and hit on hir back.  A phone interview was on 10/17/18 at 4:29 be reached. (Nurse report related to the between Resident #10 t	abusive to other residents on ent to the Emergency 5/13/18 for psychiatric D provider had not felt benefit from a psychiatric so she was transferred back  15/18 indicated Resident #10 ased anxiety and agitation. Onlysical aggression toward ication adjustments were  It dated 6/9/18 completed by IA # 9 informed her that I up to another resident egan to pull and hit him. No end to either resident. Is quarterly MDS do he had short-term and roblems and severely aking.)  undated, completed by NA ent #8 was sitting in the hall walked up to him and started in ". Resident #8 started hit  as attempted with Nurse #4 PM. Nurse #4 was unable to #4 completed the incident 6/9/18 physical altercation I0 and Resident #8.)  as attempted with NA # 9 on NA #9 was unable to be	Fé	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODI HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	E	10.10.20.10	
(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 COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	DATE	1
F 689	#8.) A PNP note dated 6/2 Resident #10 recently also reported increas and agitation. The P was irritable and anguadjustments were materials.	the 6/9/18 physical Resident #10 and Resident  13/18 indicated staff reported by hit another resident. Staff ed confusion, restlessness, NP indicated Resident #10 by with staff. Medication and by the PNP.	F	889			
	adjustments. She had but no physical aggree behaviors were reported. The annual MDS assindicated Resident #'impaired. She had on 1 to 3 days during the Resident #10 require of 1 for bed mobility a supervision of 1 for we corridor, and locomod #10 was not steady of to stabilize without strimpairment with rang a wheelchair.  e.) A nursing note dan Nurse #5 indicated Nothlering "get out of mentered Resident #32 the arm, and twisted Resident #10 was remoom. Resident #32 the room. Resident #32 the arm, and twisted Resident #32 the arm, and twisted Resident #32 the arm, R	essment dated 10/3/18 10's cognition was severely ther behavioral symptoms on the MDS review period. If the extensive assistance and transfers. She required ralking in room, walking in ion on the unit. Resident on her feet, but she was able aff assistance. She had no the of motion and she utilized the day of the day o					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		,	C 10/18/2018	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	completed by NA #' up trays and heard Resident #10 had e and grabbed her ha twist.  A 24 hour and 5 wo allegation of resider between Resident # 10/4/18 was review as NA # 10 provided Resident #10 entere grabbed her on the intervene and tried if Resident #329's wri room and assisted if #10 to release Resi #10 was then separ skin tear was noted x-ray was obtained results were negativ relocated to another #10. The allegation substantiated.  An interview with the at 10:15 AM indicate Interview of Mental	_	F 68	39			
	on 10/17/18 at 4:45 was familiar with Re Resident #10 had p	vas conducted with Nurse #5 PM. Nurse #5 stated she esident #10. She indicated hysical behaviors directed nts in the past. She reported					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, Z HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	IP CODE	10/10/2010	
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F 689	to any other residents member to keep their that it could be difficul Resident #10 in their because she moved a confirmed she was wof the physical alterca and Resident #329. Yelling from Resident she went to the room holding Resident #32 room and was trying from Resident #329. #10 was able to be re #329's room. She re had a skin tear on he ordered to ensure no A phone interview wa 10/17/18 at 4:15 PM. familiar with Resident #10 was very active the awake. She reported around the common a resident rooms. She had physical behavior in the past. She indice Resident #10 in their ensure no physical all other resident. NA #1 providing care for one other NA on the unit of monitored Resident #were always at least revealed it was some at all times because sconstantly. NA #10 co	e sure she wasn't too close and for at least one staff reye on her. She indicated It at times for staff to keep eyesight at all times about constantly. Nurse #5 orking on 10/4/18 at the time ation between Resident #10 She stated she had heard #329's room. She indicated and she saw Resident #10 9's wrist. NA #10 was in the to separate Resident #10 Nurse #5 stated Resident emoved from Resident ported that Resident #329 r wrist and an x-ray was further injury.  Is conducted with NA #10 on NA #10 indicated she was at #10. She stated Resident throughout the time she was at #10. She stated Resident hroughout the time she was at Resident #10 walked areas, the hall, and into stated that Resident #10 rs directed at other residents extend that staff tried to keep eyesight at all times to tercations occurred with any 10 explained that if she was at of her residents that the or the nurse on the unit 10. She indicated there 2 NAs on the unit. She times difficult to monitor her	F	689			

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 10/10/2010
(X4) ID PREFIX TAG	FIX (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)	LD BE COMPLETION
F 689	between Resident # indicated she was in setting up her meal the room. She state that Resident #10 hroom and grabbed She reported she w #10 from Resident: #5 entered the room the residents.  Resident #10 was on PM ambulating with room of the facility's were present in the observation.  Resident #10 was on PM ambulating with room of the facility's mem staffs' eyesight during the facility's mem staffs' eyesight during (DON) on stated that she experience from the presidents. She also provide adequate set to resident physical 2. Resident #56 was 6/27/18 and most rewith diagnoses that behavioral disturbation.	#10 and Resident #329. She in Resident #329's room tray when she heard yelling in ed she looked over and saw had entered Resident #329's her wrist and was twisting. Went over to separate Resident #329 and at that time Nurse in to assist her with separating  Observed on 10/15/18 at 12:30 in a shuffled gait a common is memory care unit. Staff common room during this  Observed on 10/17/18 at 2:00 in a shuffled gait in the hallway hory care unit. She was within ing this observation.  Onducted with the Director 10/18/18 at 3:35 PM. She ected residents to be physical behaviors of other of stated she expected staff to upervision to prevent resident	F 68		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
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F 689	verbal/physical agg related to: cognitive placement to [nursin reported [history] of other residents." The 7/16/18. Intervention part, provide one sure you have their speaking or touching slowly and from the An initial psychiatric was completed by the Practitioner (PNP) of indicated that staff in been aggressive verpresented as angry hitting staff.  The annual MDS as indicated Resident impaired. He had plays, other behavior and rejection of card MDS review period extensive assistance of 2 or in Resident #56 was review and rejection of card was only able to staff the had no impairment he utilized a wheeled. An incident report of Nurse #8 indicated pushing Resident #reached around her	cterized by ineffective coping; ression or combativeness impairment and recent ing facility]. Resident has a hitting staff members and its focus area was initiated on ons for Resident #56 included, on one sitter as needed, be esident's attention before g, and approach the resident front.  It evaluation for Resident #56 he Psychiatric Nurse on 7/17/18. The PNP reported Resident #56 had rebally and physically. He g, yelling out, demanding, and resessment dated 9/6/18 #56's cognition was severely shysical behaviors on 1 to 3 oral symptoms on 4 to 6 days, e on 1 to 3 days during the resident #56 required the rece of 1 for bed mobility and unit. He required the extensive more staff with transfers. The resident with staff assistance, each with range of motion and	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 10/10/2	010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETION DATE
F 689	redness to her left of quarterly MDS asses short-term and long severely impaired d.  A nursing note date. Nurse #8 indicated in the dining room we pushing Resident # reached around and side of her face". To by staff and new ord Nurse Practitioner (the Emergency Depth A written statement NA #12 indicated Rewere in the dining roobserved Resident if face.  An incident report d. Nurse #8 indicated in his wheeled seated in his wheeled seated in his wheeled self-propelling in her passing Resident #8 slapped the left side were separated and Resident #18's left is no injuries were not incident was noted in Emergency Medical	at #18 was observed with theek. (Resident #18's 7/9/18 resement indicated she had elerem memory problems and ecision making.)  d 10/14/18 completed by at 3:00 PM Resident #56 was when he stood up and started 18 in her wheelchair, he then d slapped her "hard on the left the residents were separated ders were received from the NP) to send Resident #56 to partment (ED) for evaluation.  dated 10/14/18 completed by resident #56 and Resident #18 from on 10/14/18 when she #56 hit Resident #18 in the  ated 10/14/18 completed by at 3:40 PM Resident #18 was resident #18	F 68	<u>'</u>		
	A nursing note date Nurse #8 indicated "once again struck [	ED as ordered for evaluation.  d 10/14/18 completed by at 3:40 PM Resident #56 [Resident #18]" on the left side was passing him in her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	()	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIF HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	CODE	16/16/2010	
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F 689	EMS arrived at 4:00 #56 to the ED for evaluation NA #11 indicate was seated in his which self-propelling in her passing Resident #56 her on the left side of The ED evaluation da Resident #56 was se aggressive behaviors Resident #56 presen no concerns with his unremarkable medicanoted to have been to infection (UTI) during	atts were separated by staff. PM to transport Resident aluation.  Statement taken by Nurse #8 d on 10/14/18 Resident #56 eelchair. Resident #18 was wheelchair and as she was 6 he reached out and struck 6 ther face.  atted 10/14/18 indicated ent in for evaluation of a and a medical screening. ted with normal vital signs, appearance, and an al exam. Resident #56 was reated for a urinary tract y his hospitalization on /18. Resident #56 had been	F	689			
	culture was ordered to while at the ED. The Resident #56 likely has recommended diswith an antibiotic orde #56 was discharged. An inservice sign in sindicated the subject response to resident must include separate them from harm. The staff had received the Director of Nursing (I)	2 weeks. A urinalysis and for Resident #56 on 10/14/18 and ED physician indicated ad chronic colonization and scharge back to the facility ered for one week. Resident to the facility on 10/14/18.  Sheet, dated 10/15/18, covered was, "Immediate to resident abuse/altercation ion of residents to protect the sign in sheet indicated 27 to inservice provided by the DON).					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING				C <b>18/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER	0.0200		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010	
		AND REHABILITATION CENTE		HIGH	HWAY 177 S BOX 1489			
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F 689	Continued From page	e 81	F	689				
	10/14/18 through 10/ provided with one to	18/18 indicated he was one supervision.						
	on 10/15/18 at 12:30 self-propelling in his vall of the facility's me	sident #56 was conducted PM. Resident #56 was wheelchair up and down the emory care unit. He had an er providing one to one						
	on 10/18/18 at 9:15 A familiar with Resident Resident #56 had per physical and verbal b staff. Nurse #8 confir 10/14/18 when Resid #18 on two separate 3:40 PM). She stated occurred when Resid were in the dining root that Resident #56 slat face. Nurse #8 stated Responsible Parties (received an order to sevaluation. She report Resident #56's unit to building to copy Resident #56's unit to building #56's unit to building to copy Resident #56's unit to building #56's unit to building #	riods of agitation as well as ehaviors directed toward rmed she was working on ent #56 slapped Resident occasions (3:00 PM and d that the first incident ent #56 and Resident #18 om. NA #12 reported to her pped Resident #18 in the d she notified the (RPs) and the NP and she send Resident #56 to ED for orted she had exited o go to the front of the						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/10/2010	
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F 689	Resident #18 a second that in hindsight she stated that in hindsight she stated that separated from Resided. She stated that #56 with her while she she could've asked for the could be	and time. Nurse #8 reported should've done things Resident #56 was kept lent #18 until he left for the she could've taken Resident e copied the documents, or or another staff's assistance.  ducted with NA #12 on She stated she was familiar the indicated Resident #56 on as well as physical and cted toward staff. NA #12 orking on 10/14/18 when d Resident #18 on two 3:00 PM and 3:40 PM). She effirst incident, Resident #56 re separated and Resident	F6	89			
	monitoring until EMS Resident #18 had set back to the nurses' st #56. She revealed th could separate the tw slapped Resident #18 that Resident #56 was supervision.  An interview was con 10/18/18 at 3:35 PM. expected residents to physical behaviors of stated she expected supervision to prever physical altercations. two incidents that occ Resident #56 slapped 40-minute time period	arrived. She indicated that f-propelled her wheelchair ration and near Resident nat before she or NA #11 ro residents, Resident #56 again. NA #12 indicated s now on one to one					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	CODE	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 689	separated with a staf Resident #56 at all til indicated she had init related to these incid	e 83 sidents and kept them f member staying with mes until EMS arrived. She tiated an inservice for staff ents. She reported the the process of being given to	F	689			
	2/1/16 and most rece with diagnoses that in dementia, psychotic of schizoaffective disord.  The quarterly Minimulassessment dated 7/ #74'scognition was so other behavioral symithe MDS review period the extensive assistant the limited assistance supervision of 1 with She was assessed a was only able to stab Resident #74 had no motion and she utilized.  The plan of care for a focus area, "Problem resident acts charact verbal/physical aggre- related to: cognitive in hits/strikes at staff and	Im Data Set (MDS)  1/18 indicated Resident everely impaired. She had ptoms on 1 to 3 days during od. Resident #74 required nce of 1 with bed mobility, e of 1 with transfers, and the locomotion on/off the unit. s not steady on her feet and illize with staff assistance. impairment with range of ed a wheelchair.  Resident #74 included the atic manner in which erized by ineffective coping; ession and combativeness					
	members inappropria pinches, and slaps st	ate names. Resident strikes, caff at times. Resident ther residents at times." This					

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F 689	recently revised on a Resident #74 includ resident slowly and not invading resident's you have resident's touching, provide 15 one sitter as needed area when behavior and talk with resident decrease/eliminate	ated on 6/8/17 and most 4/27/18. Interventions for ed, in part, approach the from the front, be cognizant of at's personal space, be sure attention before speaking or aminute checks and one on d, remove resident from public is disruptive/unacceptable, at in a low pitch, calm voice to undesired behavior, and	F6	289			
	Nurse #8 indicated s #74 's room by Nur reported she witnes Resident #23. No ir (Resident #23's 6/16 indicated her cogniti  A nursing note dated #8 indicated NA #8 self-propel her whee the room, and over the room, and over the room, and over the room. Resident #74 then s forearm. Resident # she had done this. separated and Resid different room with of	activity.  ated 7/17/18 completed by she was called to Resident sing Assistant (NA) #8. NA #8 sed Resident #74 "striking" njuries were observed.  6/18 annual MDS assessment ion was moderately impaired.)  d 7/17/18 completed by Nurse had witnessed Resident #74 elchair from the hallway, into to Resident #23's bed.  struck Resident #23 on the left #74 would not answer why Residents #74 and #23 were dent #74 was moved to one on one monitoring.  t #74's medical record e monitoring continued					
	An observation of R on 10/15/18 at 12:30 wheelchair in a com	esident #74 was conducted O PM. She was in her mon area of the facility's There were no physical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 0/18/2018	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COL HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010	
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F 689	on 10/18/18 at 9:15 was familiar with Re confirmed she was Resident #74 struck She stated that had but that NA #8 had her. Nurse #8 was any previous physic residents. She indi #74 had physical be was unsure if she w resident to resident  An interview was co 10/17/18 at 3:43 PM familiar with Reside was working on 7/1 struck Resident #23 observed Resident over to Resident #2 arm. She indicated noise, but that no ir to Resident #23. N were separated and incident. NA #8 wa any previous physic residents. She indi #74 had physical be was unsure if she w resident to resident  An interview was co Nursing (DON) on stated that she expe	was conducted with Nurse #8 AM. Nurse #8 stated she esident #74. Nurse #8 working on 7/17/18 when a Resident #23 on her arm. Inot observed this incident, witnessed it and reported it to asked if Resident #74 had eal altercations with other cated she believed Resident ehaviors in the past, but she was involved in any previous altercations.  Inducted with NA #8 on IN. NA #8 stated she was Int #10. NA #8 confirmed she 7/18 when Resident #74 B on her arm. She stated she #74 self-propel her wheelchair 3's bed and slap her on the the slap made an audible ujuries or redness were noted A #8 reported the residents If she informed Nurse #8 of the se asked if Resident #74 had eal altercations with other cated she believed Resident ehaviors in the past, but she was involved in any previous	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/10/2010	
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F 689	to resident physical 4. An observation AM revealed the m dementia unit was accessible area. T rear of the nurses's to residents via a si closed, was only se There were no staff medication room no members monitorin the time of the obse unlocked medication boxes of resident m the counter. Furthe accessible syringes the counter stock m medical supplies. I room multiple resid ambulating or had a station where the m An observation com AM revealed the m dementia unit was accessible area. T within the medication staff members mon door at the time of the medication room observed to be am near the nurses' sta room was located.  An observation com AM revealed the m dementia unit was room was located.	upervision to prevent resident	F 68	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	11	0/16/2018	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689 F 690 SS=D	staff members monitor door at the time of the the medication room observed to be ambut near the nurses' static room was located.  An observation was can interview with the on 10/18/18 at 9:07 A revealed the medication dementia unit was un accessible area. The within the medication staff members monitor door at the time of the stated it was her experiorms in the facility to During an interview of 10/18/18 at 3:35 PM respectation for all medications, sharps, supplies to be secure contact from resident Bowel/Bladder Incont CFR(s): 483.25(e)(1): §483.25(e)(1) The factoristic admission receives signaintain continence of the state of the st	room nor were there any pring the medication room as observation. Upon exiting multiple residents were lating or had congregated on where the medication where the medication where the medication where the medication on the observation of the conducted in a resident of the were no staff members of the medication of the DON on the DON stated it was here and other hazardous dealth was here expectation for and other hazardous dealth was here expectation for and other hazardous dealth was here expectation for and other hazardous dealth was here. Catheter, UTI of the conducted with the DON on the conducted with the DON on the DON stated it was here expectation for and other hazardous dealth out of potential sections. Catheter, UTI of the conducted with the conducted with the conducted with the conducted with the DON on the process of the conducted with the DON on the DON on the DON of the DON on the conducted with the DON on the	F6			11/15/18	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	1 10/10/2010
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F 690	incontinence, based comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical continence to the estate of the continence to the estate of the comprehensive as possible unless that continence to the estate of the continence to the estate of the comprehensive as propriety prevent urinary tracecontinence to the estate of the comprehensive as propriety prevent urinary tracecontinence to the estate of th	resident with urinary d on the resident's essment, the facility must inters the facility without an is not catheterized unless the ondition demonstrates that necessary; enters the facility with an or subsequently receives one oval of the catheter as soon the resident's clinical condition eatheterization is necessary; s incontinent of bladder the treatment and services to t infections and to restore over the control of the	F 6	90	
	ensure that a resider receives appropriate restore as much no possible. This REQUIREMENT by: Based on record reinterviews, the facilic catheter care (Residents reviewed) Findings included: Resident #54 was a			F 690 Bowel / Bladder Incontinent Catheter How corrective action will be accomplished for those residents four have been affected by the deficient practice Resident # 54 was provided with cather care as directed in the plan of care of 10/17/18 by Certified Nursing Assistation (CNA). How the facility will identify other residents	nnd to heter n ants

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345293	B. WING				′ 18/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		Н	AMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 690	Continued From page	e 89	F	690			
	The quarterly Minimu	ım Data Set dated 9/12/18			having the potential to be affected by the	ne	
		had an intact cognition with			same deficient practice		
		occurred 1 to 3 days in the			•		
	week. The resident r	-			Residents that have urinary catheters		
		for all activities of daily living			have the potential to be affected.		
	(ADL) except locomo	tion was one staff and meals			What measures will be put into place o	r	
	were set up. The act	tive diagnoses were			systemic changes made to ensure that		
	neurogenic bladder, I	UTI, and retention of urine.			the deficient practice will not recur		
					Wound Nurse provided nursing staff		
	· ·	9/13/18 revealed goals and			re-education on the Resident Care Gui		
	interventions for ADL				to include providing urinary catheter ca		
	toileting, and urinary	tract infections with			as indicated on 10/17/2018 to all CNAs	to	
	urosepsis.				include fulltime, part time and agency		
	Op 10/17/19 at 12:15	nm an absorvation was			staff. For staff not inserviced by	r to	
		pm an observation was for Resident #54. Nursing			11/15/2018 they will be in-serviced prio working on the floor. The UM will perfo		
	assistants (NAs) #1,				observation and/or interview audits for	.111	
		nd no issues were noted for			residents that have urinary catheters. T	he	
		vided the washing. There			audits will be performed 3 times a week		
	-	nptoms of pain during care.			for 4 weeks, then weekly for 2 months	•	
		as present were observed to			then quarterly thereafter. The audits wi	II	
		e to clean the insertion site of			be performed at random times on rand		
	the urinary catheter (	meatus) and urinary catheter			days including the weekend.		
	tubing.				How the facility plans to monitor its		
					performance to make sure that solution	IS	
		pm NA #2 was interviewed			are sustained		
	who stated that the tr	` ,			The audits will be performed 3 times a		
	1 '	catheter cleaning care each			week for 4 weeks, then weekly for 2		
	-	hanging the urinary catheter,			months then quarterly thereafter.		
	_	and checking that the			The results of the audits will be	•••	
	catheter was secured	1.			communicated to the DON. The DON v		
	Op 10/17/10 -+ 10:10	nm an intensious			track and trend the results and re-educ		
		) pm an interview was			or initiate counseling for nursing staff a		
		eatment nurse (TN) who ged the urinary catheter			indicated. The DON will share the resu of audits with the interdisciplinary team		
	-	ged the unitary catheter ade sure the leg strap			(IDT) weekly for 12 weeks.		
		atheter each day. The TN			The DON and/or nursing unit manager	will	
	-	no provided morning care to			present IDT corrective actions to the	V V 111	
		onal care was to perform the			monthly quality improvement (QI)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  IG	(X	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C <b>10/18/2018</b>	
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RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, 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 C ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From page	90	F 6	90			
	urinary drainage bag. On 10/18/18 at 11:10 conducted with NA #1 #54 received a bed ba observe catheter care perform catheter care her role was to hold th and had not observed NA #1 stated that cath expected to be done with Con 10/17/18 at 1:15 p conducted with the Di stated she expected t provide urinary cathet morning care.	who stated when Resident ath yesterday she did not cleaning and did not.  NA #1 commented that he resident's contracted legs what was being cleaned. Heter care cleaning was with morning care.  If was an interview was rector of Nursing DON who he nursing assistant to her care cleaning with		committee for review, identifut trends, additional corrective recommendations. The adnual and/or DON will present trends to present trends and and a possible trecommendation quarterly quality assurance aperformance improvement (committee for review, addition recommendations, and to deneed for continued monitoring continued compliance.	actions, and ninistrator nds and QI is to the and QAPI) onal etermine the		
F 692 SS=E	CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous en percutaneous endosc enteral fluids). Based comprehensive asses ensure that a resident §483.25(g)(1) Maintai of nutritional status, s desirable body weight balance, unless the re demonstrates that this preferences indicate of	autrition and hydration. and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's esment, the facility must in acceptable parameters uch as usual body weight or a range and electrolyte esident's clinical condition is is not possible or resident otherwise;	F 6	92		11/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	10/10/2	010	
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RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345				
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F 692	Continued From page	e 91	F 6	592				
	there is a nutritional provider orders a the This REQUIREMENT by: Based on observation	red a therapeutic diet when problem and the health care rapeutic diet.  is not met as evidenced ans, record review, and staff cian (RD) interview, the		F 692 Nutrition Hydration St	tatus			
	facility failed to imple	ment the interventions as rther weight loss for 1 of 3		How corrective action will be accomplished for those reside have been affected by the defi practice  The resident #75 is receiving t	icient	to		
	Findings included:			supplement recommended by Registered Dietitian (RD) and	the	ed		
	5/5/17 with multiple of dementia. The quart (MDS) assessment of Resident #75 had mo impairment, was tota had a significant weig further indicated that therapeutic and mech	erly Minimum Data Set ated 10/2/18 indicated that oderate cognitive lly dependent for eating and yht loss. The assessment Resident #75 was on a		by the physician. The order for dining was discontinued as rescurrently receiving Speech The How the facility will identify oth having the potential to be affect same deficient practice. The Certified Dietary Manager performed a 100% review of rewith new dietary supplement of the previous 30 days. The rest audit revealed 1 (one) negative	r restorati sident is erapy. her reside cted by th r (CDM) esidents' orders for ults of the	ve nts e		
	was reviewed. One of was state of nourishman requirement character inadequate intake an goal was resident wo significant weight loss approaches included liquids, use teaspoon meals refused, provio nectar thickening con Resident #75 weights	of the care plan problems ment, less than body wrized by weight loss, d decreased appetite. The uld not experience s through next review. The alternate food bites with when feeding resident, if de extra nourishment and		which was immediately addres CDM. The MDS (Minimum Dar Licensed Nurse performed an 11/20/18 on the November 20 orders for any active restorative orders. The audit revealed that the center does not have any with current orders for restorate Facility Registered Nurse (RN) an observation audit of the tray supplements on 11/8/18 during meal pass. The audit revealed 33 residents with supplements of the supplements	ssed by the ta Set) audit on 18 physic redining to currently residents tive dining y delivery general that of the tasks of tasks o	ian y J. ed of ch		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE		SURVEY LETED					
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NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DICHMON	D DINES HEAT THOADS	AND DELIABILITATION CENTE		HIG	GHWAY 177 S BOX 1489		
RICHIVION	D PINES REALI ROAKE	AND REHABILITATION CENTE		HA	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From pag weighed 137 lbs., on on 8/28/18, he weigh weighed 123 lbs. and 121 lbs. He lost 19 lb equates into a 13.57 loss).  On 6/25/18, there was dietary supplement to lunch and dinner.  The resident's dietar 8/29/18, the notes rehad 10 pounds (lbs.) meal intake was 50-and lunch and variat Recommendation was supplement to 3 time with meals. On 9/24 Resident #75's weigh current weight was 1 a significant weight last Resident #75 to a re On 10/10/18, the not #75 continued to trig loss. His current we was on multiple there to aid with needs income on 8/29/18, there was increase the dietary	ge 92  1 7/2/18, he weighed 138 lbs., and 130 lbs., on 9/12/18 he don 10/10/18, he weighed be. in 5 months (which percent significant weight as a doctor's order for a o be given 2 times a day at a very notes were reviewed. On evealed that Resident #75 weight loss in 3 months. His 100 percent (%) for breakfast ble intake for dinner 0-100 %. as to increase the dietary as a day and to be served with the order of the orde	F 6	692		r ere the oT)	
	Administration Reco	rd (MAR). as a doctor's order for rogram for significant			nurses. The CDM will perform an observation audit 3 times a week for 1 week, then weekly for 1 month for the provision of Restorative Dining, dietary supplement	s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		10/10/2010	
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F 692	On 10/10/18, there we the dietary suppleme on meals trays, and to intake of supplement.  The Medication Admit for August through Orand revealed that the provided twice a day ordered.  On 10/15/18 during luft #75 was observed in feeding him.  On 10/16/18 and 10/10/16/18 and 10/10/16/18 and 10/10/16/18 at 10:40 (DON) was interviewed 2 restorative aides. Trestorative aides. Trestorative ambulation feeding and weights. nobody was on restor program at this time.  On 10/17/18 at 11:05 was interviewed. NA of the Restorative Aid had 1 resident on restorative feed further indicated that	as a clarification order for int to be given 3 times a day of document percent of consumed.  Inistration Records (MARs) october 2018 were reviewed dietary supplement was and not 3 times a day as and not 3 times a day as and not 3 times a day as and inch observation, Resident bed. A staff member was a feeding him. There was not observed on his meal tray.  AM, the Director of Nursing ed. She stated that they had their duties were splinting, in, toileting, restorative. The DON stated that rative feeding/dining.  AM, Nurse Aide (NA) #2 #2 stated that she was one des. She stated that they torative feeding/dining at dent #75. She indicated that ed that Resident #75 had to ding/dining program. NA #2 when a resident was on a ogram, they should be in the	F 6	as recommended by the RD at by the physician. The CDM will share the results audits with the DON. The DON the results of audits with the interdisciplinary team (IDT) we weeks. The DON and/or nursing unit in present IDT corrective actions monthly quality improvement (committee for review, identificated trends, additional corrective active activ	s of the I will share seekly for 12 manager will to the QI) ation of ctions, and sistrator is and erly quality approvement additional ermine the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 692	them to eat.  On 10/17/18 at 12 interviewed. She been trending for stated that the factoristing of the consisting weekly. Resident #75's we during the meeting the restorative feet of the supplement had written the orthogram and the interest of the supplement of th	had to assist and encouraged 2:45 PM, the RD was verified that Resident #75 had significant weight loss. She sility had a weight committee department heads and they had . The RD indicated that eight loss had been discussed g and the interventions including eding program and the increase t. She also indicated that she ders for the restorative feeding increase of the supplement. ated that she had identified at the dietary orders were not inursing and dietary staff by the exigned off the orders and t implemented. The RD stated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a clarification element because the order dated she had to write a cl	F 6	92			

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	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE	·	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
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F 693 SS=D	signed off the order of the supplement to 3 the supplement to 3 the sent a diet slip to diet made a copy of the operation to transcribe and to indepartment. Nurse # the name of the nurse the order.  On 10/18/18 at 3:40 ff (DON) was interviewed she expected the interplemented as on Tube Feeding Mgmt/CFR(s): 483.25(g)(4)-(5) Ent (Includes naso-gastriboth percutaneous endoscenteral fluids). Based comprehensive assessmenter that a resident \$483.25(g)(4) A resident eat enough alone or venteral methods unle condition demonstration clinically indicated an resident; and	PM, Nurse #10 was 10 was the nurse who lated 10/10/18 to increase imes a day. She stated that the order to the MAR nor lary department but she rder and gave it to the nurse inform the dietary 10 was unable to remember the she had given the copy of  PM, the Director of Nursing the DON stated that the reventions for weight loss to rdered. Restore Eating Skills (5)  Iteral Nutrition or and gastrostomy tubes, indoscopic gastrostomy and topic jejunostomy, and on a resident's issment, the facility must		993		11/15/18

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/10/2010	
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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 CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 693	Continued From page	e 96	F 6	93			
F 693	and to prevent complincluding but not limit diarrhea, vomiting, de abnormalities, and na This REQUIREMENT by: Based on record revinterview, the facility of tube feeding for 2 reviewed for tube fee Findings included:  1. Resident # 20 was 2/28/17 with multiple dysphagia. The quar (MDS) assessment diassessment indicated assessment indicated assessed for cognitive Resident #20 had a compassion was initiated on 4/26/10 to infuse at 40 millilited 7 AM.  On 10/17/18 at 9 AM, observed in bed with 40 ml per hour.  On 10/17/18 at 11:05 observed in bed with 40 ml per hour.	ications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers. is not met as evidenced ew, observation and staff failed to follow doctor's order of 3 sampled residents ding (Residents #20 & #30).  admitted to the facility on diagnoses including terly Minimum Data Set ated 8/22/18 indicated that feeding tube and on nanically altered diet. The dighthat Resident #20 was not e status.  current doctor's order which for tube feeding formula er (ml) per hour from 7 PM to the Resident #20 was the tube feeding infusing at AM, Resident #20 was the tube feeding infusing at	F 6	F 693 Tube Feeding Management/Restore Eating Sk How corrective action will be accomplished for those resident have been affected by the defici- practice Resident #20 and #30 are currer receiving tube feedings as order physician was verified by visual observation of the tube feeding preview of documentation on the (Medication Administration Reco- current physician orders by the I (Director of Nursing) and UM (U Manager) on 10/18/18. How the facility will identify other having the potential to be affected same deficient practice  Residents with tube feeding order the potential to be affected. What measures will be put into president practice will not recon- on 11/7/18 The Unit Manager (I re-educated by the Director of N reviewing all new physician order tube feeding orders prior to the r morning Interdisciplinary Team (I	es found to ient  Intly	e nts	
	work on different halls	AM, Nurse #6 was ted that she was assigned to s and she didn't know that feeding had to be turned off		meeting including start and stop UM will observe that residents a receiving enteral tube feedings a 3 times weekly on random days	ire as ordere	ed	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI				X3) DATE SURVEY COMPLETED	
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F 693	Continued From page	e 97	F	693				
	resident's feeding tub On 10/18/18 at 3:40 F	PM, the Director of Nursing			random times including the weekends to compliance with physician orders.  How the facility plans to monitor its performance to make sure that solution are sustained			
	she expected the ord followed as ordered.	ed. The DON stated that er for tube feeding to be			The UM will report the finding of the review to the IDT during the next IDT meeting. On 11/7/2018, Director of Nursing (DOI initiated re-education of the licensed	N)		
	9/27/18 with multiple dysphagia. The quar (MDS) assessment d Resident #30 had lon	terly Minimum Data Set ated 8/2/18 indicated that g and short term memory ssment did not indicate that			nurses on tube feeding orders and administration of tube feedings includin MAR review. For licensed nurses not inserviced by 11/15/2018 they will be inserviced prior to working in the facility New hires and agency staff will receive this education during orientation to the facility.	/.		
	was initiated on 9/27/	urrent doctor's order which 17 for tube feeding to infuse r hour and to be off at 7 AM			The UM will perform an observation au 3 times a week for 1 week, then weekly for 1 month for the provision of tube feedings as recommended by the RD a ordered by the physician.	/		
		AM, Resident #30 was tube feeding infusing at 50			The UM will share the results of the auwith the (DON). The DON will share the results of audits with the interdisciplinateam (IDT) weekly for 12 weeks.	Э		
	work on different halls Resident #30's tube f at 7 AM. Nurse #6 w resident's the feeding	ted that she was assigned to s and she didn't know that eeding had to be turned off as observed to turn off the tube at 9:10 AM.			The DON and/or nursing unit manager present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, ar recommendations. The administrator and/or DON will present trends and QI committee recommendations to the			
	(DON) was interviewe	PM, the Director of Nursing ed. The DON stated that er for tube feeding to be			quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine th	e		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From pag	e 98	F	693	need for continued monitoring to ensur continued compliance in the area of tul feeding management.	
F 757 SS=D	Drug Regimen is Fre CFR(s): 483.45(d)(1)	e from Unnecessary Drugs (6)	F7	757		11/15/18
	_	sary Drugs-General. regimen must be free from An unnecessary drug is any				
	§483.45(d)(1) In exceduplicate drug therap	essive dose (including by); or				
	§483.45(d)(2) For ex	cessive duration; or				
	§483.45(d)(3) Withou	ut adequate monitoring; or				
	§483.45(d)(4) Withouse; or	ut adequate indications for its				
	§483.45(d)(5) In the consequences which reduced or discontinu	indicate the dose should be				
	stated in paragraphs section. This REQUIREMEN by: Based on record rev facility failed to monit test as ordered for 2	ombinations of the reasons (d)(1) through (5) of this  T is not met as evidenced riew, and staff interview, the for and to draw the laboratory of 5 sampled residents ssary medications (Residents			F 757 Drug Regimen is Free from Unnecessary Drugs How corrective action will be accomplished for those residents found have been affected by the deficient practice Laboratory tests for residents #279 and #280 were obtained on 10/18/18. The	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	9/28/18 with multiple septicemia, stage 4 sosteomyelitis.  The admission Minimassessment dated 10 Resident # 279 had rimpairment and was and deep tissue injurassessment also indicinguosis of septicem.  The hospital dischargindicated that Resider and required 6 weeks indicated to continue (IV) 2 grams daily an mgs (by mouth) twice notes further indicate the resident should hweekly and a hepatic weeks.  Resident #279 had do for ceftriaxone 2 grandily and doxycycline mouth twice a day for and a complete blood 7 to be drawn on 10/10 Resident #279's med and there were no latincluding the CBC and copy chart and electrons.	s admitted to the facility on diagnoses including sacral pressure ulcer and formal pressure ulcer and sum Data Set (MDS) 0/5/18 indicated that moderate cognitive admitted with unstageable by (DTI) pressure ulcers. The cated that the resident had a mia.  The cated that while on antibiotic, and that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that while on antibiotics, ave a CBC and renal panel of the function panel every 2  The cated that the resident had a cated that while on antibiotics.  The cated that the resident had a cated that the res	F	757	results for resident # 279 were abnormedut not critical labs, the physician was made aware of the results of the labs of 10/18/18 by the licensed nurse assigned to the resident. The results for resident #280 revealed abnormal but not critical labs, the resident's physician was made aware of the results on 10/18/18 by the licensed nurse assigned to the resident How the facility will identify other resident having the potential to be affected by the same deficient practice. On 11/7/2018, the Unit Manager (UM) or re-educated on reviewing all new physician orders for lab orders prior to next morning Interdisciplinary Team (ID meeting by the Director of Nursing (DO). The review of the orders will include the complete processing of the order to include transcription to the Lab Sheet/Program.  How the facility plans to monitor its performance to make sure that solution are sustained. The UM will report the findings of the review to the IDT during the next IDT meeting. The end of the month changeover of physician's orders will be reviewed by 2 licensed nurses. The UM will perform an lab audit weekl of newly ordered labs for obtaining specimen for labs, results received and physician notified for 1 month then monthly thereafter for obtaining and receiving results of the laboratory order by the physician. The UM will share the results of the audits with Director of	n ed e e e e e e e e e e e e e e e e e e	
		#279, was conducted. She not find laboratory tests			results of the audits with Director of Nursing (DON).		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER  D PINES HEALTHCA	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	Resident #279.  On 10/18/18 at 10 (DON) was intervilaboratory tests (Ofor 10/1/18 were in the laboratory test their system, the porder and draw the was ordered stat, blood and sent the DON indicated that (CBC and chemis not entered into the blood was not draw the was ordered stat, blood and sent the DON indicated that (CBC and chemis not entered into the blood was not draw the was interviewed. She admitting nurse to summary and to we tests written in the The DON also state laboratory test to be recommended per summary and was infinitely diagnoses fibrillation and ver quarterly Minimum dated 8/27/18 indisevere cognitive in the hospital discharacteristics.	cBC and chemistry 7 for  2:44 AM, the Director of Nursing ewed. The DON stated that the CBC and chemistry 7) ordered tot drawn. She stated that once awas ordered and entered into chlebotomist could see the eleblood. If the laboratory test the facility staff had to draw the expecimen to the hospital. The at the ordered laboratory tests try 7) for Resident #279 were the system and therefore the win.  40 PM, the DON was again stated that she expected the read the hospital discharge write orders for the laboratory the hospital discharge instruction. The followed as ordered and as an hospital discharge summary.  Was admitted to the facility on the eadmitted on 8/20/18 with a sincluding hyperlipidemia, atrial atricular tachycardia. The in Data Set (MDS) assessment cated that Resident #280 had impairment.  The parameter of the laboratory of the laboratory of the sincluding hyperlipidemia, atrial atricular tachycardia. The in Data Set (MDS) assessment cated that Resident #280 had impairment.	F 75	The DON will share the rest with the interdisciplinary teal weekly for 12 weeks. The DON and/or nursing un present IDT corrective actio monthly quality improvemer committee for review, identitrends, additional corrective recommendations. The adrand/or DON will present treir recommendations to the quassurance and performance (QAPI) committee for review recommendations, and to dineed for continued monitoric continued compliance.	am (IDT)  ait manager will ons to the ont (QI)  fication of exactions, and oninistrator onds and order arterly quality eximprovement on a ditional etermine the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 10/18/2018
	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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 757	Continued From page Resident #280 had ac dated 8/20/18 for Lipi	dmitting doctor's orders	F 75	7	
	hyperlipidemia) 20 mi for hyperlipidemia and	ior (used to treat illigrams (mgs) at bedtime d digoxin (anti-arrhythmic or atrial fibrillation/ventricular			
		s from the drug regimen leed for digoxin level and			
	(QI) Nurse was interv	PM, the Quality Assurance iewed. She stated that she nel and digoxin level results			
	(DON) was interviewed digoxin level and the drawn on admission be stated that she didn't pharmacy recommen	AM, the Director of Nursing ed. She stated that the lipid panel should have been out they were not. She also get into the September 2018 dations for Resident #280 pxin level and the lipid panel			
F 758 SS=E	interviewed. She star digoxin level and lipid admission and when Consultant.	requested by the Pharmacy chotropic Meds/PRN Use	F 75	8	11/15/18
	affects brain activities	opic Drugs. hotropic drug is any drug that s associated with mental rior. These drugs include,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COL HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 758	categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensident, the facility of the facility o	ensive assessment of a must ensure that— ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive oursuant to a PRN order on is necessary to treat a condition that is documented and orders for psychotropic drugs is. Except as provided in attending physician or her believes that it is ern order to be extended or she should document their ent's medical record and	F 75	58		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURV COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	'	10/10/20	710
				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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) MPLETION DATE
F 758	Continued From page	e 103	F 7	58			
	renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on observation interview, and Psychia	n, record review, staff atric Nurse Practitioner		F 758 Free from Unnecessa Psychotropic Meds/ PRN use	ıry		
	residents reviewed for	tion as ordered for 1 of 5 or unnecessary psychotropic nt #8 received an additional perdal (antipsychotic		How corrective action will be accomplished for those resider have been affected by the definition practice On 10/18/18 the order for Risp by mouth every am was re-write reflect the order that was written.	cient erdal 1m tten to		
	The findings included	l:		8/29/18. On 11/14/18, the Direct Nursing (DON) and nursing Un	ctor of	ıer	
	and most recently readiagnoses that included dementia with behavioral A physician's order de Risperdal (antipsychomilligrams (mg) 3 times	ated 6/19/18 indicated otic medication) 0.5 es daily for 3 days then		(UM) verified that the Monthly I orders, dated for 11/1/18 through 11/30/18, and the current Nove MAR (Medication Administration were reflective of the order that written for Risperdal 1 mg by mam for resident #8 on 8/29/18. Director of Nursing and Unit Materials	Physiciangh ember 20 on/ Recor t was nouth eve The anager	18 rd)	
	had short-term and lo and moderately impa He had no behaviors	m Data Set (MDS) 6/18 indicated Resident #8 ong-term memory problems ired decision-making skills. and no rejection of care. antipsychotic medication on		visually observed the current Mocumentation of the medicatic administration as ordered. The observation by the DON and not manager revealed that residen receiving medication as ordere evidence by the documentation. How the facility will identify oth having the potential to be affect same deficient practice.	on ursing ur ut was ed as n. er reside	nts	
	8/22/18 indicated a re	Practitioner (PNP) note dated ecommendation to reduce erdal 1 mg once daily to be daily.		On 11/7-8/18, the desk nurse of review of all residents with new antipsychotic orders for the predays. The review identified five	v evious 30		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING COMPLI				
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TAPAWIE OF TH	COVIDER OR OUT FEET				IIGHWAY 177 S BOX 1489		
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					IAMLET, NC 28345		
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F 758	Continued From pa	ge 104	F 7	758			
	decrease in Reside once daily to 0.5 mg	8/29/18 indicated Resident #8			orders requiring further investigation. desk nurse and DON immediately obtained clarification and took necessary action, including notification of the physician and resident/resident representative as appropriate.	ıry	
		behaviors and aggression with			What measures will be put into place o		
		changes. The PNP indicated			systemic changes made to ensure that		
		nurse to give Resident #8			the deficient practice will not recur		
		ow for one dose due to			On 11/14/18, the DON completed		
	• •	ors/agitation and to increase			re-education of the nurse unit manager		
	Risperdal back to 1				on reviewing all new physician orders f antipsychotics prior to the next morning	9	
		ed 8/29/18 indicated the PNP			interdisciplinary team (IDT) meeting. The	ne	
		nd new orders were given to			review of the orders will include the		
	change Risperdal to	o 1 mg once daily.			complete processing of the order to include transcription to the medication		
	A physician's order	dated 8/29/18 indicated			administration record (MAR).		
		ow one time and an increase			The nurse unit manager will report the		
	in Resident #8's Ris	sperdal from 0.5 mg once daily			finding of the review to the IDT team		
	to 1 mg once daily.				during the next morning IDT meeting. On 11/14/18, the DON implemented the	е	
	A review of the Aug	just 2018's hard copy			practice that the end-of-month		
	Medication Adminis	stration Record (MAR)			changeover of MARs will be reviewed	оу	
	indicated Risperdal	was administered as ordered			two licensed nurses.		
	to Resident #8.				How the facility plans to monitor its		
					performance to make sure that solution	ıs	
	A PNP note dated 9	9/5/18 indicated Resident #8			are sustained		
		al Dose Reduction (GDR) of			On 11/14/18, the desk nurse will begin		
		t 2018. Medications were			auditing 10% of the resident medication	n	
		lly ordered and staff noted an			administration records MARs for	_	
	improvement in mo	od and behaviors.			changeover accuracy each month for 1	2	
					weeks, then quarterly for 12 months.		
		otember 2018 hard copy MAR			The DON will share the results of the		
		ealed two physician's orders			audits with the interdisciplinary team (II	UT)	
	•	first order, dated 8/22/18, was			weekly for 12 weeks.		
	• •	d on the hard copy MAR and			The DON and/or nursing unit manager	will	
		0.5 mg once daily for second order, dated 8/29/18,			present IDT corrective actions to the monthly quality improvement (QI)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	DATE SURVEY COMPLETED
		345293	B. WING _			C 10/18/2018
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	DDE	10/10/2010
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758	indicated Risperdal #8. Both orders, Ris 1.0 mg, were adminithrough 9/30/18. Th 0.5 mg once daily haphysician on 8/29/18 discontinued on the resulted in the admir mg of Risperdal once Resident #8.  An observation was his room in his whee PM. There were no Resident #8 was ale  An observation was the hallway of his un 10/17/18 at 11:05 AN issues observed. Reoriented to self only.  An interview was con Nursing (DON) on 10 DON was asked who changeover of MARs monitoring MARs to administered as ordenormal process was review the next moniprevention of transcriprinted out at the encindicated the third shiresponsible for reviet the month to ensure	the hard copy MAR and I mg once daily for Resident perdal 0.5 mg and Risperdal stered once daily from 9/1/18 e 8/22/18 order for Risperdal id been discontinued by the id, but had not been September 2018 MAR. This distration of an additional 0.5 e daily for 30 days for conducted of Resident #8 in Ilchair on 10/15/18 at 12:15 behavioral issues observed. It and oriented to self only. Conducted of Resident #8 in it in his wheelchair on M. There were no behavioral esident #8 was alert and conducted with the Director of 10/18/18 at 11:30 AM. The 10/18/18/18 at 11:30 AM. The 10/18/18/18 at 11:30 AM. The 10/18/18 at 11:30 AM. The 10/18/18/18 at 11:30	F 7	committee for review, identification trends, additional corrective recommendations. The admand/or DON will present trends assurance and performance (QAPI) committee for review recommendations, and to do need for continued monitoring continued compliance.	actions, and ninistrator nds and arterly quality improvement v, additional etermine the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	, ,	DATE SURVEY COMPLETED
		345293	B. WING			C
	ROVIDER OR SUPPLIER  D PINES HEALTHCAF	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	·	10/18/2018
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR 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 758	physician's orders related to Resident with the DON. The Resident #8 were redown to the DON confirmed Resident #8 were redown to the Additional 0.5 mg of days in September hard copy MARs wincluded the 8/22/1 Risperdal 0.5 mg of reported the 8/29/1 Risperdal 1 mg on the handwritten onto the when the handwritten onto the when the handwritten was added onto the 8/29/18, that the 8/mg should have be explained that since the hard copy MAR error was not caughten the end of August. That during the mornadmitted a total of evacuated from other related emergencies number of new administration of the warm of t	the DON continued. The dated 8/22/18 and 8/29/18  #8's Risperdal were reviewed september 2018 MARs for eviewed with the DON. The sident #8 was administered an f Risperdal once daily for 30 2018. She stated that the ere printed on 8/29/18 and had 8 physician's order for nace daily for Resident #8. She 8 physician's order for ace daily for Resident #8 was be MAR. She revealed that en order for Risperdal 1 mg as September 2018 MAR on 22/18 order for Risperdal 0.5 en discontinued. The DON at the 8/29/18 order came after as were printed (8/29/18), the hat during the MAR review at She additionally explained with of September the facility 49 residents who were the facilities due to weather as. She revealed that this high missions disrupted the facility's and she felt this was why the evered at the end of month was conducted with the PNP 2 PM. She confirmed that illed the GDR of Risperdal in the changed his Risperdal once daily on 8/29/18. She dent #8 had received an f Risperdal once daily for 30	F	758		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 10/18/2018	
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		
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F 758	Continued From page	e 107	F 758	3		
	days in September 20 expected her orders to	018. The PNP indicated she to be followed.				
F 760 SS=D	Residents are Free o CFR(s): 483.45(f)(2)	f Significant Med Errors	F 760		11/15/18	
	medication errors. This REQUIREMENT by: Based on record rev interview, the facility medication error whe not administered as o resident reviewed wit  Findings included: Resident #279 was a 9/28/18 with multiple septicemia and osteo  The admission Minim assessment dated 10 Resident # 279 had r impairment, had a sta and had diagnoses o osteomyelitis.  The hospital discharg indicated that Reside and required 6 weeks indicated to continue intravenous (IV) 2 gra	is not met as evidenced iew and staff and pharmacist failed to prevent a significant in prescribed antibiotics were ordered for 1 of 1 sampled th infection (Resident # 279).  dmitted to the facility on diagnoses including omyelitis.  num Data Set (MDS) 0/5/18 indicated that moderate cognitive age 4 sacral pressure ulcer if septicemia and  ge summary dated 9/27/18 ant #279 had osteomyelitis s of antibiotics. The notes with ceftriaxone (antibiotic) ams daily and doxycycline		F 760 Residents are Free of Significe Med Errors How corrective action will be accomplished for those residents found have been affected by the deficient practice Resident #279 is receiving medication ordered by the physician. On 11/14/18 Director of Nursing (DON) and nursing unit manager verified that the Monthly Physician orders, dated for 11/1/18 through 11/30/18, and the current November 2018 MAR (Medication Administration/ Record) were reflective the orders for resident #279. How the facility will identify other reside having the potential to be affected by the same deficient practice The desk nurse performed a review of residents' with new antibiotic orders for the previous 30 days. The Desk Nurse review included availability of medicative administer as ordered. Any negative findings were addressed/investigated	d to as the e of ents he	
	day until 10/31/18.	rams (mgs) by mouth twice a octor's orders dated 9/28/18		immediately by the auditor, including notification of the physician as appropriate. What measures will be put into place of	г	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COL	)E		
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345			
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				DEFICIENCY)			
F 760	Continued From r	nago 100		00			
1 700	Continued From p	<del>-</del>	F 7				
		grams (GM) intravenous (IV)		systemic changes made to en			
		line 100 milligrams (mgs) by		the deficient practice will not			
		/ for septicemia/osteomyelitis.		On 11/8/2018, Unit Managers			
		2 antibiotics did not have a stop		re-educated by the DON on r	•		
	date.			new physician orders for anti	•		
	The Sentember 2	018 Medication Administration		to the next morning interdisci (IDT) meeting. The review of	•		
	•	for Resident #279 were		will include the complete prod			
		ptember 29 and 30, the boxes		order to include transcription	•		
		ot have nurse's initials to		medication administration rec			
		axone 2 grams IV and the AM		as well as the availability of the			
		ne were administered. Resident		ordered medication. The UM	•		
		d doses of ceftriaxone (9/29		the finding of the review to th	-		
		oses of doxycycline (AM dose).		during the next IDT meeting.			
		cooc or deriyeyemre (rum dooc).		the month changeover of MA			
	The October 2018	B MARs were reviewed. On		reviewed by 2 licensed nurse			
		gh 18 (except on the 15), the		How the facility plans to mon			
		R for ceftriaxone and		performance to make sure th			
		and PM dose) had circled initials		are sustained			
		medications were not		The desk nurse will audit 10%	% of the		
	administered. Res	sident #279 had 5 missed doses		MARs for changeover accura	icy each		
	of ceftriaxone IV a	and 9 doses of doxycycline.		month for 12 weeks, then qua			
				thereafter. The UM will share	the results		
	On 10/18/18 at 9:	05 AM, Nurse #9 was		of the audits with Director of I	Nursing		
	interviewed. Nurs	e #9 stated that she was		(DON).			
	assigned to Resid	lent #279 on October 14 and 16.		The DON will share the resul	ts of audits		
	She stated that sh	ne did not administer the		with the interdisciplinary team	ı (IDT)		
	ceftriaxone and th	e doxycycline on October 14		weekly for 12 weeks.			
		hey were not available. She		The DON and/or nursing unit			
	also stated that sh	ne had faxed a request form for		present IDT corrective action			
	refill to pharmacy.			monthly quality improvement			
				committee for review, identifie			
		15 AM, the Pharmacist from the		trends, additional corrective a			
		y was interviewed. She stated		recommendations. The admi			
		the ceftriaxone and the		and/or DON will present trend			
		o stop date and the pharmacy		recommendations to the quar			
		p date of 10 days. The		assurance and performance	•		
		I that according to the pharmacy		(QAPI) committee for review,			
	records, they had	sent a total of 13 bags of		recommendations, and to det	termine the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` <i>'</i>	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345293	B. WING _	B. WING		C 10/18/2018	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	ceftriaxone to the factor on 10/1 and 3 bags of doxycycline on 9/28/1 any more refill request Pharmacist stated that pharmacy but the ceft from their pharmacy.  On 10/18/18 at 10:10 interviewed. She stated that other nursing facility at the help. She remember either 9/29/18 or 9/30 the antibiotics but she on 10/18/19 at 11:30 interviewed. She stated Resident #279 on Octhat she didn't adminit doxycycline on both of available. She stated	lity (3 bags on 9/28, 7 bags in 10/8) and 20 capsules of 8 and they had not receive st from the facility. The at they had a backup triaxone IV had to come  AM, Nurse #11 was sted that she worked at the and she came at this facility itered that she had worked in 18 and had administered itered forgot to initial the MAR.  AM, Nurse # 6 was seed that she was assigned to tober 17 and 18. She stated ster the ceftriaxone and the lates because they were not 10 that she had faxed a refill narmacy on 10/17/18 but the	F7	760	need for continued monitoring to ensur continued compliance.	re	
F 761 SS=E	(DON) was interviewed expected the nurses of the pharmacy in advantage medication did not consider the also stated that is medications were addications were addicated. Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals	to fax the request form to since and to call when the me during the night delivery. She expected that ministered as ordered. d Biologicals (1)(2)  of Drugs and Biologicals is used in the facility must be with currently accepted	F7	761			11/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 10/18/2018	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	10/10/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 761	§483.45(h)(1) In according personnel to have according to the Comprehensive Econtrol Act of 1976 a abuse, except when the package drug distribute quantity stored is minimate be readily detected. This REQUIREMENT by:  Based on record revinterview, the facility is medications and to do in 2 of 2 medications medication room and Findings included:  1. On 10/17/18 at 11: room was observed.	y and cautionary expiration date when of Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.  Cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit tion systems in which the imal and a missing dose can it is not met as evidenced ew, observation and staff failed to discard expired ate multi dose medications rooms observed (main dementia care unit).	F 76	F 761 Label /Store Drugs and Biologicals How corrective action will be accomplished for those residents found have been affected by the deficient practice The expired medications and undated multi dose medications were discarded 10/17/18 by the Director of Nursing (DON).	d on	
	observed:  Three (3) - 118 millilit  Loperamide Hydroch  with expiration date o	oride (anti diarrhea drug)		How the facility will identify other resident having the potential to be affected by the same deficient practice.  All resident have the potential to be affected.  What measures will be put into place of the same deficient.	he	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 10/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE		0/10/2010	
				HIGHWAY 177 S BOX 1489			
RICHMON	D 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From pag	e 111	F 7	61			
		d Purified Protein Derivatives nose tuberculosis) that was		systemic changes made to ensithe deficient practice will not real.  All licensed nurses will be re-ethe Director of Nursing or the U	ecur educated by		
	Loperamide HCL had and were expired. Shottle of PPD had no stated that PPD shot opened and it was gropening.  On 10/17/18 at 12:28	11 verified that the 3 bottles of d expiration date on 6/2018 the also verified the opened o date of opening. Nurse #1 uld have been dated when good for 30 days after		Manager (UM) regarding the d checking of medication carts for medications and dating of multi medications by 11/15/2018. Note and agency staff will receive the education during orientation to How the facility plans to monitor performance to make sure that are sustained  The UM's will perform observa	laily or expired ti-dose ew hires nis the facility. or its t solutions		
	1 7	red. She stated that nurses checking the medication spired medications.		for expired meds and undated medications weekly. The UM vall medication carts and medicare audited monthly.	will ensure		
	On 10/18/18 at 3:40 PM, the DON was again interviewed. She stated that she expected nursing staff to discard expired medications and to date multi dose medications including PPD and to discard it per the manufacturer's specification.			The results of the audits will be communicated to the DON. The share the results of audits with interdisciplinary team (IDT) we weeks.  The DON and/or nursing unit represent IDT corrective actions	ne DON will n the eekly for 12 manager will		
	8:34 AM of the demeroom. The observation undated, 10 milliliter injectable lidocaine 1 vial was marked as high The vial was not many a dispose by date. Frefrigerator revealed bottle of Tuberculin (Derivative (PPD) (Mator PPD solution was neither dated with an	as conducted on 10/17/18 at entia unit medication storage ion revealed an opened, (ml) glass vial (bottle) of 10milligrams (mg)/ml. The naving been a multi-dose vial. rked with an opened date or Further observation of the an opened and undated TB) Purified Protein entoux) solution. The bottle observed to have been a opened date or a dispose appeared to have been used		monthly quality improvement (committee for review, identificative and recommendations. The adminand/or DON will present trends recommendations to the quart assurance and performance in (QAPI) committee for review, a recommendations, and to deteneed for continued monitoring continued compliance.	ation of ctions, and histrator s and erly quality nprovement additional ermine the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 10/18/2018
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	100.00.20.00
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F 761	Review of the packag solution discovered in solution revealed the recommendations we and entered (a needl top) and in use for 30 discarded.  An observation and in Nursing (DON) was of 9:07 AM of the deme room. The observation undated, 10 milliliter injectable lidocaine 1 vial was marked as hother than the vial was not marked as a dispose by date. Frefrigerator revealed bottle of Tuberculin (Derivative (PPD) (Matof PPD solution was neither dated with an by date. The bottle adue to the cap having observed to have bestated it was her experimental was her expectation injectable medication injectable medication injectable medication injectable medication injectable medication.	g been removed and was en less than full.  ge insert with the PPD to the box with the PPD manufacturer's ere if the vial were opened e inserted into the rubber of days, the bottle should be enterview with the Director of conducted on 10/18/18 at entia unit medication storage on revealed an opened, (ml) glass vial (bottle) of Omilligrams (mg)/ml. The enaving been a multi-dose vial. ked with an opened date or urther observation of the an opened and undated	F 76		
F 842	·	dentifiable Information	F 84	2	11/15/18

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842 SS=E	CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (i) A facility may not resident-identifiable f (ii) The facility may resident-identifiable f accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical resident must maintain medical that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The facall information contains	nt-identifiable information. release information that is to the public. elease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted ds and practices, the facility al records on each resident mented; le; and	F8	342			
	(ii) Required by Law; (iii) For treatment, pa operations, as permi with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research p	or their resident e permitted by applicable law; syment, or health care tted by and in compliance					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345293	B. WING _	B. WING		C 10/18/2018		
	ROVIDER OR SUPPLIER  D PINES HEALTHCAR	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842	by and in compliance §483.70(i)(3) The farecord information a unauthorized use.	ge 114 ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or	F 8	42				
	(ii) Five years from there is no requirem (iii) For a minor, 3 yelegal age under State	ears after a resident reaches e law.						
	(i) Sufficient information (ii) A record of the results of an and resident review determinations concount (v) Physician's, nurse professional's progressional's progressional services reports as	lucted by the State; e's, and other licensed						
	Based on record re facility failed to mair regarding code staturesidents reviewed (Residents #8, #11, Findings included:  1. Resident #11 was	view and staff interviews, the stain accurate medical records us for 6 of 25 sampled regarding code status #29, #73, #74, and #280).		F 842 Resident Records – Information How corrective action will be accomplished for those resident have been affected by the definition of the services of the services director, medical recordirector, minimum data set (MI and/or Director of Nursing (DO)	nts found to cient , the social ords DS) nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345293	B. WING _	<del>-</del>	•	0/18/2018	
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KICHWICK	D FINES HEALTHOP	THE AND REHABILITATION CENTE		HAMLET, NC 28345			
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				DEFICIENCY)			
F 842	Continued From p	page 115	F 8	42			
	diabetes, end stag	ge renal disease, and		contacted the resident/resider	nt		
	Parkinson's disea	se.		representative and updated th	ne code		
				status for Resident #8, #11, #	29, #73,		
	The quarterly Min	imum Data Set dated 10/2/18		#74, and #280 to ensure the f	facility had		
	revealed the resid	lent had an intact cognition.		accurate medical records rega	arding code		
	The resident requ	ired extensive assistance of two		status for all current residents	).		
	staff for all transfe	ers and dressing, and set up for		How the facility will identify ot	her residents		
	meals. Active dia	gnoses were heart failure,		having the potential to be affe	cted by the		
	Parkinson's disease, peripheral vascular disease,			same deficient practice			
	and diabetes.						
				On 10/18/18 through 11/14/18	3, the social		
	A review of the re-	sident's electronic physician		services director completed a	n audit of		
	order dated 5/10/	10 documented full code status.		the current code status docum	nented in the		
				medical record of all current re	esidents for		
	A review of the re-	sident's physician progress note		accuracy. The audit revealed	l 58 out of		
	dated 10/8/18 dod	cumented do not resuscitate		101 multiple residents did not	have an		
	(DNR) and noted	that the resident's advance care		updated code status documer	nted in the		
	directive and heal	thcare proxy were documented		medical record or the medical	l record		
	in the chart.			contained conflicting docume	ntation		
				regarding the preferred code	status. This		
	A review of the re-	sident's medical record revealed		audit of 101 residents include	s 49		
	there was no phys	sician signed DNR		evacuees that were sent to th	e facility as		
	determination and	I no DNR red sticker on the		a result of Hurricane Florence	from		
	binder of the reco	rd as was observed with other		evacuation shelters.			
	resident charts wi	th DNR advance directive.		On 10/18/18 through 11/14/18	3, the social		
				services director, medical rec	ords		
	On 10/17/18 at 11	:30 am an interview was		director, minimum data set (M	1DS) nurse,		
	conducted with th	e resident ' s attending		nursing unit manager, and/or	DON		
	physician who sta	ted he would review the medical		contacted the resident/resider	nt		
	record and correc	t the advanced directive when		representative and updated th	ne code		
	in the facility on M	londay.		status for residents identified	during the		
				audit.			
	On 10/17/18 at 5:	30 pm an interview was		The Social Services Director	will discuss		
	conducted with th	e Social Worker (SW) who		the advance directive status v	vith the		
	observed the hard	d copy and electronic		resident or the resident's repr	esentative at		
	documentation of	the resident 's medical record		annually, at significant change	e,		
for the physician order and progress		order and progress notes. SW		readmission from hospital and			
	commented that t	he physician order and progress		change in advance directives	or resident's		
	note did not match. SW stated she would call the			request.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		1,	C 10/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	7/10/2010	
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCAR	E AND REHABILITATION CENTE		HAMLET, NC 28345			
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F 842	Continued From pag	ge 116	F 84	2			
	the progress note w	ine where the DNR status in as obtained.  pm an interview was		What measures will be put into systemic changes made to ensithe deficient practice will not re On 10/18/18, the DON commu	sure that ecur		
	conducted with SW with the physician w	who stated after speaking tho felt the order was correct		with the medical director on the inaccuracy of the code status i	e in the		
	-	ogress note on Monday. The ician informed her to follow		medical record; the DON/medi also informed the nurse practit On 11/14/18, the medical direct practitioner completed docume	ioner. ctor/nurse		
	On 10/18/18 at 4:30 pm an interview was conducted with the Director of Nursing who stated she expected the resident's record to be accurate.  2. Resident #29 was admitted to the facility on 12/7/17 with multiple diagnoses which included altered mental status, peripheral vascular disease, chronic kidney disease stage 3, unspecified dementia without behavioral disturbance, encephalopathy, CKD stage 3, and epilepsy.			the applicable code status of re that reside in the facility. On 1 facility was maintaining a curre residents with a "do not resusc (DNR)" order to have available	esidents 1/14/18, the ent list of citate		
				medical director and nurse pra during their visits to the center. On 11/14/18, the social service nurse unit manager, weekend manager, admissions director, DON began discussing advance directives with residents and/o representatives upon admission re-admission and annually.	es director, nurse and/or ced r residents'		
	Set dated 8/2/18 rev severely cognitively required extensive a transfers, one perso	dent's quarterly Minimum Data vealed the resident was impaired. The resident assistance of two staff for all on for all remaining activities except meals were set up		How the facility plans to monitor performance to make sure that are sustained On 11/14/18, the social service began auditing 10% of current each quarter to ensure accurate medical records regarding cod On 11/14/18, the social services	t solutions es director residents cy of e status.		
	1/10/18 revealed a f	dent's medical record was a rective DNR form and DNR		began sharing the results of au the interdisciplinary team (IDT) for six months. The IDT will m recommendations and take co action based on audit outcome The social services director an medical records director will pr	udits with ) quarterly ake rrective es. d/or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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		345293	B. WING _			10/18/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
DIO!!!!				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
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F 842	Continued From page	e 117	F 8	42			
	record and correct the in the facility on Mondon On 10/17/18 at 5:30 p conducted with the Scobserved the hard condocumentation of the for the physician order advanced directive D the physician and red binder. SW commentant advance directive and advance directive or the physician and red binder.	sident 's attending he would review the medical e advanced directive when day. om an interview was ocial Worker (SW) who py and electronic resident's medical record		corrective actions to the mont improvement (QI) committee identification of trends, addition corrective actions, and recommendations quarterly quality assurance as performance improvement (Quemonittee for review, addition recommendations, and to det need for continued monitoring continued compliance.	for review, onal imendations. N will present to the nd (API) and ermine the		
	with the physician whon Monday and correct the physician informed. On 10/18/18 at 4:30 pconducted with the Dishe expected the residuccurate.  3. Resident #8 was at 2/1/16 and most receive with diagnoses that in and dementia with between the properties of the quarterly Minimulassessment dated 7/6 had short-term and local properties.	cho stated after speaking o would review the record ct the status. The SW stated d her to follow the order.  In an interview was irector of Nursing who stated dent's record to be considered to the facility on onthe readmitted on 6/26/17 included psychotic disorder havioral disturbance.					
	A Nurse Practitioner (	(NP) note dated 9/11/18					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD	E		0.20.0	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489				
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F 842	Continued From page	e 118	F 8	342				
		B's code status was Do Not ith comfort measures only.						
	A physician note date Resident #8's code s measures only.	ed 10/8/18 indicated tatus was DNR with comfort						
	Resident #8's hard copy physician's order summary for October 2018 indicated his code status was full code.							
	10/17/18 revealed the DNR determination a the binder of the reco	ent #8's medical record on ere was no physician signed nd no DNR red sticker on ord as was observed with with DNR advance directive.						
	Worker (SW) on 10/1 physician's progress progress note (dated Resident #8's code s measures only was rootober 2018 physiciandicated Resident #8 as well as the medica physician signed DNI reviewed with the SW code status documer not matched. She rephysician regarding to resident on 10/17/18 going to review the cothis upcoming Monday	I. The SW confirmed the station for Resident #8 had wealed she spoke with the his issue related to another and he indicated he was ode status documentation by (10/22/18) when he						
	signed DNR determing full code. The SW in	r. She reported the if there was no physician nation that the resident was a idicated after this issue was on on 10/17/18 she began						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345293	B. WING			C 10/18/2018	
NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCA	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/16/2016	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
residents' medical documentation related documentation related to the first at the status sometimes and was then not read was then not read was then not read was then not read was the first at the status was documentated in the first at the status was documentated in the status was documentated was no phydetermination that the status to be up to documentated with diagnoses that dementia.  The quarterly Mining assessment dated was sessment dated was sessment dated was code status was a Nurse Practition.	it on each current facility records to ensure all the ated to code status matched.  was conducted with the NP on M. The NP stated that when a targed to the hospital and acility that the resident's code changed while in the hospital reflected in her progress notes is progress notes. She stated the resident records on her next to ensure the appropriate code ented in her progress notes. The physician's statement that resident was a full code conducted with the Director of 18 at 3:35 PM. She stated she ents' medical records to be ocumentation related to code	F 84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING _	B. WING			C 10/18/2018	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489	<u></u>	10/10/	2010	
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(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 COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	-	(X5) COMPLETION DATE	
F 842	Continued From page	e 120	F 8	342				
	reviewed on 10/18/18 order dated 6/15/16 is code status was full of the Reside 10/18/18 revealed the DNR determination at the binder of the reconstruction of the resident charts. An interview was consumed with the sum of the resident charts. An interview was consumed with the resident #74's code reviewed with the SW order dated 6/15/16 to code status was full of record that contained determination was resident #74 had no she spoke with the pirelated to another resident when he returned to physician stated that signed DNR determination the signed DNR determination to the SW in brought to her attentic completing an audit of residents' medical residents'	dent #74's medical record on ere was no physician signed and no DNR red sticker on ord as was observed with with DNR advance directive.  Inducted with the Social 8/18 at 11:20 AM. The note (dated 8/6/18) and NP 9/11/18) that indicated						
	-	as conducted with the NP on The NP stated that when a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 1 <b>0/18/2018</b>	
	ROVIDER OR SUPPLIER	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 842	resident was dischareadmitted to the fastatus sometimes of and was then not reor in the physician's she would review the visit to the facility to status was docume. The NP confirmed if there was no phydetermination that the An interview was consuring on 10/18/1 expected the reside accurate and for dostatus to be up to dost	arged to the hospital and cility that the resident's code hanged while in the hospital affected in her progress notes a progress notes. She stated he resident records on her next he ensure the appropriate code anted in her progress notes. The physician's statement that sician signed DNR he resident was a full code at 3:35 PM. She stated she ents' medical records to be cumentation related to code ate. Was admitted to the facility on the diagnoses including a quarterly Minimum Data Set dated 8/27/18 indicated that severe cognitive impairment.	F 8-	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	TIPLE CONSTRUCTION  NG	l' /	(X3) DATE SURVEY COMPLETED	
		<b>345293</b> B. WING		1	C 10/18/2018		
	ROVIDER OR SUPPLIER	RE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP OF HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACCORSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	physician of Resid might be an error of might be an error of the physician of Resider of the physician's order in records was the corresident.  On 10/18/18 at 4:3 conducted with the she expected the raccurate.  6. Resident #73 w 8/29/16. The residincluded: Diabetes disease (COPD), of Review of Resider Data Set (MDS) rewith an Assessment 10/1/18. The residing cognitively intact a supervision with lith Activities of Daily I mobility, transfer (swheelchair), eating A review was comphysician progress Practitioner (NP), of documentation next	stated that she had called the ent #280 who stated that it on his part.  10 PM, interview with the Nurse onducted. She stated that the non her progress notes might. The code status written on the note had been the hard copy or electronic orrect code status for the code status for the note had been the hard copy or electronic orrect code status for the note had been the hard copy or electronic orrect code status for the note had been the hard copy or electronic orrect code status for the note had been the hard copy or electronic orrect code status for the note had been the hard copy or electronic orrect code status for the note had been and interview was a Director of Nursing who stated resident's record to be note had a diagnoses to complete the note had a quarterly assessment and the ference Date (ARD) of the note had been and as having required the or no assistance for all Living (ADLs) including bed such as from a bed to a go, and toileting.  The pleted of Resident #73's and toileting.  The pleted of Resident #73's and toileting.  The pleted of Resident #73's and toileting.	F	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C <b>10/18/2018</b>	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COD HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	E	10.10.20.10	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		
F 842	physician progress no resident's physician, documentation next to was "Do Not Resuscitate A review completed of Resident 73's Electror revealed a physician a full code.  An observation was continued an interview with the (MRD) on 10/17/18 and observation revealed Resident #73's EMR Resident #73's EMR Resident #73 was and the drop-down menuthad access to the restructure stated when a sign document, indicated Not Resuscitate (DNI copy of chart under the An observation of Rechart revealed no gold document under the AMRD stated Resident A phone interview was 10/18/18 at 4:00 PM. status written in her praccurate. The NP fur written on the physicial of the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the EM correct code status for the chart or the ch	sted of Resident #73's ote, completed by the dated 9/10/18. The o Code Status in the note state (DNR/no Cardio ation (CPR))."  on 10/16/18 at 9:12 AM of onic Medical Record (EMR) is order for the resident to be conducted in conjunction with Medical Records Director at 12:07 PM. The a drop-down menu in providing the information full code. The MRD stated was available for staff who sident's EMR. The MRD is resident was a full code golden rod sheet or stop ating the resident was a Do R), in the resident's hard he Advance Directives tab. Its ident #73's hard copy of the iden rod sheet or stop sign Advance Directives tab. The it #73 was a full code.  as conducted with the NP on The NP stated the code orogress notes may not be orther stated the code status ian's order in the hard copy MR would have been the	F8	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		
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(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)		
F 842	stated it was her experience to be accurate	/18/18 at 4:30 PM she ectation for the resident's	F 842		4447	
F 867 SS=E	§483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct identifies REQUIREMENT by: Based on record revi	sessment and assurance.  ality assessment and must: ement appropriate plans of tified quality deficiencies; is not met as evidenced ew, observation, resident	F 867	F867 QAPI /QAA Improvement Activities	11/15/18	
	interview, and staff interview, the facility 's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 4/26/18 recertification survey in the areas of Self Determination (F561), Abuse and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessary Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). These 8 deficiencies were cited again on the current recertification survey of 10/18/18. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility 's inability to sustain an effective Quality Assessment and Assurance program.  The findings included:  This tag is cross referenced to:			The facility's quality assurance and performance improvement (QAPI) committee failed to maintain implemer procedures and monitor interventions the committee put into place following 4/26/18 recertification survey in the arc of: Self Determination (F561), Abuse Neglect (F600), Assessment Accuracy (F641), Activities of Daily Living Care (F677), Accidents (F689), Unnecessar Medications (F757), Unnecessary Psychotropic Medications (F758), and Significant Medication Errors (F760). These eight (8) deficiencies were cited again on the current recertification surcompleted on 10/18/18. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance (Caprogram.	that the eas and  y  vey	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345293	B. WING		40	)/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		// 10/2016	
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCA	ARE AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
F 867	Continued From p	page 125	F 86	57			
	1a. F561 Self Det	ermination: Based on record					
	review, observation	ons, staff interviews, and		On 11/12/18, the corporate	facility		
		, the facility failed to provide		consultant in-serviced the f	•		
		duled for 1 of 2 residents		administrator related to the			
	reviewed for choice	ces (Resident #54).		functioning of the QAPI Co			
	During the recerti	fication survey of 4/26/18 the		the purpose of the committ identifying issues and corre			
	_	at F561 Self Determination for		deficiencies related to the	- '		
	failing to honor a resident 's choice to receive			Determination (F561), Abus			
	showers over bed			(F600), Assessment Accura	•		
				Activities of Daily Living Ca	are (F677),		
		nd Neglect: Based on record		Accidents (F689), Unneces	•		
	1	on, and staff interview, the		Medications (F757), Unnec			
		to provide supervision and to ical behaviors of cognitively		Psychotropic Medications ( Significant Medication Erro			
		s for 2 of 2 residents (Residents		Significant Medication End	15 (1700).		
		ewed for neglect. This failure		The facility QAPI Committe	ee is comprised		
		ent #10 initiating physical		of the: medical director, ac	•		
	altercations with	cognitively impaired residents		director of nursing, minimu	m data set		
	1 *	8, #26, #74, and #329) and		(MDS) nurses, quality			
		oping a cognitively impaired		improvement/infection cont			
		t #18) twice in a 40-minute time		admissions director, wound	-		
	period.			unit managers, social servi activities director, dietary m			
	During the recerti	fication survey of 4/26/18 the		environmental services dire			
		at F600 Abuse and Neglect for		maintenance director, payr			
		vide adequate supervision of		bookkeeping, a staff nurse			
	cognitively impair	·		assistant, pharmacy consu	_		
		ent Accuracy: Based on record		On 11/12/18, the corporate	•		
		nterview, the facility failed to		consultant in-serviced the			
		n Data Set (MDS) assessments		committee and reviewed th			
		areas of hospice care (Resident		function of QAA/QAPI com			
		(Resident # 280), diagnoses & #11) and nutrition (Resident		reviewed on-going complia	IIICE ISSUES.		
	#30) for 4 of 20 sampled residents whose MDS assessments were reviewed.			The quarterly QAPI commi	ttee will hold a		
				meeting in December 2018			
				deficiencies from the 10/18			
	During the recerti	fication survey of 4/26/18 the		go over the approved plan	of correction		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345293	B. WING _			10/	/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
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KIOIIIION	DI INCO NEACTIOAN	E AND REHADIEHATION SERVE		H	AMLET, NC 28345			
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F 867	Continued From pa	ge 126	F 8	367				
	facility was cited at	F641 Assessment Accuracy			(PoC) with the medical director and			
	•	ne MDS accurately in the			pharmacy consultant.			
	areas of medication	ns, physical restraints, and						
	Activities of Daily Li	ving.			On 11/14/18, the administrator complete	ted		
					in-servicing with the department heads	on		
					the appropriate functioning of the QAP	I		
		f Daily Living Care: Based on			Committee and the purpose of the			
		d review, and staff interviews			committee to include identifying issues			
		provide fingernail care for one			and correcting repeat deficiencies in th			
of two dependent residents revi					areas of Self Determination (F561), Ab	use		
	of Daily Living (ADL	.s) (Resident #5).			and Neglect (F600), Assessment Accuracy (F641), Activities of Daily Liv	ina		
	During the recertific	cation survey of 4/26/18 the			Care (F677), Accidents (F689),	irig		
		F677 ADL Assist Care for			Unnecessary Medications (F757),			
	•	continent care and nail care.			Unnecessary Psychotropic Medication	s		
	,g p				(F758), and Significant Medication Erro			
	e. F689 Accidents:	Based on record review,			(F760).			
	observation, and st	aff interview, the facility failed						
	to provide supervisi	on of cognitively impaired			After the facility consultant in-service o	n		
		n histories of combative			11/12/18, the facility QAPI Committee			
		ts #10, #56, and #74) to			began identifying other areas of quality			
		ercations with other cognitively			concern through the quality improvement	ent		
		for 3 of 3 residents reviewed			(QI) review process during the daily			
		ent incidents. The facility also			interdisciplinary team (IDT) meetings a	nd		
		e of two medication storage			monthly QI committee meetings, for			
	rooms (memory car	e unit).			example: review of rounds tools, review work orders, review of Point Click Care			
	During the recertific	cation survey of 4/26/18 the			(Electronic Medical Record), review of			
		F689 Accidents for failing to			resident council minutes, review of			
	•	nterventions, failing to provide			resident concern logs, review of pharm	acv		
		on for cognitively impaired			reports, and review of regional facility	,		
		monitor a resident 's			consultant recommendations.			
	_	failing to thoroughly analyze						
		ausative factors and			The QI committee will meet at a minim	um		
	implement appropri	ate interventions to prevent			of monthly and QAPI committee meets	а		
	further falls.				minimum of quarterly to identify issues			
					related to quality assessment and			
		ry Medications: Based on			assurance activities and will develop a			
	record review, and staff interview, the facility				implement appropriate plans of action	ior		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	343233	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CO	DDE L	10/18/2018	
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From page	e 127	F 8	867			
F 867	failed to monitor and as ordered for 2 of 5 of for unnecessary med 280).  During the recertificate facility was cited at Finded and places and	to draw the laboratory test sampled residents reviewed ications (Residents #279 & # tion survey of 4/26/18 the 757 Unnecessary to monitor a resident 's sordered.  Psychotropic Medications: In, record review, staff atric Nurse Practitioner failed to administer tion as ordered for 1 of 5 or unnecessary medications. In additional 0.5 milligrams chotic medication) for a tion survey of 4/26/18 the 758 Unnecessary tions for administering an tion to a resident without a diffiling to ensure that as otropic medications were in.  Redication Errors: Based on aff and pharmacist interview, event a significant in prescribed antibiotics were ordered for 1 of 1 sampled infection (Resident #279).	F8	identified facility concerns.  Corrective action has been identified concerns in the ar Determination (F561), Abus (F600), Assessment Accura Activities of Daily Living Car Accidents (F689), Unnecess Medications (F757), Unnece Psychotropic Medications (R Significant Medication Error The facility administrator is implementing an effective C program.	eas of: Self e and Negled cy (F641), re (F677), sary essary F758), and s (F760).		
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1, 7		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C 0/18/2018	
	ROVIDER OR SUPPLIER  D PINES HEALTHCARI	E AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP COI HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From pag		F 8	67			
	antipsychotic medica 3 months without a p	ation to a resident for almost physician 's order.					
	on 10/18/18 at 4:10 indicated he was the Committee. He state Administrator during survey of 4/26/18 as facility on 9/4/18. The reported they were a previous recertification that the facility had a residents during Sepneighboring facility weather-related emoinflux of new resider of the facility process contributed to the circular process contributed to the circular processary Medical Psychotropic Medical Medication Errors. That he believed the Assessment Accura operating with only of when their second Machine and position. He stated of hiring an addition meantime a corpora assisting with the as about the citations a and F689 Accidents residents these citat challenging behavior facility had plans to	e Director of Nursing (DON) PM. The Administrator he head of the facility 's QAA ed he was not the the previous recertification he just began his role at this he Administrator and DON haware of the citations from the on survey. They both shared hadmitted a total of 49 new hotember 2018 due to a his evacuation caused by a hergency. They indicated this his disrupted the normal flow his ses which they believed hattations at F561 Self					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING		1	C 10/18/2018	
	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	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 921 SS=E	staff members on may with challenging behat additional education of developing the skills behaviors.  Safe/Functional/Sani CFR(s): 483.90(i)  §483.90(i) Other Env The facility must provisanitary, and comfort residents, staff and the This REQUIREMENT by:  Based on observation facility failed to maint evidenced by one of unprotected electrical filament extending from protected or contained light in one of nine rolenvironment (Room facility failed to maint evidenced or contained light in one of nine rolenvironment (Room facility failed to maint evidenced or contained light in one of nine rolenvironment (Room facility failed to maint evidenced or contained light in one of nine rolenvironment (Room facility failed to fail the findings included facility failed to fail the facility failed to fail the failed of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending on the left side of the revealed the black wire extending the revealed the black wire extending the revealed the black wire extending the revealed th	education and training to naging high acuity residents aviors. She was hopeful this would assist staff in the to better manage resident tary/Comfortable Environ  ironmental Conditions ride a safe, functional, able environment for the public.  To is not met as evidenced the and staff interviews, the tain a safe environment as two over the bed lights had all wires and an exposed of a socket which were not divident with the over the bed toms reviewed for \$\frac{4}{4}406).	F 86	F 921 Safe /Functional/ Sanitary/Comfortable Environm How corrective action will be accomplished for those residen have been affected by the defic practice On 10/17/18, the maintenance or repaired the electrical wires in relative to the having the potential to be affect same deficient practice On 11/9/18, the maintenance dicompleted an observation audit	director residents ted by the irector t of	11/15/18	
	exposed wires protru was no observed glas	o filament due to several ding from the socket. There as at or near the socket. In white wire connected to the		over-the-bed lights. The audit re over-the-bed lights in disrepair a 11/9/18.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345293 B. WING			C 10/18/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/10/2010	
				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 921	Continued From page socket which returned	e 130 d into the over the bed light	F 92	1		
	frame.  During a round condupt an observation of the window side of the rowire extending above left side of the light. It the black wire was consocket which contain been a light bulb filar wires protruding from observed glass at or there was a white wire which returned into the process of the light. The black wire was consocket which contain the black wire was consocket which contain been a light bulb filar wires protruding from observed glass at or there was a white wire which returned into the contain the black wire was consocket which contain the black wire was consocket which contain the black wire was a white wire was a white wire was a white wire which returned into the contain the contain the was a white wire which returned into the contain the contai	ucted on 10/16/18 at 3:16 If room 406 was conducted. If room 406 was conducted. If room 406 was conducted. If over the bed light on the som revealed a visible black of the over the bed light on the Further observation revealed onnected to a light bulb ed what appeared to have ment due to several exposed of the socket. There was no mear the socket. In addition, we connected to the socket me over the bed light frame.  Sucted on 10/17/18 at 9:59 If room 406 was conducted. If over the bed light on the som revealed a visible black of the over the bed light on the Further observation revealed onnected to a light bulb ed what appeared to have ment due to several exposed of the socket. There was no mear the socket. In addition, we connected to the socket me over the bed light frame.		What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur.  On 11/10/18, the maintenance director and/or maintenance worker began a schedule to complete an audit of over-the-bed lights on a quarterly basis one year.  On 11/14/18, the unit manager or interdisciplinary team (IDT) member began monitoring over-the-bed lights weekly during compliance rounds.  How the facility plans to monitor its performance to make sure that solution are sustained  The maintenance director or unit manawill share the results of the compliance rounds with the administrator. The maintenance director and/or unit manawill share the results of the compliance rounds with the safety committee and quality improvement (QI) committee or monthly basis for 12 weeks.	s for  ger  ger  che	
	10/17/18 at 10:10 AM written work orders for attention such as a complete wheel off an over the the bed table. The n	M. The nurse stated she had or various issues needing all bell that did not work, a bed table, or a broken over urse further stated the staff ented work orders in the		The QI committee will review the finding for identification of trends, actions take and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The maintenant director or unit manager will present the	n, d for ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.40200	<u>                                     </u>	STREET ADDRESS, CITY, STATE, ZIP COD		10/18/2018	
	(0.115 E. (0.115 E. (1.115 E.			HIGHWAY 177 S BOX 1489	_		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 921	Continued From page managed work orders		F 9	findings and recommendation			
	interview with the Ma along with an observation with a state of the social connected to a light of the socket. There was not the socket. In addition connected to the socket. There was not the socket. In addition connected to the socket over the bed light frame unaware of the expossion over the bed light frame unaware of the expossion over the bed light, newould have liked to have over the bed light, newould have liked to have over the bed light, newould have liked to have over the bed light, newould have liked to have over the bed light, newould have liked to have over the bed light, newould have liked to have over the bed light, newould have liked to have liked to have over the socket. The repair of the electrica filament was an imposit address it promptly.  At the completion of the town orders were documented in the work orders were documented in the work orders.	An observation of the over rindow side of the room ok wire extending above the the left side of the light. Everally the black wire was outbout socket which contained we been a light bulb filament ed wires protruding from the coobserved glass at or near on, there was a white wire exet which returned into the me. The MD stated he was seed electrical wires, loose to of the possible filament. The messible filament within the eded to be repaired, and he ave had it brought to his end of the MD stated the needed wire, socket, and possible ritant matter and he would the round conducted on the MD demonstrated how		monthly QI committee to the equality assurance and perforr improvement (QAPI) committee recommendations and oversity	nance ee for further		
	submitted work order electrical wire, socket An interview was con	18. The review revealed no s documenting the exposed s, or possible filament.  ducted with the 8/18 at 9:16 AM. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C <b>10/18/2018</b>	
NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 921	over the bed lights to Administrator stated i maintenance issues v member, a work orde department would be maintenance being m	t was his expectation for the be intact. In addition, the t was his expectation if were discovered by a staff r for the maintenance completed. Upon lade aware of the identified rough the work order, the ment would be able to	FS				