DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	CONSTRUCTION	(X3) DATE S COMPL	LETED
		345293	B. WING			
	ROVIDER OR SUPPLIER	545255		REET ADDRESS, CITY, STATE, ZIP CODE	04/0	04/2019
				GHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
	conducted on 3/31/19 was found in complia CFR 483.73, Emerge ID #CYLY11.	ertification survey was b through 4/4/19. The facility nce with the requirement ncy Preparedness. Event				
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)		F 550			5/1/19
	self-determination, ar access to persons an	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				
	§483.10(b)(1) The fac	cility must ensure that the				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed				1	04/27/2019

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.

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/09/2019 1 APPROVEI 9. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING				。 04/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 1	F 5	50			
		e his or her rights without					
		n, discrimination, or reprisal					
		sident has the right to be					
		coercion, discrimination, and lity in exercising his or her					
		orted by the facility in the					
		rights as required under this					
	subpart.						
		Γ is not met as evidenced					
	by:	iow, choosystian and			F550		
		iew, observation and erview, the facility failed to			Foot Foot Foot Foot Foot Foot Foot Foot		
		t covering the urinary			Resident without a privacy bag for urina	arv	
		nt # 66) and by not providing			catheter bags, resident without the priv	-	
		by serving the meal tray in			bag was provided a privacy bag. The S	Staff	
		or 2 of 4 sampled residents			Facilitator assured privacy bag was in		
	reviewed for dignity.				place for resident 66 4/24/19. Resident		
	Findings included:				was observed eating in bed with tray or		
	Findings included:				over bed table by facility Nurse Consult on 4/24/19.	lani	
	1. Resident #66 was	admitted to the facility on			Other potentially affected residents: All		
		diagnoses including urinary			residents with catheters were audited for		
		erly Minimum Data Set			privacy bags, no other residents were		
	. ,	lated 2/22/19 indicated that			identified as not having privacy bags by	y	
		paired cognition and had an			staff facilitator on 4/24/19. An audit of		
	indwelling urinary cat	theter.			other residents that choose to have me		
	Pesident #66's care i	plan dated 3/01/19 was			in bed revealed no other residents eatin with meal trays on bed on 4/25/19 by	ng	
		plan dated 3/01/19 was e care plan problems was			facility nurse consultant.		
		urinary catheter and the goal			Measures implemented: All Nursing sta	aff	
		be free from urinary tract			were in-serviced on requirement of usin		
	infection. The approa	aches did not include			privacy bags on catheter bags. Nursing	3	
	covering the urinary of	catheter bag for dignity.			staff were in-serviced that resident tray		
					are to be placed on the bed side table I	by	
		served in bed on 3/31/19 at			director of nursing between 4/18/19		
		at 9:05 AM and 1:45 PM. He nary catheter and the urinary			through 4/29/19. These in-services wer added to nursing staff orientation starting		
	-	nary cameter and the utiliary				чy	

Facility ID: 923021

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345293	B. WING				C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 550	catheter bag was not from the hallway. Interview with NA #7 1:50 PM. NA #7 state bag was only covered of bed or out of the ro Interview with the Unic conducted on 4/1/19 a that catheter bag sho for privacy/dignity. Interview with the Dire conducted on 4/4/19 a stated that she expect be covered at all time 2. Resident #75 was a 1/26/11 with multiple dementia. The annua assessment dated 3/ #75 had moderate co independent with eati Resident #75's care p that resident was able up including opening to encourage residen room. The care plan of	covered and was visible was conducted on 4/1/19 at ed that the urinary catheter d when the resident was out form. t Manager (UM) #1 was at 2:10 PM. The UM stated uld be covered at all times ector of Nursing (DON) was at 11:25 AM. The DON ted urinary catheter bags to s for privacy/dignity reason. admitted to the facility on diagnoses including al Minimum Data Set (MDS) 15/19 revealed that Resident gnitive impairment and was	F	550	on 4/18/19. Monitoring to maintain compliance: The Unit Manager/Wound Nurse will monito for 12 weeks, 3 catheters per day, 5 tir per week. The Unit Manager will monit residents daily, 5 times a week, for 12 weeks to ensure compliance with meal trays on bedside table. The Activities of daily living audit tool will be used. The Wound Nurse and Unit Manager will report to the Director of Nursing any issues. The Wound Nurse and Unit Manager will correct issues on the spo and re-educate staff if compliance is no maintained. The Wound Nurse and Un Manager will report to the Quality Assurance/Performance Improvement committee on compliance. Corrective action compliance date: Ma 2019	or nes or 5 f f t t	
	(HOB) was elevated a	M, Resident #75 was . The head of the bed at 45 degrees and his dinner e him. The resident was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	
		345293	B. WING			04/	04/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		F	HIGHWAY 177 S BOX 1489		
				ŀ	HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	holding a cup of soup himself but was spillir During the observatio bed table next to resid personal stuff (water cups) and a nebulizer interviewed if his pref bed, Resident #75 did On 4/1/19 at 9:17 AM Resident #75 was obs HOB at 45 degrees a in bed. The over the personal stuff and nel An interview was con 4/2/19 at 8:56 AM. N resident's tray was set to reach his food. NA resident's tray was set to reach his food. NA resident's over the be stuff and his nebulize comment that was the served in bed instead table. The NA also di resident's preference #12 also reported tha sit up in bed or in the An interview with Nur 4/2/19 at 10:56 AM. N didn't know why the N 75's meal tray in bed. that she didn't think th preference to eat with An interview was con (UM) #1 on 4/2/19 at	<ul> <li>and was able to feed</li> <li>and the soup on his shirt.</li> <li>and, there was an over the</li> <li>dent's bed with full of</li> <li>pitcher, box of tissue paper,</li> <li>r machine. When</li> <li>berence to serve his tray in</li> <li>d not answer.</li> </ul> I and on 4/2/19 at 8:50 AM, served lying in bed with nd with his meal tray served bed table was still full of bulizer. ducted with NA #12 on IA #12 stated that the erved in bed for the resident A #12 verified that the erved in bed for the resident A #12 verified that the erved in bed for the resident A #12 verified that the erved is over the bed id not indicate that it was the to serve his tray in bed. NA t Resident #75 was able to wheelchair. se #4 was conducted on Aurse #4 stated that she NAs were serving Resident The nurse further stated hat was resident's hat was resident's hat he tray in his bed. ducted with Unit Manager 11:00 AM. The UM stated re that Resident #75 was	F	550			
	that she was not awa						

Facility ID: 923021

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			LETED
		345293	B. WING			C 04/2019
	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COE <b>HWAY 177 S BOX 1489</b>	DE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	HAI	MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 550	Continued From page	e 4	F 550			
	using the over the be to be positioned at sit	s to serve the meal trays d table and for the resident ting position if eating in bed ge of the bed or in the				
	breakfast tray on top	e edge of the bed with his of the over bed table in front ewed, Resident #75 stated				
F 561 SS=D	conducted on 4/4/19 stated that she expect resident's preference stated that Resident a meal tray served in b	s for dining. The DON #75 preferred to have his ed however the DON was cumentation that this was	F 561			5/9/19
	promote and facilitate through support of re-	right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules ( waking times), health					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/09/201 RM APPROVEI IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		345293	B. WING		0	4/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 561	choices about aspect facility that are signifi §483.10(f)(3) The res with members of the community activities I facility. §483.10(f)(8) The res participate in other ac religious, and commu- interfere with the righ facility. This REQUIREMENT by: Based on record rev staff interview, the fac showers as schedule (Resident #74) review The findings included Resident #74 was ad 10/3/18 with diagnose obstructive pulmonar muscle weakness, ar Resident #74's care p of bathing. This area 10/15/18 and included dependence of 1 for I The quarterly Minimu assessment dated 1/ #74's cognition was in	<ul> <li>ident has a right to make s of his or her life in the cant to the resident.</li> <li>ident has a right to interact community and participate in both inside and outside the</li> <li>ident has a right to outside the</li> <li>ident has a subtract outside the</li> <li>ident has a right to outside the set outside the outside the outside the focus area</li> <li>was last revised on</li> <li>d the intervention of total outside.</li> <li>in Data Set (MDS)</li> <li>10/19 indicated Resident outside the outside the focus area</li> <li>was last revised outsident outside the outside the outside the outside the outside the focus area</li> <li>was last revised the focus area</li> <li>was last revised</li></ul>	F 5	61 F561 For residents affected by the the affected resident the fac the resident April 5, 2019. Other potentially affected res 4/18/2019 & 4/19/2019 the u audited all resident showers showers provided per sched were 2 negative findings wh addressed by 4/18/2019 & 4 the resident being showered documented. Measures implemented: Init shift to shift communication residents shower preference staff daily assignment sheet were in-serviced on expecta shower schedule completen auditing will be recorded on of daily living audit tool. Monitoring to maintain comp Certified Nursing Assistants Nurses were in-serviced on	ility showered sidents: On unit manager to ensure lule. There ich were 19/2019 by d or refusal iated were the book, updated es, updated s, and staff tions of ess. The the activities	

Event ID: CYLY11

Facility ID: 923021

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	E CONSTRUCTION		0MB NO: 0938-03 X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPLETED
						С
		345293	B. WING			04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1 HAMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		DER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH COP	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIC
F 561	Continued From page	e 6	F 56	1		
		ted of the Nursing Assistant		requirement of	completing daily schedule	ed
		documentation for Resident			Director of Nursing and	
	#74 from 3/1/19 throu	ugh 4/3/19. Resident #74			ator on initiated in-servici	ng
		eive showers on Tuesdays			completed on 4/24/19.	
	-	cumentation indicated that			g of shower completion by	•
		s on 4 of 10 scheduled			ers will be completed on	
	shower days (3/1/19, 3/22/10) Resident #	74 was provided with a full			days a week for 12 weeks e Staff Facilitator has	5.
	bed bath instead of a				ervice to staff orientation	
		ays (3/8/19, 3/12/19, 3/26/19,			Manager will report to the	
	3/29/19, and 4/2/19)	and a partial bed bath on 1		Director of Nurs	sing any concerns of	
	of 10 scheduled show	ver days (3/15/19).			wers. The Unit Manager	
					Nursing will report to the	
		ducted with Resident #74 on		-	nce/Performance	of
		She reported that her bathing was a shower and		completing sho	ommittee on compliance	
		e scheduled for Tuesdays			on compliance date: May	9.
		ealed that she had not been		2019		-,
		s as scheduled and that her				
	last shower was two	Fridays ago (3/22/19).				
	An interview was con	ducted with NA #12 on				
		he stated that the facility had				
		sting of 2 NAs and she was				
		vealed there were times she				
	was pulled from the s assignment on the flo					
	An interview was con	ducted with NA #13 on				
		he stated that she was a				
		er team. The shower team				
		sday, Thursday, and Friday				
	from 5 AM to 3 PM to Residents on A beds	were provide showers.				
		nursday and B beds were				
		ery Tuesday and Friday. NA				
		owers were not provided on				
	Wednesday, Saturda	y or Sunday nor were they				
	provided after 3 PM.	She revealed there were				

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · ·	E SURVEY IPLETED
		345293	B. WING		04	C 4/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		+/0-+/2013
				HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 561	Continued From pag	e 7	F 56	1		
1 001			F 50			
		am was pulled to work an				
	-	oor. She further revealed s when a bed bath was				
		a shower. She stated that a				
	· ·	d when there was time.				
	On 4/4/19 at 1.55 PM	/l, Unit Manager (UM) #2 was				
		reported that there were				
		am was assigned to work on				
		staff turnover. He indicated				
	-	s recently as last week. He				
		ted the NA assigned to the				
	-	howers as scheduled when				
		s pulled to the floor. UM #2				
		lent #74 's showers were				
		ays and Fridays. The NA				
		imentation for Resident #74				
		4/3/19 was reviewed with UM				
		Resident #74 had no				
	·	during this time period and				
		howers were not consistently				
	provided as schedule					
	An interview was cor	nducted with the Director of				
	Nursing (DON) on 4/	4/19 at 1:00 PM. She stated				
	that she expected the	e staff to provide showers as				
	scheduled, but that s	she was aware this was not				
	always happening.	She confirmed that there				
	were times the show	er team was assigned to				
		ne DON stated that she				
	· ·	signed to the resident to				
		en the shower team was				
		that she just started a				
		ement Plan (PIP) related to				
		ast week and she believed				
	-	ng addressed. The DON				
	was informed that the					
	unresolved issues w	ith showers being provided				
		denced by Resident #74				

Facility ID: 923021

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	HIGH	EET ADDRESS, CITY, STATE, ZIP CODE <b>HWAY 177 S BOX 1489</b>	
	_ · · · · <b>_ ·</b> · · · · · · · · · · · · · · · · · ·		HAN	ALET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 561	Continued From page		F 561		
	receiving a full bed ba her scheduled showe	ath rather than a shower on r day of 4/2/19.			
		was conducted with the 5PM. She indicated she			
	needs to be honored	eferences related to bathing and for showers to be ent ' s scheduled shower			
F 623 SS=C	days. Notice Requirements CFR(s): 483.15(c)(3)	Before Transfer/Discharge -(6)(8)	F 623		5/9/19
	§483.15(c)(3) Notice Before a facility trans resident, the facility n	fers or discharges a			
	(i) Notify the resident representative(s) of the second se				
		r they understand. The opy of the notice to a			
	Long-Term Care Oml (ii) Record the reasor	oudsman.			
	and	ngraph (c)(2) of this section; ice the items described in			
	paragraph (c)(5) of th				
	(c)(8) of this section,	of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be			
	made by the facility a resident is transferred (ii) Notice must be made	t least 30 days before the d or discharged. ade as soon as practicable			
	before transfer or dis (A) The safety of indi	charge when- viduals in the facility would			

Facility ID: 923021

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DEPARTI	MENT OF HEALTH AN	ND HUMAN SERVICES					D: 05/09/2019
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION		O. 0938-0391 E SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,				IPLETED C
		345293	B. WING			04	4/04/2019
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	Continued From page	e 9	É F	623	3		
F 623	be endangered under this section; (B) The health of indi be endangered, under this section; (C) The resident's he allow a more immedia under paragraph (c)( (D) An immediate tra- required by the reside under paragraph (c)( (E) A nesident has no days. §483.15(c)(5) Conter- notice specified in pa must include the follo (i) The reason for tra- (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omf (vi) For nursing facilit and developmental d disabilities, the mailing	r paragraph (c)(1)(i)(C) of viduals in the facility would er paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ats of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; hich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which ats; and information on how orm and assistance in and submitting the appeal ass (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related ag and email address and		623	5		
	the protection and ad developmental disabi	the agency responsible for lvocacy of individuals with ilities established under Part tal Disabilities Assistance					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/20 FORM APPROV OMB NO. 0938-03	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 04/04/2019	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC TE APPROPRIATE DATE	
F 623	Continued From pag	e 10	F 62	23		
		t of 2000 (Pub. L. 106-402,	1 02			
	codified at 42 U.S.C.					
	(vii) For nursing facili	ity residents with a mental				
		sabilities, the mailing and				
	agency responsible f	elephone number of the				
		als with a mental disorder				
		e Protection and Advocacy				
	for Mentally III Individ	duals Act.				
	§483.15(c)(6) Chang	ies to the notice				
		he notice changes prior to				
	effecting the transfer	or discharge, the facility				
	-	pients of the notice as soon				
	as practicable once t becomes available.	he updated information				
	•	in advance of facility closure				
		closure, the individual who is he facility must provide				
		ior to the impending closure				
		Agency, the Office of the				
	State Long-Term Car	re Ombudsman, residents of				
		esident representatives, as				
	•	ne transfer and adequate				
	483.70(I).	dents, as required at §				
	.,	T is not met as evidenced				
	by:					
		view and family and staff		F623		
		y failed to provide the		The plan of correcting the sp	pecific	
		ent representative written ason for transfer to the		deficiency		
	hospital for 7 or 7 res			Residents #11, 65, 52, 75, 8	30, 13 and	
		dent #11, #65, #52, #75, #80,		60 s resident and/or reside	-	
			1			
	#13 and #60).			representative were mailed		
	#13 and #60). The findings included			representative were mailed nursing home transfer or dis indicating the reason for the	scharge	

Event ID: CYLY11

Facility ID: 923021

If continuation sheet Page 11 of 126

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2 FORM APPRO OMB NO. 0938-03
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
RICHIVION	D FINES REALTHCARE	AND REPABLEMATION CENTE		HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI
F 623	Continued From page	e 11	F 623		
1 020			F 023		
		originally admitted to the h diagnoses that included		The plan for identifying of potentia residents affected	ai
		gastrostomy tube (a feeding		On 4/24/19 the facility consultant	reviewed
	tube) and pain.			the unplanned discharges for the	
	, r-			days for documentation of the not	
	A medical record revi	iew revealed the resident		nursing home discharge being pro	ovided.
		e hospital on 12/12/18 for a		Following the audit notification let	ters
		placement and was admitted		were sent.	
	-	me day for respiratory		The procedure for implementing t	
		no documentation of a		acceptable plan of correction for t	he
	-	bital discharge provided to		specific deficiency cited On 4/25/19 the business office wa	
	the resident's respon	sible party.		in-serviced by the administrator o	
	A review of Resident	#11's most recent Minimum		the notice of nursing home discha	
		ed as an annual assessment		each unplanned discharge includi	
	and dated 1/8/19 rev			emergency room visit. In morning	
	cognitive deficits.			up meeting, discharges are review	
				administrator and/or business offi	
	During an interview o	on 4/2/19 at 11:45am with		manager process notices of disch	narge.
	-	ned that when a hospital			
	•	curred, the resident's		The monitoring procedure to ensu	
		s notified by phone. She		the plan of correction is effective a	
		vritten information provided		specific deficiency cited remains of	
	was the bed hold pol	icy sent with the resident.		and/or in compliance with the reg	ulatory
	0n 4/2/19 at 11·47an	n an interview occurred with		requirements The Administrator and/or Director	of
		She stated that the nurses		Nursing will review all discharges	
		responsible party by phone		12 weeks to ensure the notice of	-
		rges to the hospital and a		home discharge was provided for	•
		policy was sent with the		unplanned discharges. This audit	
		stated the Social Worker		documented on the discharge aud	
		bed hold policy to the		The results of the discharge Audit	
	responsible party.			be compiled by the Administrator	
				Director of Nursing and presented	
		as interviewed on 4/2/19 at		Quality Improvement Committee	-
	11:50am. She explai			x 3months. Identification of trend	
	-	ng a copy of the bed hold		determine the need for further act	
		's responsible party. She		and/or change in frequency of rec	
		idsman came once month		monitoring.	

Facility ID: 923021

OF DEFICIENCIES					
CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
		A. BUILDING			С
	345293	B. WING		0,	4/04/2019
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			HIGHWAY 177 S BOX 1489		
ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE
Continued From page	e 12	F 623	3		
and received a list of	all the discharges. Resident		Date of compliance May 9, 2019.		
responsible party on message was left for	4/3/19 at 11:05am.  A a return call.  A return call				
On 4/4/19 at 11:43am a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admission process and did not notify or send anything in writing to the resident's representative when a hospital discharge occurred.					
Nursing on 4/4/19 at nurses informed the responsible party who hospital occurred, bu she did not know the resident and/or response reason for the dischar	3:15pm. She stated the residents and called the en a discharge to the t not in writing. She stated facility was to inform the onsible party in writing of the rge to the hospital but would				
10/10/18 with diagno kidney disease on he	ses that included end stage modialysis, Congested				
Data Set (MDS) code	ed as a quarterly assessment				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page and received a list of #11 was readmitted t A phone call was plat responsible party on message was left for was not received fror On 4/4/19 at 11:43an occurred with the Add that she was respons process and did not r writing to the residen hospital discharge oc An interview was cor Nursing on 4/4/19 at nurses informed the f responsible party wh hospital occurred, bu she did not know the resident and/or response reason for the dischar expect the regulation 2) Resident #65 was 10/10/18 with diagno kidney disease on he Heart Failure (CHF) at A review of Resident Data Set (MDS) code and dated 1/29/19 re	ROVIDER OR SUPPLIER ID PINES HEALTHCARE AND REHABILITATION CENTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 and received a list of all the discharges. Resident #11 was readmitted to the facility on 12/14/18. A phone call was placed to Resident #11's responsible party on 4/3/19 at 11:05am. A message was left for a return call. A return call was not received from the representative. On 4/4/19 at 11:43am a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admission process and did not notify or send anything in writing to the resident's representative when a hospital discharge occurred. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15pm. She stated the nurses informed the residents and called the responsible party when a discharge to the hospital occurred, but not in writing. She stated she did not know the facility was to inform the resident and/or responsible party in writing of the reason for the discharge to the hospital but would expect the regulation to be followed. 2) Resident #65 was admitted to the facility on 10/10/18 with diagnoses that included end stage kidney disease on hemodialysis, Congested Heart Failure (CHF) and Diabetes Mellitus. A review of Resident #65's most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 1/29/19 revealed she was cognitively	345293       B. WING	345293           STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345           D PINES HEALTHCARE AND REHABILITATION CENTE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREE/ ID PRECIDENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PROVIDERS PLAN OF COR (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PRECIDENCY (EACH CORRECTIVE ACTIONS CROSS-REFERENCED TO THE A DEFICIENCY)           Continued From page 12 and received a list of all the discharges. Resident #11 was readmitted to the facility on 12/14/18.         F 623           A phone call was placed to Resident #11's responsible party on 4/3/19 at 11:05am. A message was left for a return call. A return call was not received from the representative.         D ate of compliance May 9, 2019.           On 4/4/19 at 11:43am a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admission process and did not notify or send anything in writing to the resident's representative when a hospital discharge occurred.         An interview was conducted with the Director of Nursing on 4/4/19 at 3:15pm. She stated the nospital occurred, but not in writing. She stated she di not how the facility was to inform the resident and/or responsible party in writing of the reason for the discharge to the hospital but would expect the regulation to be followed.         2) Resident #65 was admitted to the facility on 10/10/18 with diagnoses that included end stage kidney disease on hemodialysis, Congested Heart Failure (CHF) and Diabetes Mellitus.         3	NUME       STREET ADDRESS. CITY, STATE, ZIP CODE       INCOMPER OR SUPPLIER     STREET ADDRESS. CITY, STATE, ZIP CODE       ID PINES HEALTHCARE AND REHABILITATION CENTE     INCOMPT STREMENT OF DEFICIENCIES       IS SUMMARY STATEMENT OF DEFICIENCIES     D       ICACH DEFICIENCY MUST BE PRECEDED BY FULL     D       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG       Continued From page 12     D       and received a list of all the discharges. Resident     F 623       Date of compliance     May 9, 2019.       Continued From page 12     F 623       and received for a return call. A return call     May 9, 2019.       Conduct from the representative.     May 9, 2019.       On 4/4/19 at 11:43am a telephone interview     May 9, 2019.       An interview was conducted with the Director of     May 9, 2019.       Nursing on 4/4/19 at 3:15pm. She stated the     May 9, 2019.       An interview was conducted with the Director of     Nursing on 4/4/19 at 3:15pm. She stated the       hospital discharge to the hospital but would     Precision responsible party ming in writing of the       resident #65 was admitted to the facility on     10/10/18 with diagnoses that included end stage       kidney disease on hemodialysis. Congested     Heat Failure (CHF) and Diabetes Mellitus.       A review of Resident #655 was admitted to the facility on     May 9, 2019.

Facility ID: 923021

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES	(X2) MUL		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	l` í				PLETED
		345293	B. WING				C /04/2019
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0 11 20 10
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489		
	1				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	2/22/19. There was n notice of hospital disc resident's responsible During an interview o Nurse #4, she explair discharge occurred th party was notified by only written informatic hold policy sent with t On 4/2/19 at 11:47am the Unit Manager #1. called the resident's r regarding the dischar copy of the bed hold p resident. She further mailed a copy of the b responsible party. The Social Worker wa 11:50am. She explain	o documentation of a written charge provided to the e party. In 4/2/19 at 11:45am with ned that when a hospital ne resident's responsible phone. She added that the on provided was the bed the resident. In an interview occurred with She stated that the nurses responsible party by phone rges to the hospital and a policy was sent with the stated the Social Worker bed hold policy to the as interviewed on 4/2/19 at	F	623			
	policy to the resident <sup>1</sup> added that the Ombu and received a list of #65 was readmitted to 2/27/19. A phone call was place responsible party on 4 message was left for was not received from On 4/4/19 at 11:43am occurred with the Adm that she was respons process and did not m	s responsible party. She dsman came once month all the discharges. Resident o the facility on 1/22/19 and ced to Resident #65's 4/3/19 at 11:00am. A a return call. A return call					

Facility ID: 923021

If continuation sheet Page 14 of 126

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345293	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	0-10200			TREET ADDRESS, CITY, STATE, ZIP CODE	04/	04/2019
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	hospital discharge oc An interview was com Nursing on 4/4/19 at nurses informed the r responsible party whe hospital occurred, but she did not know the resident and/or respo reason for the dischar expect the regulation 3) Resident #52 was	curred. ducted with the Director of 3:15pm. She stated the esidents and called the en a discharge to the not in writing. She stated facility was to inform the nsible party in writing of the rge to the hospital but would to be followed.	F	523			
	A medical record reviewas transferred to the 1/15/19 and 3/2/19. To of a written notice of h to the resident's response of the resident's responsible and dated 3/14/19 review of Resident and dated 3/14/19 review of Resident and the dated 3/14/19 review of Resident and the set (MDS) code and dated 3/14/19 review of Resident and the set (MDS) code and the set (MDS) c	ew revealed the resident e hospital on 10/31/18, There was no documentation nospital discharge provided onsible party. #52's most recent Minimum d as a quarterly assessment vealed he had severe					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FC	DRM APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB	NO. 0938-0391		
	ATE SURVEY OMPLETED		
A. BUILDING	С		
345293 B. WING	04/04/2019		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			
HAMLET, NC 28345			
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE	DATE		
DEFICIENCY)			
F 623 Continued From page 15 F 623			
regarding the discharges to the hospital and a			
copy of the bed hold policy was sent with the			
resident. She further stated the Social Worker			
mailed a copy of the bed hold policy to the			
responsible party.			
The Social Worker was interviewed on 4/2/19 at			
11:50am. She explained that she was			
responsible for sending a copy of the bed hold policy to the resident's responsible party. She			
added that the Ombudsman came once month			
and received a list of all the discharges. Resident			
#52 was readmitted to the facility on 11/1/18,			
1/16/19 and 3/4/19.			
A telephone interview was conducted with			
Resident #52's responsible party on 4/4/19 at			
10:20am. She indicated that she had received a			
phone call from the nurse at the time of his hospital discharge and received the bed hold			
policy in the mail. She further stated that she had			
not received any written notices of hospital			
discharges at those times.			
On 4/4/19 at 11:43am a telephone interview			
occurred with the Admissions Director. She stated			
that she was responsible for the admissions			
process and did not notify or send anything in writing to the resident's representative when a			
hospital discharge occurred.			
An interview was conducted with the Director of			
Nursing on 4/4/19 at 3:15pm. She stated the nurses informed the residents and called the			
responsible party when a discharge to the			
hospital occurred, but not in writing. She stated			
she did not know the facility was to inform the			
resident and/or responsible party in writing of the reason for the discharge to the hospital but would			

Facility ID: 923021

If continuation sheet Page 16 of 126

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345293	B. WING _				C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	expect the regulation 4. Resident #13 was a 5/5/17 with multiple did dementia. The annual assessment dated 1/7 #13 had moderate co Review of Resident # that he was discharge hospital on 3/16/19 du notes did not indicate responsible party (RP the reason for the disc On 4/2/19 at 11:45 AN interviewed. Nurse # called the RP to notify and the reason for the added that the Social responsible for sendir policy to the RP wher discharged. On 4/2/19 at 11:50 AN The SW stated that si sending a copy of the but she was not respon in writing of the reason On 4/3/19 at 11:01 AN called and he/she star received a letter from him/her that the resid hospital and the reason	to be followed. admitted to the facility on iagnoses including al Minimum Data Set (MDS) 1/19 indicated that Resident gnitive impairment. 13's nurse's notes revealed ed and was admitted to the ue to hypernatremia. The that Resident #13's P) was notified in writing of charge. M, Nurse #4 was 4 stated that she normally y him/her of the discharge e discharge. Nurse #4 Worker (SW) was ng a copy of the bed hold in the resident was M, the SW was interviewed. he was responsible for bed hold policy to the RP onsible for notifying the RP in for the discharge. M, Resident #13's RP was ted that he/she had not the facility informing ent was discharged to the on for the discharge. The ident #13 was discharged to	F	523			
	On 4/4/19 at 11:05 AM	M, the Director of Nursing					

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	D HUMAN SERVICES					APPROVED
CENTERS FOR MEDICARE & M		(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMP	LETED
	345293	B. WING				C 04/2019
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMOND PINES HEALTHCARE A	ND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489		
			H	IAMLET, NC 28345		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>F 623 Continued From page (DON) was interviewed she was not aware of the facility had to notify the resident was discharge DON added that nurses RP when a resident was not in writing. She indice regulation to be followed.</li> <li>On 4/4/19 at 11:43 AM was interviewed. She seresponsible for admissing responsible for notifying was discharged to the facility on 12/7/17 with including dementia. The Data Set (MDS) assesses indicated that Resident cognition.</li> <li>Review of Resident #80 that he was discharged to the facility on 11/30/18 du breathing and with low on room air and on 4/2 unresponsiveness and not indicate that Resided (RP) was notified in wridischarge.</li> <li>On 4/2/19 at 11:45 AM interviewed. Nurse #4 called the RP to notify and the reason for the added that the Social V</li> </ul>	d. The DON stated that the regulation that the a RP in writing when a ed to the hospital. The iss had been notifying the as discharged by phone but cated that she expected the ed for notification. I, the Admission Director stated that she was sions but she was not ing the RP when a resident hospital. riginally admitted to the multiple diagnoses he admission Minimum isment dated 2/28/19 t #80 had impaired 0's nurse's notes revealed d and was admitted to the ue to shallow and labored oxygen saturation of 86% 2/19 due to 1 wheezing. The notes did ent #80's responsible party riting of the reason for the 1, Nurse #4 was is stated that she normally him/her of the discharge discharge. Nurse #4	F	623			

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			HGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	policy to the RP wher discharged. On 4/2/19 at 11:50 Al The SW stated that si sending a copy of the but she was not respo- in writing of the reaso Attempted to call the unsuccessful. On 4/4/19 at 11:05 Al (DON) was interviewed she was not aware of facility had to notify th resident was discharg DON added that nurs RP when a resident w not in writing. She ind the regulation to be fo On 4/4/19 at 11:43 Al was interviewed. She responsible for admis responsible for notifyi was discharged to the Director reported that readmitted back to the 6. Resident #75 was of facility on 1/26/11 with including dementia.	A, the SW was interviewed. he was responsible for bed hold policy to the RP ponsible for notifying the RP in for the discharge. RP of Resident #80 but was M, the Director of Nursing ed. The DON stated that the regulation that the he RP in writing when a ged to the hospital. The es had been notifying the vas discharged by phone but dicated that she expected bilowed for notification. M, the Admission Director stated that she was sions but she was not ng the RP when a resident e hospital. The Admission Resident #80 was e facility from the hospital. briginally admitted to the n multiple diagnoses The annual Minimum Data nt dated 3/15/19 indicated	F	623			

Facility ID: 923021

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	
		345293	B. WING				。 04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Review of Resident # that he was discharge hospital on 2/1/19 due on 2/12/19 due to sho oxygen saturation of 8 The notes did not indi responsible party (RF the reason for the dis On 4/2/19 at 11:45 AI interviewed. Nurse # called the RP to notify and the reason for the added that the Social responsible for sendir policy to the RP when discharged. On 4/2/19 at 11:50 AI The SW stated that st sending a copy of the but she was not respo in writing of the reaso Attempted to call the unsuccessful. On 4/4/19 at 11:05 AI (DON) was interviewed she was not aware of facility had to notify the resident was discharge DON added that nurs RP when a resident w not in writing. She ind the regulation to be for	75's nurse's notes revealed ed and was admitted to the e to shortness of breath and ortness of breath and low 87% on 3 liters of oxygen. icate that Resident #75's P) was notified in writing of charge. M, Nurse #4 was 4 stated that she normally y him/her of the discharge e discharge. Nurse #4 Worker (SW) was ng a copy of the bed hold n the resident was M, the SW was interviewed. he was responsible for bed hold policy to the RP onsible for notifying the RP on for the discharge. RP of Resident #75 but was M, the Director of Nursing ed. The DON stated that the regulation that the he RP in writing when a ged to the hospital. The es had been notifying the was discharged by phone but dicated that she expected oblowed for notification. M, the Admission Director	F	623			

If continuation sheet Page 20 of 126

CENTERS FOR MEDICARE & MEDICAID SERVICES       STATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA     (X2) MULTIPLE CONSTRUCTION     (X3) DATE SL       AND PLAN OF CORRECTION     IDENTIFICATION NUMBER:     A DUM DIMO     COMPLE	JRVEY
A. BUILDING	TED
C	
345293 B. WING 04/04	4/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	
HAMLET, NC 28345	
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE	DATE
DEFICIENCY)	
F 623     Continued From page 20     F 623	
responsible for admissions but she was not responsible for notifying the RP when a resident	
was discharged to the hospital. The Admission	
Director reported that Resident #75 was	
readmitted back to the facility from the hospital	
7. Resident #60 was admitted to the facility on	
7/1/18 and readmitted on 2/11/19 with diagnoses	
that included dementia.	
The quarterly Minimum Data Set (MDS)	
assessment dated 1/10/19 indicated Resident #60 had short-term and long-term memory	
problems and severely impaired decision making.	
A medical record review revealed the resident	
was transferred to the hospital on 2/9/19. There was no documentation of a written notice of	
hospital discharge provided to the resident's	
responsible party. Resident #60 was readmitted	
to the facility on 2/11/19.	
During an interview on 4/2/19 at 11:45 AM with	
Nurse #4, she explained that when a hospital	
discharge occurred the resident's responsible	
party was notified by phone. She added that the	
only written information provided was the bed	
hold policy sent with the resident.	
On 4/2/19 at 11:47 AM an interview occurred with	
the Unit Manager #1. She stated that the nurses	
called the resident's responsible party by phone	
regarding the discharges to the hospital and a copy of the bed hold policy was sent with the	
resident. She further stated the Social Worker	
mailed a copy of the bed hold policy to the	
responsible party.	
The Social Worker was interviewed on 4/2/19 at	

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345293	B. WING		04/04/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODI HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 623 F 636 SS=D	11:50 AM. She explaresponsible for sendin policy to the resident' added that the Ombut and received a list of A family interview war Resident #60's respon 11:30 AM. On 4/4/19 at 11:43 All occurred with the Adr that she was response process and did not re writing to the resident hospital discharge occur An interview was con Nursing on 4/4/19 at 1 nurses informed the re responsible party whe hospital occurred, but she did not know the resident and/or respon reason for the dischar expect the regulation Comprehensive Asse CFR(s): 483.20(b)(1) §483.20 Resident Asse functional capacity. §483.20(b) Comprehersive	ined that she was ng a copy of the bed hold s responsible party. She dsman came once month all the discharges. s attempted by phone with nsible party on 4/1/19 at M a telephone interview missions Director. She stated ible for the admission notify or send anything in t's representative when a curred. ducted with the Director of 3:15 PM. She stated the residents and called the en a discharge to the t not in writing. She stated facility was to inform the nsible party in writing of the rge to the hospital but would to be followed. assments & Timing (2)(i)(iii) sessment duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument.	F 623		5/1/19

Facility ID: 923021

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345293	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 636	goals, life history and resident assessment by CMS. The assess the following: (i) Identification and d (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (v) Vision. (vi) Mood and behavie (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritio (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge planni (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The ass include direct observation with the resident, as w licensed and nonlicent members on all shifts §483.20(b)(2) When r timeframes prescriber chapter, a facility musicasses to the frames specified	dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least emographic information  or patterns. II-being. ing and structural problems. and health conditions. onal status. ts and procedures. ing. of summary information hal assessment performed gered by the completion of it (MDS). of participation in sessment process must ation and communication well as communication with ised direct care staff	F	636			

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If continuation sheet Page 23 of 126

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		<b>IPLETED</b>
		345293	B. WING		04	-
NAME OF PI	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP		dent he corporate reimbursement wed resident #60 who is not terviewed based on staff nd resident status. ected residents he facility nurse consultant n audit of all residents' d mood assessments last 30 days to ensure all ta set assessments (MDS) ompleted appropriately with e findings. re for implementing the blan of correction for the ciency cited	
				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	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 636	Continued From page	e 23	F 63			
		43(b) of this chapter do not				
	apply to CAHs.	r dave after admission				
		r days after admission, ons in which there is no				
		the resident's physical or				
		or purposes of this section,				
		a return to the facility				
		absence for hospitalization				
	or therapeutic leave.)					
	(iii)Not less than once					
		Γ is not met as evidenced				
	by:					
	-	iew and staff interview, the		F 636		
	facility failed to comp			Affected resident		
	resident on the Minim				mbursement	
		eas of cognition and mood		auditor reviewed resident #6		
		esidents whose MDS		able to be interviewed based	l on staff	
	-	eviewed (Resident #60).		interviews and resident statu Potential affected residents	IS.	
	The findings included	i:		On 4/24/19 the facility nurse completed an audit of all res		
	Resident #60 was ad	lmitted to the facility on		cognition and mood assessn	nents	
		ently readmitted on 2/11/19		completed in last 30 days to		
	with diagnoses that in	ncluded dementia.		minimum data set assessme		
				have been completed approp	priately with	
		2/11/19 indicated Resident		zero negative findings.		
	#60 was alert, pleasa	antly confused, and		The procedure for implemen		
	consistently talking.			acceptable plan of correction	n for the	
	The survey of the set of			specific deficiency cited		
	The quarterly Minimu			On 4/17/19, the corporate M		
		14/19 indicated Resident		in-serviced the facility social		
	#60 had clear speech			and MDS nurses related to a	•	
		s, and sometimes understood		coding the MDS on Cognition		
		he Cognitive Patterns		C01100 and Mood Sect D01		
		prehensively assessed for		resident assessment instrum		
		tion C0100 was coded to		manual. This in-service was		
	indicate Resident #60			orientation on 4/25/19 by the		
		ef Interview for Mental		nursing (DON) for any new fa	acility SVV	
	Status (BINS) was no	ot conducted. Section D, the		and MDS nurses.		

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		ID HUMAN SERVICES			FORM	: 05/09/201 APPROVE
STATEMENT OF DEFICIENCIES (X1) PRO		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	IPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		345293	B. WING _		04/0	; )4/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIOI DATE
F 636	coded to indicate Res understood and the r not conducted. Secti #60's 2/14/19 MDS w Worker (SW). An interview was com 4/4/19 at 4:46 PM. T completed Sections C quarterly MDS asses Sections C and D of t Resident #60 were re reported that Resider sensical answers for mood interview, so st interview instead. Th unaware of the codim the Resident Assess manual for the compl interviews in Sections An interview was con Nursing (DON) on 4/4 indicated her expecta	bt comprehensively th #60. Question D0100 was sident #60 was rarely/never esident mood interview was ons C and D of Resident vere completed by the Social ducted with the SW on he SW indicated she C and D of Resident #60's sment dated 2/14/19. the 2/14/19 MDS for eviewed with the SW. She the #60 was unable to provide the BIMS and the resident he completed the staff the SW indicated she was g instructions specified in ment Instrument (RAI) etion of the resident is C and D. ducted with the Director of	F6	The monitoring proce the plan of correction specific deficiency ci and/or in compliance requirements The MDS nurse, DO facilitator will audit 3 assessments weekly ensure that Cognitio assessment is accur manual. This audit w the minimum data set The monthly Quality Assurance/Performa committee will review minimum data set au months for identifica taken, and to determ and/or frequency of a and make recommen monitoring for contin administrator and/or findings and recomm monthly Quality Assu	n is effective and that ited remains corrected e with the regulatory N, and/or staff completed MDS / x 12 weeks to n and Mood rate as per RAI vill be documented on et audit tool. ance Improvement w the results of the udit tool monthly for 3 tion of trends, actions nine the need for continued monitoring, indations for ued compliance. The DON will present the nendations of the urance/Performance ittee to the quarterly isurance/Performance ittee for further	
F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy		F 6	May 1, 2019 41		5/1/19
	The assessment mus resident's status.	st accurately reflect the				

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 05/09/20 FORM APPROVE MB NO. 0938-039		
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 04/04/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, C	ITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BO) HAMLET, NC 2834				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE		
F 641	Continued From page	e 25	F 64	1				
	Based on record rev interview, and staff in code the Minimum Di accurately in the area #28, #67, and #75), f of daily living (Reside (Resident #34), active tube feeding (Reside #51) for 7 of 22 samp The findings included 1. Resident #67 was 10/11/18 with diagnos Mellitus (DM) and he side of the body). Resident #67's Febru summary included th administered by inject - Exenatide (anti-diat injection 2 milligram ( subcutaneous injectio - Depo-testosterone i (ml), intramuscular in The quarterly Minimu assessment dated 2/ #67's cognition was i injections and 2 insul MDS look back perio of Resident #67 ' s 2/ MDS Nurse #2.	<ul> <li>iew, observation, resident therview, the facility failed to ata Set (MDS) assessment as of medications (Residents alls (Resident #28), activities ent #28), tracheostomy care e diagnoses (Resident #22), nt #52), and pain (Resident oled residents.</li> <li>admitted to the facility on ses that included Diabetes miplegia (paralysis of one</li> <li>arry 2019 physician's order e following medications tion: petic medication) pen (mg) powder for suspension, on once weekly njection 200 mg/milliliter jection once every 2 weeks</li> <li>Im Data Set (MDS) 22/19 indicated Resident ntact. He was noted with 3 in injections during the 7-day d. The Medication Section (22/19 MDS was coded by</li> <li>#67 ' s Medication</li> </ul>		F641 Accuracy of A The plan of co deficiency By 4/25/19 the assessments #34, #22, #52 minimum data submitted to t The procedur acceptable pla specific deficie Audit of all res comprehensiv submitted and ensure falls, n daily living, tra tube feeding, coded by facil from 4/24/19 th additional neg Systemic chai The MDS nur- corporate rein correctly codin assessment p instrument (R medications a tracheostomy feeding, and p Any newly him in-serviced by reimbursement the MDS asset The monitorin	prrecting the specific e minimum data set for residents #28, #67, #75 e, and #51 were modified by a set nurses (MDS) and he national repository. e for implementing the an of correction for the ency cited sidents with submitted ve MDS assessments d accepted in last 30 days to medications, activities of acheostomy care, fractures and pain were accurately lity consultant completed through 4/25/19. No gative findings noted. nges se was in-serviced by the nbursement auditor on ng the of the MDS per the resident assessment AI) manual, including falls, activities of daily living, care, fractures, tube pain on 4/17 and 4/18/19. ed MDS nurses will be v facilities corporate nt auditor to accurately cod essments to include falls. ing procedure to ensure that	v t e		
				specific defici	rrection is effective and tha ency cited remains corrector pliance with the regulatory	ed		

Facility ID: 923021

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 641	<ul> <li>#67 was administered type during the 2/22/1</li> <li>An interview was con on 4/1/19 at 4:08 PM working as an MDS Nover a month ago. Sexperience coding the Section of the 2/22/19 #67 was reviewed with confirmed she coded Resident #67 for the 2/22/19 MDS was revised at this 2</li> <li>#67 was coded inaccinsulin injections. ME was just learning the a mistake.</li> <li>An interview was con Nursing on 4/4/19 at expected the MDS to 2. Resident #28 was 12/21/17 with diagnosimajor depressive discont and the modified qua (MDS) assessment d Resident #28's cognit She was coded with 2</li> </ul>	jection on 2/16/19. Resident d no other injections of any 19 MDS look back period. ducted with MDS Nurse #2 . She stated she began Nurse at this facility a little he reported she had no prior e MDS. The Medication 9 quarterly MDS for Resident th MDS Nurse #2. She this section. The MAR for look back period of the <i>v</i> iewed with MDS Nurse #2. //22/19 MDS for Resident urately for injections and DS Nurse #2 revealed she coding rules and she made	F 64	The director of nursing, and/ or sta facilitator, will audit 3 completed M assessments weekly x 12 weeks t ensure falls, medications, activitie daily living, tracheostomy care, fra tube feeding, and pain were coder correctly using the MDS Audit Too The monthly Quality Assurance/Performance Improver committee will review the results of MDS Audit Tool monthly for 3 mor identification of trends, actions tak to determine the need for and/or frequency of continued monitoring make recommendations for monit continued compliance. The admin and/or director of nursing (DON) w present the findings and recommendations of the monthly of Assurance/Performance Improver committee to the quarterly executi Quality Assurance/Performance Improvement committee for further recommendations and oversight. Compliance date: May 1, 2019	IDS o s of incture, d l. nent of the ths for ten, and oring for istrator vill Quality nent ve

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 04/04/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE		(X5) COMPLETION DATE	
F 641	forehead - 11/5/18 fall that result of her head - 12/2/18 fall that result of her head An interview was con- on 4/3/19 at 10:40 AM previous MDS Nurse of Resident #28's 12/2 Nurse #1 indicated sh verify it was complete they utilized the risk m Electronic Medical Res MDS for falls. She re- management section verified that the 12/26 was coded inaccurate 2b. The quarterly Min assessment dated 3/7 #28's cognition was s coded with 1 fall with MDS assessment (122 A review of Resident 1 nursing notes indicates sustained the following through 3/18/19: - 1/13/19 fall that resul- - 1/17/19 fall with no in- - 2/5/19 fall with no in-	sulted in a bump to the lited in a "knot" to the back lited in 4 staples to the back ducted with MDS Nurse #1 A. She stated that a completed the falls sections 26/18 quarterly MDS. MDS the signed the assessment to a. MDS Nurse #1 stated that nanagement section of the ecords (EMR) to code the viewed the risk of Resident #28's EMR and 6/18 modified quarterly MDS ely for falls. imum Data Set (MDS) 18/19 indicated Resident everely impaired. She was no injury since her prior 4/26/18). #28's incident reports and ed that Resident #28 ig falls from 12/27/18 lited in 5 staples to her head njury njury jury lited in bruising to her eye, njury	F 6	41				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		STRUCTION	(X3) DATE COMP	SURVEY PLETED
	345293	B. WING				C 104/2019
NAME OF PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
RICHMOND PINES HEALTHCARE A	AND REHABILITATION CENTE			VAY 177 S BOX 1489		
			HAML	ET, NC 28345		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641 Continued From page	28	F 6	41			
<ul> <li>on 4/3/19 at 10:40 AM working as an MDS Ne over a month ago. Sh experience coding the coded the section relat #28's 3/18/19 MDS. M she utilized the risk ma Electronic Medical Red MDS for falls. She rev management section of verified that the 3/18/1 coded inaccurately for stated that she was stit the EMR and she mad 2c. A review of the Ma summary indicated Re Pristiq (antidepressant (mg) once daily.</li> <li>The quarterly Minimum assessment dated 3/1 #28 's cognition was s coded with no antidepr 7-day MDS look back A review of Resident # Administration Record back period of the 3/18 3/18/19) indicated Res administered the antid Pristiq on 7 of 7 days. An interview was cond on 4/3/19 at 10:40 AM</li> </ul>	of Resident #28's EMR and 9 quarterly MDS was falls. MDS Nurse #2 ill learning how to operate de an error. Arch 2019 physician's order esident #28 was ordered t medication) 50 milligrams in Data Set (MDS) 8/19 indicated Resident severely impaired. She was ressant usage during the period. #28's Medication I (MAR) for the 7-day look 8/19 MDS (3/12/19 through sident #28 was					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE COMP	
		345293	B. WING				04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	experience coding the coded the section rela Resident #28's 3/18/1 section of Resident #3 was reviewed with MI 2019 MAR that indica administered the antio days was reviewed w stated that she was n antidepressant medic had not coded it on the 2d. The quarterly Min assessment dated 3/7 #28's cognition was s coded as independent bed mobility, transfers on unit, locomotion or and eating. Resident dependent of 1 for dre A review of the Nursir documentation for Re Daily Living (ADLs) dr back period (3/12/19) the following: - Bed mobility ranged set up assistance to exter - Walking in room ran no set up assistance for up assistance to exter - Walking on unit rang no set up assistance for up assistance for up assistance for with no set up assistance for assistance for assistance for assistance for assistance for up assistance for assistance for up assistance for assistance for up assistance for assistance for up assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for assistance for ass	e MDS. She stated she ated to medications for 9 MDS. The medication 28's 3/18/19 quarterly MDS DS Nurse #2. The March ted Resident #28 was depressant Pristiq on 7 of 7 ith MDS Nurse #2. She ot aware Pristiq was an ation and this was why she e MDS. imum Data Set (MDS) 18/19 indicated Resident everely impaired. She was t with set up help only for s, walking in room, walking n unit, locomotion off unit, #28 was coded as essing and toileting. ing Assistant (NA) sident #28's Activities of uring the 3/18/19 MDS look through 3/18/19) revealed from independent with no lependent with 1 assist im independent with no set	F	641			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORMA	05/09/2019 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		INSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345293	B. WING			04/04/2019			
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		HIGH	ET ADDRESS, CITY, STATE, ZIP COL IWAY 177 S BOX 1489 ILET, NC 28345	DE			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE	
F 641	assist - Eating ranged from assistance to depend - Toileting ranged from dependent with 1 ass - Dressing ranged fro dependent with 1 ass An interview was con on 4/3/19 at 10:40 AM working as an MDS Nover a month ago. S experience coding the coded the section rela #28's 3/18/19 MDS. T #28's 3/18/19 quarter MDS Nurse #2. The for Resident #28 duri back period (3/12/19 reviewed with MDS N revealed she was still how to code the MDS An interview was con Nursing on 4/4/19 at expected the MDS to 3. Resident #22 was 5/15/18 with diagnose abnormalities of gait a osteoporosis. A review of Resident Set (MDS) dated 1/8/ a severely impaired or required extensive as transfers, dressing, a	ince to dependent with 1 independent with no set up ent with 1 assist n limited with assist to ist m extensive with 1 assist to ist ducted with MDS Nurse #2 A. She indicated she began lurse at this facility a little he reported she had no prior e MDS. She stated she ated to ADLs for Resident The ADL section of Resident VMDS was reviewed with NA documentation of ADLs ng the 3/18/19 MDS look through 3/18/19) was lurse #2. MDS Nurse #2 in the process of learning of or ADLs. ducted with the Director of 3:15 PM. She indicated she be coded accurately. admitted to the facility on es of unspecified and age-related #22's annual Minimum Data 19 revealed the resident had ognition. The resident	F 6	:41					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
		345293	B. WING				04/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	the diagnoses of fract or fall. A review of Resident 12/18/18 revealed the pain to the right arm. revealed no signs or resident stated she fe and found on her rood alert but confused (ba Resident #22 nurses' 11:00 am documente and noted her right sh with her left shoulder. her right arm without Practitioner (FNP) as determined she shou Room (ER). A review of Resident 12/21/18 revealed sh facility transferring. T osteoporosis. The re her right arm today as revealed fracture of ri was subacute and ch An interview was con am with the Director of that there were multip contributing to MDS e progress. The DON f expected the MDS to An interview was con with the MDS Coordin	e MDS was not coded for ture of right humerus (arm) #22's Incident Report dated e resident complained of A head to toe assessment symptoms of injury. The ell, was hollering out for help m floor. The resident was aseline). note dated 12/21/2018 at d the resident was assessed noulder to be asymmetrical . The resident could not lift pain. The Family Nurse sessed the resident and ld be seen in Emergency #22's ER note dated e fell three days ago at the There was a history of sident was noted not using s usual. X-ray report ight humerus, non-union that ronic appearing. ducted on 4/2/19 at 10:00 of Nursing (DON) who stated oble transcription error errors and an audit was in further stated that she be accurately coded.	F	641				
		nator who stated that the s missed and would be						

Facility ID: 923021

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		ID HUMAN SERVICES				FORM	APPROVED		
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPI F		(X3) DATE	0. 0938-0391		
	CORRECTION	IDENTIFICATION NUMBER:	l` '				LETED		
						(	0		
		345293	B. WING			04/04/2019			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489					
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IAMLET, NC 28345				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE ) TAG CROSS-REFERENCED TO THE APPROPRIATE				COMPLETION DATE		
					DEFICIENCY)				
F 641		- 00							
F 041	Continued From page corrected.	9.32	F t	641					
	corrected.								
	4. Resident #34 was 12/21/15 with diagnos	admitted to the facility on							
	obstruction and trach								
		#34's quarterly MDS dated resident had an intact							
		d total dependence for							
		e assistance for all other							
	activities of daily living								
		monia and respiratory was oxygen dependent.							
		"No" for tracheostomy care.							
	0								
		an interview was conducted to stated that facility staff							
		nage her tracheostomy care							
	each shift.								
	On 4/1/19 at 9:30 am	an observation was done of							
		esident had no shortness of							
		distress noted. The resident							
		ostomy with a slit gauze							
	able to cough and cle	dry and intact. She was							
		bes not require suctioning.							
	A review of Resident	#21/a traatmant							
		#34's treatment documentation for January							
		ostomy care each day and							
	as needed.	-							
	An interview was con	ducted on 4/2/19 at 10:00							
		o stated that she expected							
	the MDS to be accura	-							
	An interview was con	ducted on 4/4/19 at 2:00 pm							

Facility ID: 923021

If continuation sheet Page 33 of 126

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		345293	B. WING			04/04/2019		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345					
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 641	tracheostomy was mis corrected.	nator who stated that the	F	641				
	1/20/11 with the diagr dementia, restlessnes	noses of dysphagia,						
	2/1/19 revealed the re impaired cognition with understood or unders required total depend active diagnoses were knees, restless leg sy and movement disord	th no speech and was rarely tands. The resident ence for all ADLs. The e contractures of hips and indrome, and extrapyramidal ler. Pain assessment for lication was coded "no" for						
	Physician order dated documentation that R mg three times a day	esident #51 had Tylenol 650						
	2019 treatment admir the resident received	#51's January and February histration record revealed Tylenol 650 mg TID for the lookback period dated						
	with Nurse #1 who sta	ducted on 4/1/19 at 3:30 pm ated that Resident #51 e times a day for generalized						
	am with the Director of	ducted on 4/2/19 at 10:00 of Nursing (DON) who stated MDS to be accurately						

Facility ID: 923021

If continuation sheet Page 34 of 126

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					/I APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY	
			A. BUILDII	NG _			С	
		345293	B. WING			04/04/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•	- I	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489			
				Н	IAMLET, NC 28345			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ATE	DATE	
F 641	Continued From page	e 34	F6	641				
		ducted on 4/4/19 at 2:00 pm						
		nator who stated that the						
	pain medication admi	sed and would be corrected.						
	, ,	admitted to the facility on						
		ses that included dysphagia ), and seizure disorder.						
		erly Minimum Data Set						
		ated 11/16/18 indicated the						
		% or more calories via the copic Gastrostomy (PEG- a						
	way of receiving nutri							
	A review of the Overt							
		erly MDS assessment dated esident received 51% or						
	more calories via the							
		S coded as a quarterly ad 3/4/19, assessed the						
		cognitive impairment. He						
		nce from staff for eating via						
		noted that he received 26 to						
	50% of calories thru t	ine PEG lube.						
	A nursing note dated	3/16/19 indicated the						
		r drink anything by mouth						
	and received 100% o tube.	f his meals via the PEG						
	Review of Resident #							
		in place for nutrition via the						
		phagia and nothing by mouth priate goals and interventions						
	were present.							
	A	at a bound along a state of the state						
	A review of the currer	nt physician orders revealed						

	-	ID HUMAN SERVICES					APPROVED				
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391				
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ECONSTRUCTION	(X3) DATE COMF	SURVEY				
			A. BUILD	NG_			C				
		345293	B. WING				04/2019				
NAME OF PI	ROVIDER OR SUPPLIER	I	<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE						
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		F	HGHWAY 177 S BOX 1489						
				HAMLET, NC 28345							
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION				
TAG		LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE					
	1		-								
F 641	Continued From page	35		641							
1 041		d a continuous enteral		041							
		s (ml) per hour via the PEG									
	tube.										
	On 4/4/10 at 0.05 am	an interview was conducted									
		#1. After reviewing the									
		3/4/19 MDS, she stated the									
	dietary manager code	ed that section.									
	On 4/4/19 at 9:20am	an interview occurred with									
		She reviewed the nutrition									
		DS and stated the 26-50% of									
	calories thru the PEG and should have beer	tube was marked in error									
		ith the Director of Nursing									
	on 4/4/19 at 3:20pm s										
	expectation for the M	DS to coded accurately.									
	7. Resident #75 was	originally admitted to the									
	facility on 1/26/11 with										
	Set (MDS) assessme	The annual Minimum Data									
		) of 3/15/19 indicated that									
	Resident #75 had mo	derate cognitive impairment									
		anticoagulant medication for									
	7 days during the ass	sessment period.									
	Review of Resident #	75's physician's orders for									
	March 2019 revealed										
	anticoagulant medica	tion.									
	Resident #75's March	1 2019 Medication									
	Administration Record	d (MAR) was reviewed and									
		nt #75 had not received an									
	anticoagulant medica period.	tion during the assessment									
	Interview with MDS N	lurse #1 was conducted on									

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 641 F 656	Resident #75's orders Resident #75 did not anticoagulant medica anticoagulant medica period. The MDS Nu coding error on her pa 3/15/19 was inaccura Interview with the Dira 4/4/19 at 11:05 AM w stated that she expect be coded accurately.	IDS Nurse #1 reviewed s and MARs and verified that have an order for an tion and had not received an tion during the assessment rse indicated that it was a art, the annual MDS dated	F 64		5/9/19
SS=D	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized se	cility must develop and densive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ded in the comprehensive hprehensive care plan must g- the to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	345293		B. WING		04/04/2019
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
	BT INEO MEAEMIOANE			HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 656	findings of the PASAF rationale in the reside (iv)In consultation wit resident's representa (A) The resident's god desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident's community was asse- local contact agencie entities, for this purpor (C) Discharge plans i plan, as appropriate, requirements set forth section.	PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate	F 65	6	
	and resident interview develop a care plan fi interventions (Reside motion/contracture pr and failed to impleme (Resident #51), for ea #60), for nail care (Re interventions (Reside (Resident #28), for 5 Findings included: 1. Resident #34 was 12/21/15 with diagnos obstruction and trach A review of Resident Data Set (MDS) date	nt #34) and range of revention (Resident #51), ent the care plan for nutrition ating assistance (Resident esident #51), for suicidal nt #24), and for falls of 22 residents reviewed. admitted to the facility on ses of esophageal		<ul> <li>F656</li> <li>The plan of correcting the specific deficiency</li> <li>By 4/25/19 resident #34's care plat updated to include tracheostomy of and #51's care plan was updated include decreased range of motion (therapy) by the minimum data set (MDS), or facility consultant.</li> <li>On 4/24/19 the facility consultant observed resident #51's meal tray included the care planed intervent nutrition.</li> <li>On 4/24/19 the facility consultant observed meal assistance being p to resident # 60 as designated on plan.</li> <li>On 4/24/19 the facility consultant</li> </ul>	an was care, to n t nurse v that tions for

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/09/2019 RM APPROVED IO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345293	B. WING		0	C 4/04/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	2 38	F 65	6		
F 656	and respiratory failure dependent. The MDS tracheostomy care. A review of Resident 1/22/19 revealed no to were identified. On 4/1/19 at 9:30 am with Resident #34 wh Hospice staff manage each shift. The resid On 4/1/19 at 9:30 am Resident #34. The resid On 4/1/19 at 9:30 am Resident #34. The resid breath or respiratory had a capped trached surrounding that was able to cough and clea independently and do On 4/3/19 at 3:20 pm with the Treatment Ni Hospice does not pro- services, the facility r care which included of cannula cleaning as r provided was document treatment administrat	fer and extensive ctivities of daily living iagnoses were pneumonia e. The resident was oxygen 5 was coded "No' for 34's care plan updated on racheostomy interventions an interview was conducted to stated that facility and e her tracheostomy care ent had no concerns. an observation was done of esident had no shortness of distress noted. The resident ostomy with a slit gauze dry and intact. She was ear her secretions bes not require suctioning. an interview was conducted urse (TN) who stated when wide the resident care nurse provided tracheostomy daily dressing change and needed. Facility care ented on each resident's	F 65	<ul> <li>observed the nails of resident # ensure nail care had been providesignated by care plan. The care plan was updated on facility consultant for resident # ensure suicide precautions were and accurate. On 4/24/19 the facility consultat observed resident #28 and all interventions on fall care plan will place.</li> <li>The procedure for implementin acceptable plan of correction for specific deficiency cited On 4/25/19 the facility consultat all residents with tracheostomy interventions and care plan in p no negative findings. On 4/24/19 the MDS nurses au residents with contractures to e plan in place. There was 1 neg finding. Negative findings imme addressed by the auditor. On 4/24/19 the facility consultat observed breakfast for residem community dining with no negat findings noted related to assist provided per care plan. On 4/26/19 nursing staff audite residents' nails. No negative fir noted. On 4/24/19 the facility consultation</li> </ul>	vided as 4/24/19 by 24 to re current ant were in g the or the ant audited to ensure blace with udited all ensure care ative ediately ant ts in ative ance being ed all adings were	
	and documented in the the resident's medical On 4/4/19 at 9:30 am	ne Hospice narrative notes in I record. an interview was conducted		completed an audit of residents care plan for suicide precaution interventions in place, no nega findings.	s with a ns. All tive	
		nator who stated she was ent #34's care plan. The		On 4/26/19 the MDS nurses au residents with fall care plans to		

Facility ID: 923021

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/09/20 <sup>-</sup> // APPROVE ). 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		345293	B. WING				C 104/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
				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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 656	Continued From page	e 39	F 6	56			
	1.5	e resident's MDS was not		50	interventions in place. No negative		
		my care, so the care plan			findings were noted.		
	was not developed.				Systemic Change		
					On 4/14/19 the corporate reimburseme	ent	
	An interview was con	nducted on 4/4/19 at 4:00 pm			auditor in-serviced the MDS nurses on	1	
		lursing (DON) who stated			development of care plans and revisio	n to	
	that she expected sta				meet resident current status. This		
		plan to meet the needs and			in-service will be provided to any new		
	preferences of each i	individual resident.			MDS nurses.		
					On 4/18/19 the director of nursing and staff facilitator in-serviced nursing staff		
	2a Resident #51 was	s admitted to the facility on			(licensed nurses, and Certified Nursing		
	1/20/11 with the diag	-			Assistants) on following the residents	-	
	dementia, restlessne				plan/care guide and ensuring		
					interventions are in place. This in-serv	ice	
	A review of Resident	#51's quarterly MDS dated			was added to the orientation for newly		
		esident had a severely			hired nursing staff.		
		ith no speech and was rarely			The monitoring procedure to ensure the		
	understood or unders				the plan of correction is effective and t		
		lence for all ADLs. The			specific deficiency cited remains corre		
	•	e contractures of hips and yndrome, and extrapyramidal			and/or in compliance with the regulato requirements	ry	
	and movement disord				The administrator, director of nursing,		
					staff facilitator, or unit manager will au	dit	
	A review of Resident	#51's care plan updated			10 resident care plans weekly x 12 we		
	2/6/19 did not reveal	documentation which			to ensure care plan(s) are present		
		oal or intervention for range			tracheostomy care, and decreased rar	-	
	of motion and preven	tion of further contractures.			of motion (as appropriate) and that can	e	
	On 2/24/40 at 4:00	m Decident #51 was			plan interventions are in place for nail	ion	
	On 3/31/19 at 4:30 p	m Resident #51 was			care, meal assistance, suicide prevent		
		The resident was also			and falls by observation. This audit wil documented on the intervention audit		
		ntary movement of her			The monthly Quality		
	extremities.	,			Assurance/Performance Improvement		
					committee will review the results of the		
	On 3/31/19 at 4:35 pi	m an interview was			intervention audit tool monthly for 3		
		ing Assistant (NA) #5 who			months for identification of trends, acti	ons	
	stated that the reside	-			taken, and to determine the need for		
	movements of her ex	tremities and was not			and/or frequency of continued monitor	ing,	

Event ID: CYLY11

Facility ID: 923021

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		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
					C
		345293	B. WING		04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 656	Continued From page	e 40	F 65	6	
	currently receiving re range of motion (PRC since the resident had On 4/3/19 at 12:30 pr conducted with NA # #51 was not currently restorative nursing se On 4/3/19 at 2:40 pm with the Therapy Mar Resident #51 has not long time (several mo receiving preventative The resident had a ne padded to accommod and jerking and to pre was not receiving ress contracture care. Th know if there was a p restorative nursing. F was provided by the l the champion for reso	storative nursing for passive DM) and it was a long time d therapy services. m an interview was 1 who stated that Resident v receiving PROM or ervices by the NAs. an interview was conducted mager who stated that t had therapy services for a onths) and was not currently e contracture prevention. ew wheel chair that was date the extremity movement event injury. The resident storative NA for PROM e Therapy Manager did not alan in place by nursing for Restorative nursing services NA staff with two NAs being		and make recommendation monitoring for continued ca administrator and/or direct will present the findings an recommendations of the m Assurance/Performance In committee to the quarterly Quality Assurance/Perform Improvement committee for recommendations and ove Completion date May 9, 20	ompliance. The or of nursing ad nonthly Quality nprovement executive nance or further ersight.
	that she expected sta comprehensive care preferences of each i b. Resident #51 was 1/20/11 with the diago dementia, restlessnes	aff to develop a plan to meet the needs and ndividual resident. admitted to the facility on noses of dysphagia,			
	2/1/19 revealed the re	esident had severely th no speech and was rarely			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE COMP			
		345293	B. WING				04/2019		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE		
F 656	required total depend active diagnoses were dysphagia. The resid diet. A review of Resident 2/6/19 revealed a foct double portion diet ar each meal. A review of Resident provided by the Dieta the resident was to re- portion enriched mea On 4/2/19 at 8:30 am the resident in her be served. The breakfas #5 verified that the me the DM verified that the M verified that the me the DM verified that the scheduled to feed Re- observed the resident meals. NA #2 who state scheduled to feed Re- observed the resident meals. NA #2 comme resident was still hung- second meal. On 4/4/19 at 8:35 am with the DM who state a single portion and d resident did not receiv morning or in the pas On 4/4/19 at 12:30 pr conducted with Dietal cook would announce	ence for all ADLs. The e protein mal-nutrition and lent received a therapeutic #51's care plan updated us for nutrition with pureed, nd nutritional supplement for #51's diet order meal ticket ry Manager (DM) revealed eceive pureed, double l. an observation was done of d and her breakfast tray was st was a single portion. NA eal portion was single and ne meal portion was single. an interview was conducted d she was regularly sident #51 and had not t receive double portion ented that if she felt the gry she would order a an interview was conducted ed Resident #51's meal was loes not know why the ve a double portion this t. m an interview was ry Aide #1 who stated the	F 6	556					

Facility ID: 923021

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		3) DATE SURVEY COMPLETED C			
		345293	B. WING			04/04/2019			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL	)E				
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
F 656	DA #1 commented tha announce "double" the received a single port believed this was a me mis-communication. An interview was con- with the DON who stat to implement the resident c. Resident #51 was 1/20/11 with the diagend dementia, restlessness A review of Resident 2/1/19 revealed the re- impaired cognition with understood or unders required total depend active diagnoses were the extremities. A review of Resident 2/6/19 revealed the re- received total daily ca and cutting finger nail On 3/31/19 at 4:00 per of Resident #51 in he bedside visiting and cor- resident's nails were for commented that he we could resist and offered hand. The family me staff about the nails.	at the cook did not is morning and the resident is morning and the resident is morning and the resident is morning and the resident is morning and the resident at the cook did not is morning and the resident ducted on 4/4/19 at 4:00 pm ated that she expected staff dent's care plan. admitted to the facility on noses of dysphagia, ss, and agitation. #51's quarterly MDS dated esident had a severely th no speech and was rarely thands. The resident ence for all ADLs. The e involuntary movements of #51's care plan updated esident was dependent and are which included cleaning is. m an observation was done r bed. Her family was at the commented that the long. A family member vas aware that the resident ed to hold the resident's mber stated he would inform	F 6	56					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		345293	B. WING _				C 04/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489 AMLET, NC 28345	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	scheduled to care for commented that the r and the resident woul nails. NA #5 further of were not pressing on her hands were close not aware the resident intervention to cut her scratching. On 4/4/19 at 8:30 am Resident #51's nails were were now dirty. An interview was com- with the DON who stat to implement the resident 3. Resident #24 was diagnoses of adult fai behavioral disturbance Resident #24 signed facility to contract for participate in outpatie after her suicide attern A review of Resident 1/9/19 revealed the re- understands and her resident required sup- personal care and wa ADLs. Active diagnos dementia, bipolar disc and suicide attempt. A review of Resident	Resident #51. NA #5 and esident's nails were long d not allow staff to cut her ommented that the nails the resident's palms when d. NA #5 stated she was t had a care plan r nails to prevent accidental an observation was done of which remained long and ducted on 4/4/19 at 4:00 pm ted that she expected staff dent's care plan. admitted on 9/10/12 with lure to thrive, dementia with e, and bipolar disorder. an agreement with the safety and agreement to nt treatment dated 5/18/18	F6	556			

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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         NAME OF PROVIDER OR SUPPLIER       345293       B. WING       04/04/2019         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345       HIGHWAY 177 S BOX 1489 HAMLET, NC 28345       STREET ADDRESS, CITY ATTE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO DATE       (X5) COMPLETIO DATE			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
345293     B. WING     04/04/2019       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE     HIGHWAY 177 S BOX 1489       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG				· /				PLETED	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE       HIGHWAY 177 S BOX 1489         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       COMPLETION DATE			345293	B. WING				-	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE       HAMLET, NC 28345         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       COMPLETIO DATE	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO DATE         COMPLETIO DATE	RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE						
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
F 656       Continued From page 44       F 656         behavior. Intervention was for a "dig bell" and not a corded call bell to prevent inappropriate suicide attempt usage.       A review of Resident #24's nurses' notes from last recertification to 4/4/19 revealed the resident has regular behaviors and the staff had assessed for suicidal risk and ideation. Resident has periodically had 11: supervision. The resident contracted for safety.         On 4/3/19 at 5:00 pm an observation was done of Resident #24 who was resting in bed and did not want to have visitors. The resident acorded call light in her bed.       On 4/3/19 at 5:05 pm an interview was conducted with NA #11 who stated that Resident #24 was conducted with NA #11 who stated that Resident #24 was conducted with NA #11 was not an have verbal and physical behaviors. The resident and physical behaviors. The resident sound and physical ideation or attempts. NA #11 was not aware that the resident #24 who stated that the resident #24 who stated that the corded call light according to her care plan.         On 4/3/19 at 5:15 pm an interview was conducted with Nurse #13 assigned to Resident #24 who stated that the resident #24 who stated that was observed for suicidal ideation or attempts. Nurse #13 was not aware that the resident #24 who stated that was observed for suicidal ideation or attempts. Nurse #13 was not aware that the resident #24 who stated that the resident #24 who stated that was observed for suicidal ideation or attempts. Nurse #13 was not aware that the resident #24 who stated that was who was the room was not phate physic. A ding bell wan	F 656	behavior. Intervention a corded call bell to p attempt usage. A review of Resident last recertification to 4 has regular behaviors for suicidal risk and ic periodically had 1:1 s contracted for safety. On 4/3/19 at 5:00 pm Resident #24 who wa want to have visitors. call light in her bed. On 4/3/19 at 5:05 pm with NA #11 who state calm today but can ha behaviors. The reside had precautions for si NA #11 was not awar not have access to a to her care plan. On 4/3/19 at 5:15 pm with Nurse #13 assign stated that the resident ideation or attempts. that the resident ' s ca for a "dig bell" and no On 4/4/19 at 9:00 am Resident #24 in her b breakfast tray was in ware. The resident h ding bell was not obse	n was for a "dig bell" and not revent inappropriate suicide #24's nurses' notes from 4/4/19 revealed the resident and the staff had assessed beation. Resident has upervision. The resident an observation was done of as resting in bed and did not The resident had a corded an interview was conducted ed that Resident #24 was ave verbal and physical ent was observed for and uicidal ideation or attempts. e that the resident should corded call light according an interview was conducted ned to Resident #24 who nt was observed for suicidal Nurse #13 was not aware are plan had an intervention at a corded call light. an observation was done of bed. The resident's the room and had plastic ad a corded call light. A erved. an interview was conducted	F	556				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345293	B. WING			C 04/04/2019		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		н	IGHWAY 177 S BOX 1489			
				Н	IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	prior history of suicida supervised for suicida resident had no sharp plastic ware for her m observed that the res NA #11 was not awar have a ding bell in lie her care plan. NA #1 to the resident's care On 4/4/19 at 9:30 am with the MDS Coordir responsible for Resid Coordinator stated the plan had the intervent corded call bell for su The Coordinator was changes to this care p An interview was con with the DON who stat to implement the resid 4. Resident #28 was 12/21/17 with diagnos s, schizophrenia, uns repeated falls. The q (MDS) assessment da Resident #28's care p of the risk for falls cha falls and injury. This 12/22/17. The interve anti-rollbacks to Resid (initiated on 4/30/18 a An incident report dat Nurse #7 indicated Ru unwitnessed fall on 1	al attempt and was al ideation and attempt. The o objects in her room and ideals. NA #11 stated and ident had a corded call light. e that the resident was to u of the corded call light for 1 stated that she had access plan. an interview was conducted nator who stated she was ent #24's care plan. The e resident's current care tion of a ding bell and not a icidal prevention/safety. not informed of any olan intervention. ducted on 4/4/19 at 4:00 pm ated that she expected staff dent 's care plan. admitted to the facility on ses that included Alzheimer' teadiness on feet, and uarterly Minimum Data Set ated 12/26/18 indicated tion was severely impaired. olan included the focus area aracterized by a history of area was initiated on entions included dent #28's wheelchair and last revised 7/27/18). ted 10/20/18 completed by	F	656				

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED
						С
		345293	B. WING		0	4/04/2019
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP COD	θE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	2 46	F 656			
	The fall investigation 10/20/18 completed k new intervention that prevent a repeat fall w Resident #28's whee signed as complete b The investigation follou unsigned, indicated F 10/20/18 at 10:50 AM going to be put into p wheelchair to stabilize Resident #28's care p updated on 10/23/18 of anti-rollbacks on w A work order dated 1 indicated anti-rollback Resident #28's whee indicated the anti-roll 10/25/18. A phone interview wa on 4/3/19 at 2:43 PM nurse assigned to the fall completed an inci fall investigation check that this form had a q interventions were go prevent repeated falls explained that someti think of an appropriat this question blank ar what new intervention	checklist form dated by Nurse #7 indicated the was put into place to was to add anti-rollbacks to lchair. This checklist was by Unit Manager (UM) #1. by up form, undated and Resident #28 had a fall on 1 and that anti-rollbacks were lace on Resident #28's e it for her. blan related to falls was with the repeat intervention theelchair. 0/24/18 completed by UM #1 ks were to be added to lchair. This work order backs were added on as conducted with Nurse #7 . Nurse #7 stated that the e resident at the time of the dent report and initiated the cklist form. She explained puestion on it about what new bing to be implemented to s. Nurse #7 further imes she was unable to te intervention, so she left and let one of UMs determine in was appropriate. The tigation checklist, and p form that indicated				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 656	believed one of the U intervention of anti-ro investigation checklis with certainty if Resid anti-rollbacks at the ti indicated that if it was that the anti-rollbacks on Resident #28's wh 10/20/18 fall. An interview was con at 2:40 PM. The incid checklist, and investig indicated anti-rollback for Resident #28 after reviewed with UM #1. indicated anti-rollback #28's wheelchair on 1 UM #1. The care pla intervention of anti-ro on Resident #28's car and last revised 7/27/ 10/20/18 fall was revi confirmed she had co 10/24/18 for anti-rollb wheelchair. She was Resident #28's anti-ro the time of her 10/20/ was on her care plan. An interview was con Nursing on 4/4/19 at 3 expected care plan in implemented.	<ul> <li>#7. Nurse #7 stated she Ms had wrote the Ilbacks on the fall</li> <li>t. She was unable to recall ent #28's wheelchair had me of the 10/20/18. She is noted as a new intervention were probably not in place eelchair at the time of</li> <li>ducted with UM #1 on 4/2/19 ent report, investigation gation follow up form that as were to be implemented r the 10/20/18 were</li> <li>The work order that as were added to Resident</li> <li>10/25/18 was reviewed with in that indicated the Ilbacks was already in place re plan (initiated on 4/30/18</li> <li>18) at the time of her ewed with UM #1. UM #1</li> <li>ompleted the work order on acks to Resident #28's unable to explain why ollbacks were not in place at 18 fall when this intervention</li> <li>ducted with the Director of 3:15 PM. She indicated she</li> </ul>	F 65	56	
	that included dementi	-			

		ID HUMAN SERVICES			FOR	D: 05/09/2019 M APPROVED
STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	<u>D. 0938-0391</u> E SURVEY PLETED
		345293	B. WING		04	C / <b>04/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL		
				HIGHWAY 177 S BOX 1489		
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 656	dining room to encou Resident #60 ' s care included the focus are related to cognitive du interventions, initiated 2/6/19, indicated Res meals in the dining ro The quarterly Minimu assessment dated 2/ #60 had short-term a problems and severe She required the exte eating. An observation was con 0 n 3/31/19 at 6:05 PM in her room with assist Assistant #10. An observation was con 0 n 4/3/19 at 6:10 PM her room with assist An interview was con 4/3/19 at 5:30 PM. S unaware that Resider order to eat all of her She stated that she w Resident #60 ' s unit shift and she had diffi residents out of bed a her own. She indicat	eat community style in the rage intake. plan, initiated on 7/2/18, ea of assistance for eating eficit and dysphagia. The d on 7/2/18 and revised ident #60 was to eat her oom to encourage intake. m Data Set (MDS) 14/19 indicated Resident nd long-term memory ly impaired decision making. ensive assistance of 1 for conducted of the dinner meal <i>A</i> . Resident #60 was eating stance provided by Nursing conducted of the dinner meal . Resident #60 was eating in nce provided by NA #11. ducted with NA #10 on	F 65	6		
	4/4/19 at 2:55 PM. S that Resident #60 wa in the dining room. S there were 2 NAs and one of the NAs had c	ducted with NA #11 on he stated she was aware s supposed to eat all meals he revealed that normally d the nurse on the unit, but alled off on 4/3/19 for the r revealed that because she				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/09/2019 FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C	
		345293				04/04/2019	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		HIGI	EET ADDRESS, CITY, STATE, ZIP CODE HWAY 177 S BOX 1489 MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656 F 657 SS=D	<ul> <li>was the only NA on F</li> <li>was unable to get her</li> <li>time limitations.</li> <li>An interview was con</li> <li>Nursing on 4/4/19 at</li> <li>expected care plan in</li> <li>implemented.</li> <li>Care Plan Timing and</li> <li>CFR(s): 483.21(b)(2)</li> <li>§483.21(b) Comprehe</li> <li>§483.21(b)(2) A comp</li> <li>be- <ul> <li>(i) Developed within 7</li> <li>the comprehensive at</li> <li>(ii) Prepared by an infinctudes but is not lim</li> <li>(A) The attending phy</li> <li>(B) A registered nurse</li> <li>resident.</li> <li>(C) A nurse aide with</li> <li>resident.</li> <li>(D) A member of food</li> <li>(E) To the extent pract</li> <li>the resident and their</li> <li>An explanation must</li> <li>medical record if the</li> <li>and their resident rep</li> <li>not practicable for the</li> <li>resident's care plan.</li> <li>(F) Other appropriate</li> <li>disciplines as determ</li> <li>or as requested by th</li> <li>(iii)Reviewed and rev</li> <li>team after each asse</li> <li>comprehensive and cases</li> </ul> </li> </ul>	Resident #60 ' s unit that she r out of bed for dinner due to ducted with the Director of 3:15 PM. She indicated she iterventions to be d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that hited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the	F6				5/1/19

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	-	ID HUMAN SERVICES			PRINTED: 05/09/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	345293		B. WING		04/04/2019
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP C HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BECOMPLETIONTHE APPROPRIATEDATE
F 657	interviews, the facility resident's care plan fa (Resident #51) for 1 of Findings included: Resident #51 was ad 1/20/11 with the diage dementia, restlessnes A review of Resident Data Set dated 2/1/19 severely impaired cog was rarely understoo resident required tota activities of daily livin diagnoses were histo movement. A review of Resident 2/6/19 revealed a foc actual fall and an inter rails. On 4/2/19 at 8:30 am the resident in her be mattress with a low b The resident did not f On 4/3/19 at 8:30 am	iew, observation, and staff of failed to revise the or padded side rails of 22 residents reviewed. mitted to the facility on noses of dysphagia, ss, and agitation. #51's quarterly Minimum 9 revealed the resident had gnition with no speech and d or understands. The 11 dependence for all g (ADLs). The active ry of falls and involuntary #51's care plan updated on us falls prevention and ervention for padded side an observation was done of d. The resident had a scoop ed and fall mat in place. nave side rails and/or pads.	F 65	F657 The plan of correcting the s deficiency On 4/24/19 the facility cons resident #51's care plan to inaccurate intervention of p rails. The procedure for impleme acceptable plan of correction specific deficiency cited Audit completed of all resid intervention of padded side consultant on 4/25/19. No findings noted. Systemic change On 4/18/19 the director of r staff facilitator in-serviced r certified nursing assistants nurses, on ensuring interve care plan and/or care guide and if the intervention is no accurate the licensed nurse the care plan. This in-servic completed on 4/29/18. This added to the orientation for nursing staff. The monitoring procedure for the plan of correction is effect specific deficiency cited rer and/or in compliance with t requirements The director of nursing, assist of nursing, unit manager, a facilitator will audit 5 reside	sultant updated remove badded side enting the on for the lents with e rails by facility negative hursing and hursing staff, and licensed entions on the e are in place o longer e will update ce was s in-service was r newly hired to ensure that ective and that mains corrected he regulatory sistant director nd/or staff
	with the Director of N	ducted on 4/4/19 at 4:00 pm ursing who stated that she ew and update the resident's 7.		halls, on random shifts to ir shifts, and on random days weekends) weekly x 12 we and revise care plan interve	nclude all 3 to include eks, to review

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293		B. WING _		C 04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 657	CFR(s): 483.21(b)(3)( §483.21(b)(3) Compre- The services provided as outlined by the cor must- (i) Meet professional s This REQUIREMENT by: Based on record revi interviews, the facility transcribe physician c medication ordered by	eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, nprehensive care plan, standards of quality. i is not met as evidenced ews, observations and staff	F 6	needed. This audit will be the care plan audit tool. The monthly Quality Assurance/Performance In committee will review the care plan audit tool month for identification of trends, and to determine the need frequency of continued monther make recommendations for continued compliance. The and/or director of nursing findings and recommendat monthly Quality Assurance Improvement committee to executive Quality Assurance Improvement committee for recommendations and over Date of compliance May 1	mprovement results of the aly for 3 months actions taken, d for and/or onitoring, and or monitoring for le administrator will present the ations of the e/Performance or the quarterly nce/Performance or further ersight 1, 2019. 5/1/19
	The findings included	:		at the twice daily dose. The procedure for implem acceptable plan of correct	enting the

Event ID: CYLY11

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2 FORM APPRO' OMB NO. 0938-0
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 658	Continued From page	e 52	F 65	58	
	Resident #53 was ad 10/8/18. Her diagnos anxiety. A review of the medic dated 12/19/18 for Bu three times a day for A review of the reside Orders for January 20 by mouth three times initiated on 12/19/18) The January 2019 Ma Record (MAR) reveal Buspar three times a 1/1/19 to 1/31/19. Th be given at 8:30am, 20 A review of the most (MDS) coded as a qu dated 2/5/19 revealed cognitive deficits. She with meals and exten staff members for all Living (ADL's). A review of the month February 2019 includ twice daily (not as init The February 2019 M	mitted to the facility on ses included depression and cal record revealed an order uspar 10 milligrams (mg) anxiety. ent's monthly Physician 019 included Buspar 10mg a day for anxiety (as edication Administration led she received 10mg of day as prescribed from he Buspar was scheduled to 12:00pm and 8:30pm. recent Minimum Data Set earterly assessment and d the resident had moderate e required setup assistance sive to total assistance from other Activities of Daily hly Physician Orders for led Buspar 10mg by mouth tiated on 12/19/18). MAR revealed she received ice daily at 8:30am and		<ul> <li>specific deficiency cited</li> <li>On 4/24/19 the unit mana new orders for the past 7 transcription to the medica administration record was additional negative finding Systemic change</li> <li>On 4/18/19 the director of and the staff facilitator (SF in-service with licensed net transcription of orders. Th completed on 4/29/19. Th added to the orientation for licensed nurses.</li> <li>When a new order is rece will transcribe the order to administration record accor manager, DON, or SF will order to ensure transcriptic completed accurately with the order being obtained. The monitoring procedures the plan of correction is ef specific deficiency cited re and/or in compliance with requirements The DON, SF, and/or unit audit 5 residents (on rand include all residents) daily (on random days to includo week) x 12 weeks, to ensi- orders were transcribed to administration record accor</li> </ul>	days to ensure ation a accurate. No gs noted. inursing (DON) F) began an urses on correct is in-service was is in-service was or newly hired wide the nurse of the medication urately. The unit review the new ion was nin 72 hours or to ensure that ffective and that emains corrected the regulatory manager will om halls to '3x per week de all 7 days per ure any new o the medication urately. This
		nly Physician Orders for Buspar 10mg by mouth / (not as initiated on		audit will be documented of daily living audit tool. The monthly quality improvement/performance (QAPI) committee will rev of the activities of daily liv	e improvement iew the results

Facility ID: 923021

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			MPLETED
			5.14/11/0			С
		345293	B. WING			4/04/2019
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( HIGHWAY 177 S BOX 1489	JODE	
	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 658	Continued From page	- 53	F 658	3		
	1.0	R revealed she received	1 000	for 3 months for identificati	on of trends	
		aily at 8:30am and 8:30pm		actions taken, and to deter	•	
	from 3/1/19 to 3/31/1			for and/or frequency of cor		
	On 4/1/10 at 2:54 and			monitoring, and make reco		
	-	an interview occurred with She identified her signature		for monitoring for continue The administrator and/or D		
	•	check on Resident #53's		the findings and recommen		
	February physician o	rders. She reviewed the		monthly QAPI committee to		
		MAR stating that it was an		executive QAPI committee		
	-	ly such an error should have rected. The Unit Manager #1		recommendations and ove Date of compliance	ersight	
		uld complete a medication		May 1, 2019.		
		the situation and obtain a				
	clarification order from	n the physician.				
	On 4/1/19 at 430pm a	an interview was conducted				
		ursing (DON). She stated it				
		an error during the February				
		ngeover resulting in Resident iven twice daily instead of				
	three times a day as					
	During a phone interv	view with Nurse #5 on 4/3/19				
	at 11:30am she expla	ained when she completed				
	MAR checks for the					
	<b>.</b> .	ked at the current MAR and onth. She added that she				
		d back to the January MAR				
		when she completed change				
	over from Feb to Mar	ch2019.				
	During an interview w	vith the DON on 4/4/19 at				
	3:20 she stated it was	s her expectation for orders				
	to be transcribed corr	-		_		= 10 11 0
F 677 SS=E		or Dependent Residents	F 677			5/9/19
	§483.24(a)(2) A resid					

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	IO. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	<b>IPLETED</b>
		345293	B. WING			С
	ROVIDER OR SUPPLIER	545295		STREET ADDRESS, CITY, STATE, ZIP CODE	0	4/04/2019
	NOVIDER OR OUT LIER			HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 677	Continued From pag		F 67	7		
		living receives the necessary				
		good nutrition, grooming, and				
	personal and oral hy					
		T is not met as evidenced				
	by:					
		view, observation, resident		F677	-	
		terview, the facility failed to		The plan of correcting the specif	IC	
		o residents who required		deficiency		
		e with eating, bathing,		On 4/23/19 resident #9 was obs		
		ygiene, and/or nail care for 4		facility consultant being provided		
		ed for the provision of activity		meal assistance by facility certif		
	of daily living (ADL) care (Residents #9, #51,	care (Residents #9, #51, #74,		nursing assistant (CNA) at the s	ame time	
	and #80).			as resident #9's table mates.		
	The findings include:	4.		On 4/23/19 resident #51 was ob	•	
	The findings included	J.		facility consultant with all nails tr		
	1 Regident #0 was a	admitted to the facility on		and without sharp edges. Nail ca provided by facility CNA and/or		
		5				
	0/12/09 with diagnos	es that included dementia.		nurse by observation on 4/23/19 Resident #74 was discharged fr		
	The quarterly Minimu	um Data Set (MDS)		on $4/23/19$ .		
		2/19 indicated Resident #9's		Resident # 80 refused shower o	n 1/22/10	
		ely impaired. Resident #9		Resident observed without facia		
	was dependent on 1			4/24/19 by facility consultant. Re		
		ior eating.		8- was shaved by facility CNA o		
	Resident #9 's active	e care plan included the		prior to observation.	11 4/24/13	
		nce with eating. The				
		d total assist with eating.		The procedure for implementing	the	
		out out out ig.		acceptable plan of correction for		
	An observation was	conducted of the dinner meal		specific deficiency cited		
		unit where Resident #9		On 4/24/219 the unit manager o	bserved	
		The meal trays arrived on		all residents for nail care. Any no		
		There was one Nursing		findings were addressed by unit	-	
		10, assigned to the memory		during audit.	5	
		#9 was observed to be laying		On 4/24/2019 the unit manager	observed	
		eyes closed on 3/31/19 at		the meal for all residents in the		
		eal tray was placed on her		care unit to ensure residents we	-	
		table by NA #10. This table		provided with assistance needed	d. No	
		to the bed, outside of the		negative findings noted.		
		d the cover remained on the		On 4/22/2019 the unit manager		1

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	•
RICHMON	RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 677	Resident #9 was not 6:45 PM when NA #1 began to provide tota resident. An interview was con 4/3/19 at 5:30 PM. So only NA working on F 3/31/19 during the 2m there were 5 resident eating assistance and rooms for dinner on 3 Medication Aide #2 w the dinner meal on 3/ stay in the memory co provide supervision to there. NA #10 reveal of the residents who eating when she was revealed that it took 4 Resident #9 with eating because she was the unit. An interview was con Nursing (DON) on 4/4 indicated that she exp to be assisted with Ad	bbservation revealed that assisted with eating until 0 entered the room and I eating assistance for the ducted with NA #10 on She stated that she was the Resident #9 's unit on of shift. She indicated that is on that unit who required d they were all eating in their 3/31/19. She stated that vas also on this unit during (31/19, but that she had to are unit 's dining room to the residents who ate in led it was difficult to feed all needed assistance with the only NA. She further	F 67	7 resident showers to ensure provided per schedule. An findings were addressed b resident being showered or documented. On 4/24/2019 the unit mar facial hair with no negative On 4/18/19 the director of an in-service with nursing a providing assistance with a living including nail care, s showers. This in-service we on date. This in-service was orientation for new nursing 4/18/19 by the staff facilita The monitoring procedure the plan of correction is eff specific deficiency cited re and/or in compliance with a requirements The unit manager will mon 5 random days per week, the weekend days and all mea weeks using the activities a audit tool. Monitoring on the include the shower schedu care, a meal tray pass to e assistance is provided for Managers will report contir concerns to the Director of an include the Director of a manager will report contir concerns to the Director of a none statement and the provide the provide of the provide	y negative y date by the or refusal hager audited all e findings. nursing began staff on activities of daily having, and vas completed as added to the g staff on tor. to ensure that fective and that mains corrected the regulatory hitor 5 residents, to include al times, for 12 of daily living he floors will ule, shaving, nail ensure eating. The Unit huing issues or
	resident was assisted it allowed opportunity which could be unapp causing them to eat li- there were a few staf 3/31/19 due to illness	was served to the time the d with eating was too long as for the meal to get cold betizing to the resident ess. The DON revealed that f who had called off on and/or other emergencies with less staff than originally		residents of not received th Unit Managers and/or Dire will report to the Quality Assurance/Performance In committee the effectivenes monitoring and identify any issues.	ector of Nursing nprovement ss of the y continuing

Facility ID: 923021

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
			A. BUILDING	G			C
		345293	B. WING			04/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 677	Continued From page	F 67	77	committee will review the results of th activities of daily living audit tool for 3	-		
	2. Resident #74 was 10/3/18 with diagnose obstructive pulmonar muscle weakness, ar			activities of daily living audit tool for 3 months for identification of trends, act taken, and to determine the need for and/or frequency of continued monito and make recommendations for monitoring for continued compliance.	tions		
	The quarterly Minimu assessment dated 1/ #74 's cognition was behaviors and no reje was assessed as ext more for transfers, ex personal hygiene and on 1 for bathing.			The administrator and/or DON will pre- the findings and recommendations of monthly QI committee to the quarterly executive quality assurance performa improvement (QAPI) committee for fu- recommendations and oversight.	the nce rther		
	Resident #74 ' s activ focus areas of bathin hygiene. The interve #74 was dependent of	ve care plan included the g, dressing, and personal ntions indicated Resident on 1 for assistance with ired physical assistance with oming and dressing.			2019	ay 0,	
	3/31/19 at 4:35 PM. in a hospital gown. So normally was provide care which included a clothing once per day stated that she had n today (3/31/19) and so because the facility d Resident #74 indicate remain in the hospita	d with her morning personal a bed bath and changing her v during the first shift. She ot received her morning care she believed this was idn ' t have enough staff. ed that she preferred to I gown, but she wanted to gown as she had slept in the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345293	B. WING				C 104/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	·	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Assistant (NA) bathin Resident #74 for 3/31 confirmed Resident # type of bathing (partia shower) on 3/31/19. An interview was con at 12:10 PM. She sta shift on 3/31/19 and v #74. NA #2 indicated all of her residents wi provided morning per worked the 1st shift. 22 assigned residents calling off. She stated provide Resident #74 she had not changed 3/31/19 because of tii that NA #5 worked the that she informed her to bath Resident #74. An interview was con at 2:50 PM. NA #5 st provided her resident their morning persona 1st shift. She stated that s #74 was not provided 3/31/19 during the 1s reported this informat she had changed Res the 2nd shift on 3/31/ An interview was con Nursing (DON) on 4/4 indicated she expected	g documentation for /19. The documentation 74 had not received any al bed bath, full bed bath, ducted with NA #2 on 4/4/19 ated that she worked the 1st vas assigned to Resident t that she normally provided th a full bed bath when she sonal care when she She reported that she had s on 3/31/19 due to an NA d that she was not able to with any type of bathing and Resident #74 ' s gown on me limitations. NA #2 stated e 2nd shift on 3/31/19 and t that she had been unable ducted with NA #5 on 4/4/19 tated that she always s with a full bed bath during al care when she worked the that she worked the 2nd vas assigned to Resident she had not known Resident with any type of bathing on t. She denied that NA #2 ion to her. She stated that sident #74 ' s gown during 19.	F	677			

Facility ID: 923021

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	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MU		CONSTRUCTION	(X3) DATE	0. 0938-0391
-	CORRECTION	IDENTIFICATION NUMBER:	` ´				PLETED
							с
		345293	B. WING				04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				н	IIGHWAY 177 S BOX 1489		
	D PINES REALINCARE	AND REHABILITATION CENTE		F	IAMLET, NC 28345		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
			1				
F 677	Continued From page	e 58	F	677			
		N revealed that there were a					
		led off on 3/31/19 due to					
		mergencies which left the					
	Tacility with less start	than originally scheduled.					
	12/7/17 with multiple	s admitted to the facility on					
	-	sion Minimum Data Set					
		ated 2/28/19 indicated that					
		paired cognition and needed					
	extensive assistance	with personal hygiene.					
	-	blan dated 3/5/19 revealed stance with personal hygiene					
		I was for him to be neat,					
		The approaches included to					
		rsonal hygiene. The resident					
	required 2 person as						
	refused to offer bed b	bath.					
	On 3/31/19 at 3:59 Pl	M. Resident #80 was					
		he was unshaven. Another					
	observation was cond	ducted on 4/1/19 at 9:33 AM					
	and at 1:50 PM and h	ne was still unshaven.					
	On 4/1/10 -+ 4-55 DM	NA (Nurging Aide) $#7$					
		l, NA (Nursing Aide) #7, #80, was interviewed. She					
		try to shave him because he					
		shaved and he only allowed					
		) to shave him during his					
		uesday and Friday. NA #7					
	•	dent #80 needed to be					
	shaved.						
	On 4/1/19 at 1:56 PM	l, NA #12 was interviewed.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 05/09/2019 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		_		04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489			
(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 CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	She stated that the fa consisting of 2 NAs a She stated that Resid fast and he needed to shower days at least that Resident #80 wa shower every Tuesda was not provided a sh she was pulled to wor the resident was not a also stated that Resid shower or personal h cussing during the ca had seen Resident #8 stated "he really need PM, NA #12 reported already been shaved was cussing. On 4/1/19 at 2:01 PM interviewed. The UM Resident #80 the mon that the resident need stated that she expect shave the resident in and if he refused to g Interview with the Dir conducted on 4/4/19 stated that she expect showers as schedule hygiene as needed. T shower team was ass lately but she expected	e 59 icility had a shower team ind she was one of them. Ient #80's beard had grown o be shaved in between his every 2 days. She reported is scheduled to have a by and Friday, however he nower last Friday because rk on the floor as NA and so shaved that day. NA #12 Ient #80 did not refuse ygiene but he would be re. She reported that she 80 the morning of 4/1/19 and Ied to be shaved". At 3:05 that Resident #80 was and he did not refuse but 1, Unit Manager (UM) #1 was reported that she had seen rning of 4/1/19 and agreed ded to be shaved. She sted the NA assigned to between his shower days et another NA to shave him. ector of Nursing (DON) was at 11:00 AM. The DON sted the staff to provide d and to provide personal The DON verified that the signed to work on the floor ed the NA assigned to the iowers and personal hygiene	F 677				

Facility ID: 923021

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	-	ID HUMAN SERVICES				FORM	/ APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,				LETED
		345293	B. WING				C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	04/2015
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		ŀ	HIGHWAY 177 S BOX 1489		
				ŀ	HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 677	12/7/17 with multiple dementia. The admiss (MDS) assessment da Resident #80 had imp totally dependent with Resident #80's care p that he required assis and bathing and the g clean and odor free. To offer showers and per resident required 2 per he refused to offer be scheduled to receive Friday. Review of the shower that Resident #80 did 3/29/19 (Friday) and 4 On 4/1/19 at 1:56 PM She stated that the fa consisting of 2 NAs at She reported that Res have a shower every however he was not p Friday because she w floor as NA. NA #12 a #80 did not refuse sho but he would be cuss? On 4/4/19 at 11:00 AN of Nursing (DON) was stated that she expect shower sas scheduler shower team was ass lately but she expected	a admitted to the facility on diagnoses including sion Minimum Data Set ated 2/28/19 indicated that paired cognition and was in bathing. Dan dated 3/5/19 revealed stance with personal hygiene goal was for him to be neat, The approaches included to rsonal hygiene. The erson assist at times and if ad bath. The resident was shower every Tuesday and r documentation revealed not receive a shower on 4/2/19 (Tuesday). N NA #12 was interviewed. cility had a shower team nd she was one of them. sident #80 was scheduled to Tuesday and Friday, provided a shower last vas pulled to work on the also stated that Resident ower or personal hygiene ing during the care. M, interview with the Director is conducted. The DON sted the staff to provide d. The DON verified that the signed to work on the floor ed the NA assigned to the	F	677			
	shower team was ass lately but she expecte	signed to work on the floor					

Facility ID: 923021

If continuation sheet Page 61 of 126

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/09/2019 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345293	B. WING		_		C 04/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 677	Continued From page to the resident.	61	RVICES				
	interviewed. The UM shower team was ass due to high staff turno	, Unit Manager (UM) #2 was reported that last week, the igned to work on the floor ver. He expected the NA ent to provide shower as					
	She stated that she w team. The shower tea Friday except Wednes 3 PM to provide showe Thursday and B beds every Tuesday and Fr shower was not provid Saturday or Sunday a revealed that starting was pulled to work on assigned to Resident and she provided him shower. She indicate refuse shower that da shower was provided	were provided showers riday. NA #13 reported that ded on Wednesday, and after 3 PM. She last week, the shower team the floor. She was #80 on Tuesday (4/2/19) a full bed bath and not a d that Resident #80 did not y. She further stated that when there was time.					
	Data Set (MDS) dated resident had severely speech and was rarel understands. The res	impaired cognition with no y understood or sident required total tivities of daily living (ADLs).					

Facility ID: 923021

If continuation sheet Page 62 of 126

		ID HUMAN SERVICES				FORM	): 05/09/2019 APPROVED
STATEMENT (	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345293	B. WING		_	( 04/0	C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	)		
			H	HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	∋ 62	F 677				
	2/6/19 revealed the re	#51's care plan updated esident was dependent and are which included cleaning r nails.					
	Resident #51 was in h the bedside visiting ar resident's finger nails	n an observation revealed her bed. Her family was at nd commented that the were long. The resident's					
	hands. A family memb aware that the resider hold the resident's ha	erved to be long on both ber commented that he was nt could resist and offered to nd (family member had not					
		The family member stated about the long finger nails.					
	with the Staff Develop	an interview was conducted oment Coordinator (SDC) aware and informed by the					
	and nail care. The fai	had refused her personal mily was made aware. The hat the family had offered to					
		resident could receive care. o other interventions for nail					
	On 4/4/19 at 8:30 am	an interview was conducted					
		d she was regularly Resident #51. NA #5 esident's nails were long					
	further commented th	staff to cut her nails. NA #5 hat the nails were not ent's palms when her hands					
	were closed. NA #5 s the resident had a car	stated she was not aware re plan intervention to cut ccidental scratching. NA #5					
	stated she would infor	-					

Facility ID: 923021

If continuation sheet Page 63 of 126

	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE		OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
			-		С
		345293	B. WING		04/04/2019
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	н	IIGHWAY 177 S BOX 1489	
			F	IAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 677	Continued From page	e 63	F 677		
	On 4/4/19 at 8:30 am	an observation was done of			
	-	nails on both hands which			
	remained long and w	ere now dirty.			
	An interview was con	ducted on 4/4/19 at 4:00 pm			
	with the Director of N				
		dent #51 could be resistive			
		the resident ' s right to			
		ovided nurses' notes dated			
	-	e resident declined nail ed that the resident needed			
		n to provide nail care and to			
		efusal without additional			
	intervention was not a	appropriate. The DON			
		ted staff to provide ADL			
<b>F</b> 00 (	care for dependent re	esidents.	<b>F</b> 00 (		= 4 4 6
F 684	Quality of Care CFR(s): 483.25		F 684		5/1/19
SS=D	CFR(5). 403.25				
	§ 483.25 Quality of ca	are			
		ndamental principle that			
		nt and care provided to			
	•	ed on the comprehensive dent, the facility must ensure			
		e treatment and care in			
	accordance with profe				
	-	nensive person-centered			
	care plan, and the res				
		is not met as evidenced			
	by: Based on record revi	iew, observation and staff,		F684	
		e Practitioner, and physician		For residents affected by the issue: On	
		failed to follow the physician		4/1/19 the facility Medical Director	
	order for orthopedic o			discontinued the sling order and ordered	d
		pedic consultation (Resident		an x-ray of the affected arm. Also, the	
	#22) for 1 of 1 resider	nt reviewed.		resident was scheduled for a routine orthopedic appointment. The resident has	

Event ID: CYLY11

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		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			1 Y /	OATE SURVEY
							С
		345293	B. WING				04/04/2019
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	(X5) COMPLETIC DATE
		,			DEFICIENCY)		
F 684	Continued From pag	e 64	F 68	84			
		Imitted to the facility on			orthopedic physician. The resident wa	ae a	
	5/15/18 with diagnos			given an injection for osteoarthritis on			
	abnormalities of gait	-			4/10/19.	I	
	osteoporosis.			Other potentially affected residents: :	The		
					unit managers, staff facilitator, and		
	A review of Resident	#22's annual Minimum Data			director of nursing audited orders for	the	
		/18 revealed the resident had			past 30 days to assure orders or refer		
		cognition. The resident			for resident care were implemented.		
		ssistance of 1 staff for			completed 4/29/19 with no negative	uuuu	
		and toileting. The active			findings.		
	-	ritis, osteoporosis, and			Measures implemented: Upon a resid	lent	
	difficulty walking.				returning to the facility from an outside		
	annoaity waiking.				appointment or emergency room visit		
	A review of Resident			paperwork for the visit and potential	, 110		
	12/24/18 revealed a			orders will be given to a nurse on-dut	v		
	potential for and histo			The receiving nurse will review the	y.		
				paperwork/orders for any new or char	naed		
	Resident #22's nurse	es note dated 12/18/2018 at			recommendations and contact the	igeu	
		that the resident was found			resident physician to obtain a telepho	ne	
		ng out for help. The resident			order. Once the order is obtained from		
		uries and none were noted.			resident's physician the nurse will		
	Pain medication was			transcribe the orders appropriately.			
	results.			Licensed nurses will in-serviced by A	oril		
					29, 2019 on the process by the direct		
	Resident #22 nurses	' note dated 12/21/2018 at			nursing and staff facilitator. This in-se		
		ed the resident was assessed			will be added to new employee orient		
		Ider to be asymmetrical with			for nurses.	ation	
	-	e resident could not lift her			Monitoring to maintain compliance: TI	he	
	right arm without pair				night shift nurses implemented a 24 h		
		sessed the resident and			chart audit to assure that new orders		
		Ild be seen in the Emergency			implemented and placed on appropria		
	Room (ER).				record such as the treatment record.		
					new nightly 24 hour chart check audit		
	The Family Nurse Pr	actitioner (FNP) progress			that was implemented will be reviewe		
	-	documented Resident #22			each morning by the Director of Nursi		
		nited range of motion (ROM)			The audit tool will be compared with t	-	
		oted, send to ER. The			previous day's resident's appointmen		
		t fall with significant injury.			the morning stand-up meeting to iden		
		than the organization injury.			residents that may have new orders.		

Facility ID: 923021

If continuation sheet Page 65 of 126

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		345293	B. WING		04	C I/ <b>04/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 684	A review of Resident 12/21/19 revealed sh facility transferring. T osteoporosis. The re her right arm today as revealed fracture of ri that was subacute an physician recommend Resident #22 had a p 12/21/18 for the resid for humerus fracture. was identified. The FNP follow up not the resident had a slin shoulder. The diagno of right humerus and with significant injury. A review of Resident 4/1/19 findings were a with soft tissue swelli angulation. No erosid Observation of Resid 4/1/19 revealed the re right arm sling. On 4/1/19 at 4:00 pm with Nurse #2 who wa history because "I ha and received no infor resident's right arm fr Nurse #2 observed th wearing the right arm	#22's ER note dated e fell three days ago at the There was a history of sident was noted not using s usual. X-ray report ight humerus with non-union ad chronic appearing. The ded orthopedic consultation. obysician order dated lent to wear a right arm sling No discontinuance of order oted dated 12/27/18 revealed ng and swathe to the right oses were displaced fracture shoulder pain caused by fall #22's X-ray report dated a proximal humerus fracture ng, displacement and ons were demonstrated. ent #22 on 3/31/19 and esident was not wearing the an interview was conducted as unaware of the resident's ve not had her for a while" mation regarding the facture or sling in report. he resident who was not	F 68-		eek) for 12 s will be g issues ed and he Director ality vement the the	
		physician who stated that the				

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(X3) DATE SURV	FY
C	
SHOULD BE CON	(X5) MPLETIO DATE
_	

Facility ID: 923021

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	PARTMENT OF HEALTH AND HUMAN SERVICES     FORM.       VTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO.       MENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION     (X3) DATE S COMPLICE       A. BUILDING	APPROVED						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /				(X3) DATE COMP	SURVEY LETED
		345293	B. WING					_ 04/2019
NAME OF P	ROVIDER OR SUPPLIER		- T	STREET ADD	RESS, CITY, STATE, ZIP CODE			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		EACH CORRECTIVE ACTION S	SHOULD BE		(X5) COMPLETION DATE
F 684	Continued From page	9 67	F 6	84	FORM OMB NC IRUCTION (X3) DATE COME COME (ADDRESS, CITY, STATE, ZIP CODE (ADDRESS, CITY, STATE, ZIP CODE (ADDRESS, CITY, STATE, ZIP CODE (ADDRESS, CITY, STATE, ZIP CODE (ADDRESS, CITY, STATE, ZIP CODE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	am with the Director of that there have been facility and an audit w #22's sling placement was not transcribed ff January 2019 and the sling placed. The res was not transcribed a An interview was con am with Resident #22 stated the resident has fractured the right arm admission to the facil use of the right arm b barely using the right commented that the r get up on her own aft asked her not to. On 4/2/19 at 1:00 pm with the FNP who sta progress note for Res orthopedic consultation 12/21/18 and the resi in her ER discharge s required orthopedic for the staff to obtain an her notes and the ER the resident returned On 4/2/19 at 12:36 pr attempted with the nu #22 fell on 12/18/18 ( facility) with no succe	of Nursing (DON) who stated transcription errors in the vas underway. Resident t/documentation on the MAR rom December 2018 to e resident did not have her ident's orthopedic consult and subsequently not done. ducted on 4/2/19 at 10:45 2's family member who ad fallen in the past and n about 2 years ago before ity. The resident had limited efore the fall and was now arm. The family member resident continued to try and er family and staff have an interview was conducted ted she wrote a plan in her sident #22 to have an on for the right arm on dent had a recommendation summary that the resident ollow up. The FNP expected orthopedic consultation from discharge summary when from the hospital.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/09/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		345293	B. WING		_	C 04/0	, )4/2019
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	pm with the Radiologi for Resident #22's rig fracture was chronic a from 12/21/18 that rea was defined as not a probably reinjured or fracture, had osteopo pathological fractures On 4/2/19 at 12:45 pr conducted with Nurse assessed Resident #2 her fall and the reside no bruising was found complained of pain. If range of motion (ROM resident was not guar had a history of right appear to be using th Nurse #3 stated that of right arm was noted b to have a deformity al The resident was sen chronic fracture of the reported. The residen not have the sling ord was not placed. Nurse physician order for the arm sling after her fall An interview was con am with the DON who multiple transcription omissions of the physic was in place. The DO	ist who read the 4/1/19 x-ray ht arm. The right arm and old. The radiograph ad subacute and chronic new fracture. The resident aggravated an existing rosis and had history of 5. m an interview was e #3 who stated she had 22 on 12/19/18 the day after ent's body was assessed and d, and the resident had not Nurse #3 did not document if <i>A</i> ) was assessed. The rding her arm. The resident shoulder surgery and did not e right arm any different. on 12/21/18 the resident's by a Nursing Assistant (NA) nd the FNP was notified. t to the ER and a subacute, e right humerus was nt's January 2019 MAR did ler transcribed and there n that the staff placed the documentation, the sling se #3 was aware there was a e resident to wear a right I due to fracture/pain.	F 684				

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/09/2019 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	COM	E SURVEY PLETED
		345293	B. WING				C / <b>04/2019</b>
NAME OF PF	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		ŀ	IIGHWAY 177 S BOX 1489		
				ŀ	HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	e 69	F	688			
F 688		crease in ROM/Mobility		688			5/9/19
SS=D	CFR(s): 483.25(c)(1)-	5		000			
	§483.25(c) Mobility.						
		cility must ensure that a					
		he facility without limited					
	-	not experience reduction in					
		ss the resident's clinical es that a reduction in range					
	of motion is unavoida	<b>C</b>					
	\$483.25(c)(2) A resid	ent with limited range of					
	motion receives appre	-					
	services to increase r	ange of motion and/or to					
	prevent further decrea	ase in range of motion.					
	§483.25(c)(3) A resid	ent with limited mobility					
		services, equipment, and					
		n or improve mobility with					
	-	able independence unless a s demonstrably unavoidable.					
		is not met as evidenced					
	by:						
	Based on record revi	iew, observation and staff			F688		
		the facility failed to provide			For residents affected by the issue: A		
		prevent further contracture			therapy referral was placed and on 4/7		
	(Resident #51) for 1 c position and mobility.	of 5 residents reviewed for			an occupational therapy assessment w completed on the resident. The	vas	
	position and mobility.				occupational therapist and created a p	lan	
	Findings included:				of care to develop a restorative progra		
	-	mitted to the facility on			specific for the resident for upper		
	1/20/11 with the diagr				extremities. On 4/22/19 the physical		
	contractures of both h	•			therapist completed an evaluation and		
	involuntary movemen	it of the extremities.			found no contractures were present in hips and lower extremities. The reside		
	A review of Resident	#51's therapy notes			was freely moving the lower extremitie		
		tment was 10/31/18 for			Other potentially affected residents: Th		
	wheel chair evaluatio	n and post fall.			licensed nurses are auditing the other		
					residents for contractures or risk of a		

Event ID: CYLY11

Facility ID: 923021

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		MEDICAID SERVICES					
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			(X3) DATE COMP	SURVEY LETED
			D. MINO				
		345293	B. WING			04/	04/2019
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 688	Continued From page	e 70	F 68	0			
1 000	10	#51's quarterly Minimum	FUC	-	racture. Audit revealed one other		
	Data Set (MDS) date			dent with potential risk. Referral to			
	resident had severely			apy of at risk resident was be			
	speech and was rare				pleted on 4/29/19.		
	understands. The re			Mea	sures implemented: The Director	of	
		ctivities of daily living (ADLs).			sing on 4/18/19 in-serviced the		
	-	s were contractures of hips			sing staff that changes in resident		
	and knees, restless le			-	ge of motion is communicated to the		
	extrapyramidal and n				se on their floor and a therapy refe		
		ent of the extremities).			le. Additionally, residents currently storative program must be	/ 011	
	A review of Resident	#51's care plan updated			umented following resident care.		
		documentation which			nitoring to maintain compliance:		
	addressed a focus, g			itoring to maintain compliance: Th	ne		
	of motion and preven		Mini	mum Data Set (MDS) nurse, unit			
	There was a focus fo			ager, staff facilitator, and/or direc	tor		
	for ADLs.				ursing will review and observe 5		
	On 2/21/10 at 1:20 m	m Decident #51 was			dents 5 times per week on randon		
	On 3/31/19 at 4:30 p	in Resident #51 was			s (to include weekends) and rando s (to include all shifts) to monitor	om	
		The resident was also			umentation by nursing staff for		
	noted to have involur				orative care, including splints/brac	es	
	movement of all her				lied as ordered. Residents on a		
					orative program that are not being		
	On 3/31/19 at 4:30 pi	m an interview was		doci	umented on will be identified and		
		amily who stated the resident			sing staff follow up to assure care		
	-	he was frequently in the bed			pleted and documented. This aud		
	and getting stiffer.				be documented on the activities of		
	On 3/31/19 at 4:35 pi	m an interview was		-	y living audit tool. Weekly audit of dents by the unit manager will be	۷	
		ing Assistant (NA) #5 who			pleted for 12 weeks to identify oth	her	
	stated that Resident	•			dents at risk for contractures. Pote		
		tremities and was not			sk residents will be identified by th		
		estorative nursing for passive			manger audit and discussed in		
	range of motion (PRO	OM) and had been a long			ning meeting and referral given to	the	
		nt had physical therapy			apy department during the mornin		
		nths). NA #5 thought the			ting. The audit tool used will be th	ne	
	resident 's contractu	res were "about the same."			vities of daily living audit tool. The		
				∣ Dire	ctor of Nursing will report to the		

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		E SURVEY PLETED
		345293	B. WING		04	C / <b>04/2019</b>
AME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(YA) ID	STIWWADA S.	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	COMPLETIO DATE
F 688	Continued From page 71		F 68	3		
	On 4/3/19 at 12:30 p			Quality Assurance/Perfor	mance	
	conducted with NA #1 who stated that Resident			Improvement committee		
	#51 was not currently receiving PROM or			of the monitoring and ide	ntify any	
	•	ervices by the NAs. The		continuing issues.		
	•	nt to receive restorative re now responsible for		Corrective action complia	ince date: May 9,	
	0	services were completed.		2019		
		ed education and two NAs				
	-	the service. A Physical				
	Therapist would mak	te the recommendation.				
	On 4/3/19 at 2:40 pn	n an interview was conducted				
		nager who stated that				
		t had therapy services for a				
		onths) and was not currently e contracture prevention by				
	• •	ne Therapy Manager agreed				
		tractures could worsening				
		resident had a new wheel				
		ed to accommodate the				
	•	and jerking and to prevent was currently not receiving				
		ROM contracture care. The				
		d not know if there was a				
	plan in place by nurs	ing for restorative nursing.				
	•	restorative nursing services				
		e NA staff after physical or services were completed.				
		er suggested checking with				
	the NAs.					
		nducted on 4/4/19 at 4:00 pm				
		lursing (DON) who stated				
	services to prevent t	aff to provide care and he start of or worsening				
	contractures.					
F 689		zards/Supervision/Devices	F 68			5/9/19

	-	ID HUMAN SERVICES				FO	ED: 05/09/2019 RM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN			TE SURVEY MPLETED C	
		345293	B. WING			0	4/04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTE		HIGI	HWAY 177 S BOX 1489		
	D FINES HEALTHCARE			HAN	MLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	Continued From page	e 72	F 6	89			
	§483.25(d) Accidents						
	The facility must ensu						
		sident environment remains					
		azards as is possible; and					
	\$483.25(d)(2)Each ro	sident receives adequate					
		stance devices to prevent					
	accidents.						
	This REQUIREMENT	is not met as evidenced					
	by:						
		iew, observation, and staff			F689		
		failed to implement fall			The plan of correcting the specific		
	thoroughly investigate	ons, and also failed to			deficiency Resident # 28 was reviewed by the	falle	
		factors and implement			committee which included nursing,	10115	
		ons to reduce the risk of			administrator, and therapy on 4/29/	2019.	
		residents reviewed for falls.			The review included root cause and		
	Resident #28 sustain	ed 10 falls in 5 months with			of falls, and care plan implementation		
	2 of these falls result	ng in multiple staples to her			(interventions in place and accurate		
	head.				resident status). Plan of care was n	ot	
	The findings included				changed at that time. The procedure for implementing the		
					acceptable plan of correction for the		
	Resident #28 was ad	mitted to the facility on			specific deficiency cited	-	
	12/21/17 with diagnos	-			Residents with falls in the past 7 da	ys	
		nrenia, unsteadiness on feet,			were reviewed by the facility consul		
	· ·	ne quarterly Minimum Data			trends, causative factors, intervention		
		ent dated 12/26/18 indicated			and care plan updates or reviews o		
	-	tion was severely impaired. d the extensive assistance			4/24/19 with no negative trends not Systemic change	ea.	
		nobility, dressing, toileting,			The facility will begin a weekly falls		
		e and the extensive assist of			committee meeting 4/29/19 to ident	ify the	
		vas assessed as requiring			root cause and complete an analys		
	supervision of 1 for w				resident patterns of falls, intervention		
		it and supervision with set			injuries and needs. Residents that p		
		ng in corridor. Resident #28			with multiple falls will be added to the	ne fall	
	-	er feet, but she was able to			committee weekly review.		
	stabilize without staff	assistance.			On 4/18/19 the director of nursing		

Facility ID: 923021

				ECONSTRUCTION		MB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
			A. BOILDING			С
		345293	B. WING			04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	TY, STATE, ZIP CODE	04/04/2013
				HIGHWAY 177 S BOX	( 1489	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 2834	15	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROV	IDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	```	ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC DATE
F 689	Continued From page 73		F 68	9		
				in-serviced the	e nursing staff on fall	
					ncluding scene evaluation,	
		plan included the focus		-	ctors, and root cause. This	
		Ils characterized by a history			added to the orientation of	t
	12/22/17 and the inte	his area was initiated on		-	taff on 4/18/19 by the staff	
		on (initiated 12/22/17)		facilitator.	Leadership staff and	
	· ·	to take rest periods as			rship were in-serviced on	
	needed when ambula	•			alysis by the administrator.	
	- Rehabilitation thera	•			en the root cause analysis	
	(initiated 6/5/18)			-	in identifying resident	
	- Evaluate effectivene	ess and side effects of		patterns or oth	ner root cause analysis	
		nd other medications with			n the daily morning	
	physician for possible			-	administrator has lead	
	dosage/elimination of				root cause analysis	
	12/22/17 and revised				ing varying topics.	
	(initiated 6/7/18)	oper non-slip footwear			g procedure to ensure that rrection is effective and that	
		activities (initiated 6/7/18)			ency cited remains correcte	
	- Have commonly use			· ·	pliance with the regulatory	
	(initiated 6/18/18)			requirements	,	
	, , , , , , , , , , , , , , , , , , ,	to participate in activities			I implement a weekly falls	
		e and physical activity for			eting to review residents	
		proved mobility (initiated			alls and identify root cause	
	6/21/18)				mplementations. The facilit	У
		ently as needed and prior to			he weekly falls committee	
	going to bed at night			-	least 12 weeks and	
	revised 6/25/18)	to take rest periods as			ger. If deemed appropriate, nittee may reduce to a	,
		it was pacing a lot. Offer			ing after the 12 weeks.	
		pain medication as needed.			ager and/or director of	
	(initiated 4/30/18 and				view all falls weekly x 12	
	- Assist during transfe	er and mobility. Anticipate			are fall interventions were in	า
		when resident was bending,			n the care plan at the time	
		hing (initiated 6/25/18)			l a fall investigation has	
	-	thin reach of the resident			ed. This audit will be	
		itiated 4/30/18 and revised			on the falls audit tool. The	
	7/27/18)	al modication side offects			rsing will report to the ance/Performance	
	- Observe for potentia	al medication side effects		USUALITY ASSUREMENT	ance/Periormance	1

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/09/2019 MAPPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING				C / <b>04/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	•	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	<ul> <li>Provide frequent sta (initiated 9/10/18)</li> <li>Ensure environmen 9/10/18)</li> <li>Encourage resident devices properly (initial - Keep call light within (initiated 10/15/18)</li> <li>An incident report dat Nurse #7 indicated R unwitnessed fall on 1 resulted in small burn forehead. Resident # left side in front of he the hallway of the me The fall investigation 10/20/18 completed b new intervention that prevent a repeat fall w Resident #28's whee indicated that the 10/ was reviewed on 10/2 meeting and the fall in complete by Unit Man The investigation follour unsigned, indicated F 10/20/18 at 10:50 AN wheelchair with no person self-propel the wheel independently. She was awareness related to interventions to prevent that Resident #28 was</li> </ul>	k for falls (initiated 9/4/18) aff observation of resident t free of clutter (initiated to use handrails or assistive tated 10/8/18) n reach and answer timely ted 10/20/18 completed by esident #28 had 0/20/18 at 10:50 AM that up to the left side of her #28 was found lying on her r wheelchair on the floor in emory care unit. checklist form dated by Nurse #7 indicated the was put into place to was to add anti-rollbacks to lchair. This checklist 20/18 fall for Resident #28 22/18 during the morning nvestigation was signed as hager (UM) #1. bw up form, undated and Resident #28 had a fall on 1. Resident #28 used a edals and was able to chair and to ambulate was noted with no safety	F	589	Improvement committee the effective of the monitoring and identify any continuing issues. The monthly QI committee will review results of the fall intervention audit too monthly for 3 months for identification trends, actions taken, and to determin the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administra and/or DON will present the findings a recommendations of the monthly QI committee to the quarterly executive of committee for further recommendation and oversight Corrective action compliance date: M 2019	the of ie ator and QA ns		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED			
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CC	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY				
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED			
							С			
		345293	B. WING			04/04/2019				
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE					
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			HWAY 177 S BOX 1489					
	-			HAMLET, NC 28345						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 689	Continued From page Anti-rollbacks were to	be put into place on	F 68	89						
		Ichair to stabilize it for her.								
		blan related to falls was with the intervention of								
		elchair. This was a repeat								
	intervention as it was	initiated on Resident #28's								
	care plan on 4/30/18.									
	A fall risk assessmen Resident #28 was at	t dated 10/23/18 indicated high risk for falls.								
	A work order dated 10/24/18 completed by UM #1 indicated anti-rollbacks were to be added to Resident #28's wheelchair. This work order indicated the anti-rollbacks were added on 10/25/18.									
	on 4/3/19 at 2:43 PM nurse assigned to the fall completed an inci fall investigation cheo that this form had a q interventions were go prevent repeated falls explained that someti answering this questi resident who already place. She reported think of an appropriat this question blank ar what new interventior incident report, invest investigation follow up anti-rollbacks were to Resident #28 after the	imes she had a tough time on if it was related to a had multiple interventions in that if she was unable to e intervention that she left nd let one of UMs determine n was appropriate. The tigation checklist, and p form that indicated b be implemented for								

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CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 093         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVICES         A. BUILDING       C       C         B. WING       04/04/200	ΞY
	19
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HIGHWAY 177 S BOX 1489	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE HAMLET, NC 28345	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) IPLETION DATE
F 689       Continued From page 76       F 689         indicated that the intervention of anti-rollbacks       was already in place on Resident #28's care plan         (initiated on 4/30/18 and last revised 7/27/18) was       reviewed with Nurse #7. Nurse #7 stated she         believed one of the UMs had added that       intervention onto the investigation checklist. She         was unable to recall with certainly if Resident       #28's wheelchair had anti-rollbacks at the time of         #28's wheelchair had anti-rollbacks were       probably not in place on Resident #28's         wheelchair.       An interview was conducted with UM #1 on 4/2/19         at 2:40 PM. UM #1 stated the nurse assigned to       the resident at the time of the fall completed an         incident report and initized the fall investigation       checklist form. She reported this nurse was         supposed to identify a new fall prevention       intervention that related to the fall. She stated         that during the moming meetings on Mondays       through Fridays all falls were reviewed with         management staff and she and UM #2 were       responsible for ensuring the investigation into the fall         inclided a review of the current fall prevention       intervention was identified. UM #1         was asked if the investigation into the fall       investigation should include a         review of this information. The incident report,       investigation into the fall         <	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/09/2019 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING				<i>,</i> )4/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	and last revised 7/27/ 10/20/18 fall was reviews was unable to explain anti-rollbacks were not 10/20/18 fall when thi on her care plan. She why the investigation care planned intervent implemented. An incident report dat Nurse #8 indicated Re fall on 11/5/18 at 10:1 "knot" to the right bac #28's Nursing Assista she was giving Resider resident stood up and NA #8. The fall investigation completed by Nurse # intervention that was repeat fall for Resider bathing". The section provided a date the far morning meeting was signature by UM #1 o investigation was com A phone interview wa 9:04 AM with Nurse # reached. A phone interview wa	are plan (initiated on 4/30/18 18) at the time of her ewed with UM #1. UM #1 why Resident #28's ot in place at the time of her is intervention was already e was also unable to explain failed to identify that this ation had not been red 11/5/18 completed by esident #28 had a witnessed 0 AM that resulted in a k of her head. Resident int (NA) reported that while ent #28 a bed bath the I fell. The NA was noted as checklist form dated 11/5/18 #8 indicated the new put into place to prevent a at #28 was to "watch during n on this checklist that all was reviewed during the blank and there was no r UM #2 to indicate the	F 68	39			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 05/09/2019 APPROVED 0: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		LETED
		345293	B. WING				C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DIGUMON				H	HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		ŀ	HAMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	E PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 689	Continued From page	e 78	F	689			
		ducted with UM #1 on 4/2/19					
		lent report and the fall					
		t form that was partially					
	· ·	nt #28's 11/5/18 fall were					
		The new intervention					
		vestigation checklist that					
		bathing" was reviewed with ed that this investigation					
		lete, but she was unable to					
	-	n as to why. She revealed					
		have turned her back on					
		ne was giving her a bed					
		ealed that "watch during					
		w intervention as this should					
		otocol for the NA while					
		. UM #1 was unable to					
		tion had been provided to					
		ent. She stated that NA #8					
	was no longer employ	ed at the facility.					
	A physician's note dat	ted 11/19/18 indicated					
		all risk related to mobility					
	impairment. He repoi						
	Resident #28's deme						
	physical decline which						
	l i	preventative measures to					
		ential injuries or fractures.					
		hat Resident #28's had					
		tors that created poor					
		ile performing essential g without assistance which					
	made safety a priority						
	made salety a pholity						
	An incident report dat	ed 12/2/18 completed by					
	Nurse #9 indicated R						
	unwitnessed fall on 12						
		ind on the floor, sitting on					
		eding noted to the back of					

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	-	ID HUMAN SERVICES				FORM	1 APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		X3) DATE	. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		COMP	LETED
		345293	B. WING			(	C 04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	I DE	04/	04/2019
				HIGHWAY 177 S BOX 1489			
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIAT	Ē	(X5) COMPLETION DATE
	Continued From page her head. She was set (ER) for evaluation. An ER note dated 12, had laceration to her length and 3 millimete laceration was repaired The fall investigation completed by Nurse 4 intervention that was repeat fall for Residen intervene for causativ indicated that the 12/2 was reviewed on 12/3 meeting and the fall in complete by UM #2. The care plan for Res was revised on 12/4/7 to "observe and interv ". A phone interview wa on 4/3/19 at 8:49 AM nurse assigned to the fall completed an inci fall investigation check she never completed about new intervention checklist. She report blank and that UM #1 question. The incide 12/2/18 fall was revie investigation checklist	e 79 ent to the Emergency Room /2/18 indicated Resident #28 scalp 2 centimeters (cm) in ers (mm) in depth. The ed with 4 staples. checklist form dated 12/2/18		CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIAT	Έ	DATE
	with Nurse #9. Nurse	sative factors" was reviewed #9 stated that this ady in place as the staff were					

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	-	ID HUMAN SERVICES				FORM	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MUI		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	` ´				PLETED
							С
		345293	B. WING			04/	/04/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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	trying to figure out the An interview was con at 3:08 PM. The incid investigation checklis 12/2/18 fall were revie intervention identified checklist that stated " causative factors" wa #2 acknowledged tha observing Resident # the cause of her falls as this was normal pr He revealed that he w noted on the investiga always related to the indicated it was an or the nurses on how to investigation checklis An incident report dat Nurse #14 indicated F unwitnessed fall on 17 Resident #28 was fou her buttocks, with ble of her scalp. She was evaluation. An ER note dated 1/1 had a laceration to he laceration was repaire The fall investigation completed by Nurse # intervention that was repeat fall was to ass ambulation when in th	rving Resident #28 and e cause of every fall. ducted with UM #2 on 4/2/19 dent report and the fall t form for Resident #28's ewed with UM #2. The new 1 on the fall investigation observe and intervene for is reviewed with UM #2. UM it the intervention of 28 and trying to figure out was not a new intervention rocedure for all resident falls. vas aware the interventions ation checklists were not fall that occurred. He ngoing process to educate properly fill out the t form. ted 1/13/19 completed by Resident #28 had an /13/19 at 10:13 PM. und in the hallway, seated on eding noted to the right side s sent to the ER for 13/19 indicated Resident #28 er scalp 2 cm in length. The ed with 5 staples. checklist form dated 1/13/19 #14 indicated the new put into place to prevent a	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED DMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345293	B. WING			C 04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT	
F 689	<ul> <li>1/13/19 fall for Reside 1/14/19 during the me investigation was sign A phone interview wa 9:08 AM with Nurse # reached.</li> <li>An incident report dar Nurse #7 indicated R unwitnessed fall with of the memory care u Resident #28 was fou back in the dining roo The fall investigation completed by Nurse a intervention that was repeat fall for Reside routinely for needs.</li> <li>The 1/17/19 fall for Reside routinely for needs.</li> <li>The 1/17/19 fall for Reside investigation was sign on 1/21/19.</li> <li>A phone interview was on 4/3/19 at 2:43 PM to the 1/17/19 fall for with Nurse #7. The in that identified the new Resident #28 routine with Nurse #7. Nurse not a new intervention monitor Resident #28</li> <li>An interview was con at 3:08 PM. The incide investigation checklis</li> </ul>	ent #28 was reviewed on orning meeting and the fall hed as complete by UM #1. Is attempted on 4/3/19 at #14 but she was unable to be ted 1/17/19 completed by esident #28 had an no injury in the dining room unit on 1/17/19 at 8:40 AM. und lying on the floor on her om on the memory care unit. checklist form dated 1/17/19 #7 indicated the new put into place to prevent a nt #28 was to observe This checklist indicated that esident #28 was reviewed on orning meeting and the fall hed as complete by UM #2 as conducted with Nurse #7 . The incident report related Resident #28 was reviewed hyestigation checklist form v intervention of observing by for needs was reviewed e #7 reported that this was in as staff had to frequently	F 68	39		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							MAPPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG _			C	
		345293	B. WING			04/	04/2019	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ACTION SHOULD BECOMPLETO THE APPROPRIATEDAT		
F 689	checklist that stated " was reviewed with UN that the intervention of routinely for needs was staff were expected to routinely for needs. An incident report dat Nurse #10 indicated F unwitnessed fall with room on the memory 11:44 AM. The fall investigation of completed by Nurse # was reaching for a cu intervention that was repeat fall was to trans slowly. This checklist for Resident #28 was the morning meeting a was signed as completed was updated on 1/21/ "transfer and change "observe resident rou The care plan related was updated on 1/22/ "assist to ambulate w an activity". A phone interview wa on 4/3/19 at 9:15 AM. nurse assigned to the	on the fall investigation observe routinely for needs" // #2. UM #2 acknowledged of observing Resident #28 as not a new intervention as to observe all residents red 1/20/19 completed by Resident #28 had an no injury in the television care unit on 1/20/19 at checklist form dated 1/20/19 #10 indicated Resident #28 p when she fell. The new put into place to prevent a isfer and change position t indicated the 1/20/19 fall reviewed on 1/21/19 during and the fall investigation ete by UM #1. to falls for Resident #28 (19 with the interventions of position slowly" and	F	589				
	staff were expected to routinely for needs. An incident report dat Nurse #10 indicated F unwitnessed fall with room on the memory 11:44 AM. The fall investigation completed by Nurse # was reaching for a cu intervention that was repeat fall was to tran- slowly. This checklist for Resident #28 was the morning meeting was signed as comple The care plan related was updated on 1/21/ "transfer and change "observe resident rou The care plan related was updated on 1/22/ "assist to ambulate w an activity". A phone interview wa on 4/3/19 at 9:15 AM. nurse assigned to the fall completed an incident	<ul> <li>b observe all residents</li> <li>b observe all residents</li> <li>c d 1/20/19 completed by Resident #28 had an no injury in the television care unit on 1/20/19 at</li> <li>c checklist form dated 1/20/19 #10 indicated Resident #28 p when she fell. The new put into place to prevent a isfer and change position t indicated the 1/20/19 fall reviewed on 1/21/19 during and the fall investigation ete by UM #1.</li> <li>to falls for Resident #28 (19 with the interventions of position slowly" and tinely for needs".</li> <li>to falls for Resident #28 (19 with the intervention of hen in hallway and direct to</li> <li>s conducted with Nurse #10 . Nurse #10 stated that the e resident at the time of the</li> </ul>						

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C / <b>04/2019</b>
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	that she had just rece from UM #1 on how to investigation checklis new interventions that of the fall in an effort further revealed that junderstood how to fill checklist form correct related to the 1/20/19 reviewed with Nurses checklist form that ide of transferring and ch reviewed with Nurses this new intervention changing positions wa fall for Resident #28. #28 had dropped her when she was reachi An interview was con at 2:40 PM. The incid investigation checklis 1/20/19 fall were revie intervention to transfe slowly that was identic checklist was reviewed unable to explain how to Resident #28's 1/2 An incident report dat Nurse #9 indicated R unwitnessed fall in he 2/5/19 at 6:01 AM. R on her right near her The fall investigation completed by Nurse # intervention that was	eived education on 4/2/19 o properly fill out the fall t form and how to develop t correlated with the cause to prevent a repeat fall. She prior to 4/2/19 she had not out the fall investigation dy. The incident report fall for Resident #28 was #10. The investigation entified the new intervention anging positions slowly was #10. Nurse #10 stated that about transferring and as not related to the 1/20/19 She reported that Resident cup on the floor and fell ng for it. ducted with UM #1 on 4/2/19 lent report and the fall t form for Resident #28 ' s ewed with UM #1. The new er and change position fied on the fall investigation ed with UM #1. UM #1 was v this intervention correlated 0/19 fall. ted 2/5/19 completed by esident #28 had an er room with no injury on tesident #28 was found lying bed.	F	689			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING				04/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	indicated that the 2/5/ reviewed on 2/6/19 dr and the fall investigat by UM #1. The care plan related was updated on 2/6/1 of adequate environm room and bathroom. A phone interview wa on 4/3/19 at 8:49 AM. Resident #28's 2/5/19 Nurse #9. The fall inv indicated the new inte adequate lighting and bathroom light on we Nurse #9 stated that s intervention. She ind dark in Resident #28' 2/5/19 fall (6:01 AM) a couldn't see what she Resident #28 was abl independently, but that bathroom on her own An incident report dat Nurse #14 indicated F unwitnessed fall on 2/ #28 was found lying of bathroom door. Her r purple with bruising n deltoid. Resident #28 evaluation. An ER note dated 2/1 evaluation of Resider	oom light on. This checklist (19 fall for Resident #28 was uring the morning meeting ion was signed as complete to falls for Resident #28 9 with the new intervention nental lighting in resident's s conducted with Nurse #9 . The incident report for 9 fall was reviewed with vestigation checklist that erventions implemented for 1 keeping Resident #28's re reviewed with Nurse #9. she had not written that icated that it would've been s room at the time of the and maybe the resident e was doing. She added that le to get up from bed at she never went to the ted 2/10/19 completed by Resident #28 had an (10/19 at 6:00 AM. Resident on the floor beside her right eye was noted to be oted to the face and right 8 was sent to the ER for	F 6	589			
		nt #28 resulted in no nd required no surgical					

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	-	ID HUMAN SERVICES				FORM	APPROVED
					CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '				PLETED
							С
		345293	B. WING				04/2019
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		н	AMLET, NC 28345		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
F 689	Continued From page	e 85	F6	689			
	interventions.						
	, i i i i i i i i i i i i i i i i i i i	checklist form dated 2/10/19					
		#14 for the 6:00 AM fall left w interventions blank. This					
	checklist indicated that						
		viewed on 2/11/19 during the					
	morning meeting and	the fall investigation was					
	signed as complete b	y UM #1.					
	A phone interview we	a attempted on $1/2/10$ at					
	· ·	s attempted on 4/3/19 at 14 but she was unable to be					
	reached.						
		ed 2/10/19 completed by					
	Nurse #11 indicated F						
		no injury on 2/10/19 at 6:37					
		n of the memory care unit. her wheelchair in the dining					
		as preparing trays. A					
		nd Nurse #11 then saw					
	Resident #28 on the f	floor in front of her					
	wheelchair.						
	The fall investigation	chacklist form dated 2/10/10					
	completed by Nurse #	checklist form dated 2/10/19 #11 for the 6:37 PM					
		erventions that were put into					
		beat fall were for Resident					
	#28's wheelchair to b	e locked when she					
		e, toilet as needed, and					
	-	checklist indicated that this					
		ent #28 was reviewed on prning meeting and the fall					
		ned as complete by UM #1.					
		s conducted with Nurse #11					
		The incident report related					
		3:37 PM for Resident #28					
	was reviewed with Nu	urse #11. The investigation					

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CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938-03         STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       C         345293       B. WING       04/04/2019	
345293 B. WING 04/04/2019	
	4/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (X5)       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     COMPLETI       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE     DATE	COMPLETION
F 689       Continued From page 86 checklist form that identified the new interventions of Resident #28's wheelchair to be locked when she attempted to ambulate, toilet as needed, and monitor closely were reviewed with Nurse #11. Nurse #11 stated that she had written these interventions on the checklist. She indicated she was still learning how to fill out the form properly at that time. She revealed that after this checklist was struned in, she received re-education from the Director of Nursing (DON) and UM #1 on how to develop an intervention that related to the fall. An incident report dated 2221/19 completed by Nurse #7 indicated Resident #28 had a witnessed fall with no injuries on 221/19 at 10:50 AM. Resident #28 was observed walking in the hail while another resident was in her pathway and she slowly fell to the floor. The fall investigation checklist form dated 2221/19 completed by Nurse #7 indicated the new intervention that was put into place to prevent a repeat fall was to "make sure environment is free of clutter including other residents". This checklist indicated that this 2221/19 fall for Resident #28 was reviewed on 2/22/19 during the morning meeting and the fall investigation was signed as complete by UM #1.         The care plan related to falls for Resident #28 was revised on 36/19. The previous intervention, initiated on 9/10/18, of ensuring Resident #28/s environment was free of clutter was updated to include the environment also being free of people in her path.         A phone interview was conducted with Nurse #7 on 4/3/19 at 2.43 PM. The incident report related to the 2/211/19 for Resident #28 was reviewed	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/09/2019 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE		
F 689	with Nurse #7. The in that identified the new environment was free reviewed with Nurse # she believed this fall h residents were return were a lot of people in explained that the inte keep Resident #28 cla was known there was moving about. An observation was c on 4/3/19 at 3:40 PM. self-propelling in her w hallway of the memor independently propell end of the unit to the wheelchair to face the then propelled back to The care planned fall were observed to be i observation. An interview was com 4/2/19 at 3:10 PM. Si facility's fall investigat included analyzing the in an attempt to drill d additionally acknowle noted on the investigat always related to that On 4/3/19 at 8:30 AM reviewed each of Res 10/20/18 through pres 4/2/19. She reported possible pattern for day	Avestigation checklist form a intervention of ensuring the e of clutter and people was #7. Nurse #7 stated that happened at the time other ing from an activity so there in the hallway. She ent of the intervention was to ear of the hallway when it going to be a lot of people onducted of Resident #28 Resident #28 was wheelchair throughout the y care unit. She ed her wheelchair from one other, maneuvered her e opposite direction, and o the other end of the unit. prevention interventions in place at the time of this ducted with the DON on he acknowledged that the ion process had not e pattern of falls as a whole own to the root cause. She dged that the interventions ation checklist were not specific fall. the DON stated she ident #28's falls from sent on the evening of she was looking for a	F	589			

Facility ID: 923021

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345293	B. WING				C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE
F 689 F 692 SS=D	not been analyzing the multiple falls to detern evident. She addition she felt it was imposs Resident #28, that it w risk of falls by drilling implementing interven root cause. A final interview was of 4/3/19 at 3:15 PM. St prevention intervention indicated that she exp investigated and anal factors and to implement the causative factors risk of further falls. Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted re (Includes naso-gastrice both percutaneous endosce enteral fluids). Based comprehensive assess 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	evealed that the facility had ese details for residents with nine if any patterns were hally revealed that although ible to prevent all falls for was possible to reduce the down to the root cause and ntions that addressed the conducted with the DON on he stated she expected fall ons to be implemented. She bected falls to be thoroughly yzed to determine causative eent interventions based on in an effort to reduce the atus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, nooscopic gastrostomy and copic jejunostomy, and d on a resident's asment, the facility must t- ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition is is not possible or resident otherwise;	F 6				5/1/19

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TATEMENT (	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING B. WING		
		345293			C 04/04/2019
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTE	H	IIGHWAY 177 S BOX 1489	
	DFINES HEALINGARE		H	IAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 692	Continued From page	e 89	F 692		
	there is a nutritional provider orders a the	red a therapeutic diet when problem and the health care rapeutic diet. Γ is not met as evidenced			
		iew, observation, and staff the facility failed to provide		F692 The plan of correcting the specific	
		erventions to prevent weight and #60) for 2 of 3 residents and hydration.		deficiency Resident #51 was observed with o portions on 4/24/19 breakfast mea	
	Findings included: 1. Resident #51 was 1/20/11 with the diag	admitted to the facility on		facility consultant. Resident #60 was observed eating breakfast in the community dining	g
	restlessness, and ag	itation.		4/24/19 by facility consultant. Duri observation resident was receiving	ng this g
	dated 12/2018 for a r	physician monthly order nutritional supplement four I pureed with thin liquids,		assistance from facility certified nu assistance. The plan for identifying of potentia	
	magic cup, and doub	-		residents affected On 4/23/19 the facility consultant	
	Data Set dated 2/1/1 severely impaired co	#51's quarterly Minimum 9 revealed the resident had gnition with no speech and		observed residents at lunch to ens they received diets as ordered with negative findings.	
	resident required tota	d or understands. The al dependence for all ADLs. s were protein mal-nutrition		On 4/23/19 the facility consultant observed lunch meal to ensure re- were receiving meal at location of	
	and dysphagia. The therapeutic diet.	resident received a		and/or order with no negative findi The procedure for implementing th acceptable plan of correction for th	ne
	2/6/19 revealed a foc	#51's care plan updated cus for nutrition with pureed, nd nutritional supplement for		specific deficiency cited On 4/18/19 the director of nursing in-serviced nursing staff on provid	ing
	each meal.			supplements, and diets as ordered proving eating assistance in the	-
		#51's diet order meal ticket ary Manager (DM) revealed		appropriate location as designated care plan or order. This in-service	-

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		ND HUMAN SERVICES			FORM	05/09/2019 APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPLI	ETED
		345293 B. WING			C 04/0	4/2019
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE	E, ZIP CODE	
		AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
RICHIVION	D FINES HEALTHCARE	AND REPABLICATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page	e 90	F 69	2		
	portion enriched mea		1.00	staff on 4/18/19 by the	e staff facilitator	
				The monitoring proce		
	On 4/2/19 at 8:30 am	an observation was done of		the plan of correction		
		ed and her breakfast tray was		specific deficiency cite		
		st was a single portion.		and/or in compliance	with the regulatory	
	<b>e</b> .	A) #5 verified that the meal ind the DM verified that the		requirements The director of nursin	unit manager	
	meal portion was single a			minimum data set nur		
	·····	3		facilitator will observe	-	
	On 4/2/19 at 8:30 am	an interview was conducted		(at random meals to i		
	with NA #2 who state	<b>č</b>		random days to includ		
		esident #51 and had not it receive double portion		x 12 weeks to ensure supplements, is provi	-	
		ented that if she felt the		resident is eating in lo		
		gry she would order a		and/or as designated		
		e resident always ate 100%		This audit will be docu	-	
	of her meal.			audit tool.		
	On 1/2/10 at 9:55 am	an abaan/ation of Decident		The results of the AD		
		an observation of Resident t meal by NA #1 a double		compiled by the Admi Director of Nursing ar		
		that the resident was calm		Quality Improvement		
	•	hen she was full with no		x 3months. Identifica	-	
	independent extremit	ty movement.		determine the need for		
	0 4440 1005			and/or change in freq	uency of required	
		an interview was conducted ed Resident #51's meal was		monitoring.		
		2/19 and does not know why		Corrective action corr	pliance date: May 1	
	÷ .	eceive a double portion that		2019	.p	
		st. The DM was aware that				
		n eating 100% of her meals				
	(single portion).					
	On 4/4/19 at 12:30 p	m an interview was				
		ry Aide (DA) #1 who stated				
		unce the ordered meal for				
	-	erved the food onto the plate				
	accordingly during th	-				
		cook did not announce				
	double" this morning	and the resident received a				

Facility ID: 923021

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
							С
		345293	B. WING			04/	04/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489		
					1AMLET, NC 28345		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 692	Continued From page	91	F	692			
		stated that she believed		002			
		o mis-communication and					
	could have occurred i	in the past.					
	An interview was con						
	An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing who stated that she						
	expected staff to follo						
	diet and nutritional su	ipplement.					
	2 Resident #60 was	admitted to the facility on					
		d on 2/11/19 with diagnoses					
	that included dementi	<b>.</b>					
	A Desistand Distisio	r (DD) note datad $2/4/40$					
		n (RD) note dated 2/1/19 esident #60 eat community					
		m to encourage intake.					
	A physician's order da	ated 2/6/19 indicated eat community style in the					
	dining room to encou						
	-	-					
	A review of Resident	-					
	indicated a weight of	119 pounds on 2/6/19.					
	Resident #60's care p	plan, initiated on 7/2/18,					
	-	ea of assistance for eating					
		eficit and dysphagia. The					
		d on 7/2/18 and revised ident #60 was to eat her					
		bom to encourage intake.					
	-	-					
	The quarterly Minimu						
		14/19 indicated Resident nd long-term memory					
		ly impaired decision making.					
		ensive assistance of 1 for					
	eating.						
	A review of Resident	#60's weight record					
	A TEVIEW OF RESIDENT						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/09/2019 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345293	B. WING					C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, Z	ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 692	indicated a weight of was a loss of 5 pound An observation was of on 3/31/19 at 6:05 PM in her room with assis Assistant (NA) #10. An observation was of on 4/3/19 at 6:10 PM. her room with assista An interview was con 4/3/19 at 5:30 PM. S unaware that Resider order to eat all of her She stated that she w Resident #60's unit of shift and she had diffi residents out of bed a her own. She indicate and fed Resident #60 3/31/19. An interview was con 4/4/19 at 2:55 PM. S that Resident #60 wa in the dining room to intake. She revealed NAs and a nurse on F of the NAs had called shift. NA #11 further f was the only NA on R that she was unable t dinner due to time lime	114 pounds on 3/22/19. This ds since 2/6/19. conducted of the dinner meal A. Resident #60 was eating stance provided by Nursing conducted of the dinner meal a Resident #60 was eating in nce provided by NA #11. ducted with NA #10 on he revealed she was at #60 had a physician's meals in the dining room. vas the only NA working on n 3/31/19 during the 2nd culty getting all of the and into the dining room on ed this was why she served of dinner in her room on ducted with NA #11 on he stated she was aware s supposed to eat all meals encourage her nutritional that normally there were 2 Resident #60's unit, but one off on 4/3/19 for the 2nd revealed that because she tesident #60's unit on 4/3/19 o get her out of bed for itations.	F	692				
	4/4/19 at 10:15 AM.	s conducted with the RD on She indicated she was #60. She stated that she						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING				C 104/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			HGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692 F 725 SS=E	recommended comm #60. She explained t that they thought Res intake eating in the di The RD stated that sh related to nutrition to An interview was com Nursing on 4/4/19 at 3 expected nutritional in by the RD and ordere consistently implemen Sufficient Nursing Sta CFR(s): 483.35(a)(1)( §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and re- resident safety and at practicable physical, n well-being of each res resident assessments and considering the n diagnoses of the facill accordance with the f at §483.35(a)(1) The fac by sufficient numbers types of personnel on nursing care to all res- resident care plans: (i) Except when waive this section, licensed	unity dining for Resident hat staff had shared with her ident #60 would have better ning room with her peers. he expected interventions be followed. ducted with the Director of 3:15 PM. She indicated she atterventions recommended d by the physician to be hted. iff (2) Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care umber, acuity and ity's resident population in acility assessment required cility must provide services of each of the following a 24-hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not		725			5/1/19

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Facility ID: 923021

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						<u>NO. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			TE SURVEY MPLETED	
			A. BUILDING	3			
		245000	B WINC		С		
		345293	B. WING			4/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
RICHMON	ID PINES HEAI THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489			
				HAMLET, NC 28345			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE	
F 725	Continued From pag	e 94	F 72	5			
	§483.35(a)(2) Excep	t when waived under					
	paragraph (e) of this section, the facility must						
		nurse to serve as a charge					
	nurse on each tour of duty.						
	This REQUIREMEN	I is not met as evidenced					
	by:						
		view, observation, resident		F725			
		nterview, the facility failed to		For residents affected by the			
		sing staff to ensure a		facility has added a certified n			
		references were honored		assistant position in the deme			
		ovide activity of daily living		meet resident needs on 4/24/2			
		residents who required		The facility has added a unit r			
		e with eating, bathing,		position to increase oversite o	on the		
		/giene, and/or nail care		dementia unit on 4/8/2019.			
		#74, and #80), and to ensure		The facility has implemented			
		unity style in the dining room		increases and sign on program			
		ysician (Resident #60). This		positions and maintain curren	t stan on		
	affected 5 of 22 sam	pied residents.		4/24/2019.	ro hoing		
	The findings includes	4.		Showers and resident care a	•		
	The findings included	1.		monitored daily and audited a the day shift. The unit manage			
	This tag is cross-refe	prred to:		each resident scheduled for a			
	11113 tay 13 01033-1010	ared to.		the day and audit and review	SHOWER IOI		
	1. F561 <sup>·</sup> Based on re	ecord review, resident		documentation that a shower	and cares		
		nterview, the facility failed to		were given or were declined.			
		scheduled for 1 of 2 residents		cares not completed are pass			
	(Resident #74) review			the evening shift verbally and			
				added nurse communication I			
				completion.			
	2. F677: Based on re	cord review, observation,		Other potentially affected resi	dents: Daily		
		nd staff interview, the facility		audits identify residents not re	-		
	failed to provide assi	stance to residents who		showers and care. Added sta	ff increase		
		total care with eating,		oversite and man power to me	onitor		
		rsonal hygiene, and/or nail		resident cares.			
	care for 4 of 6 reside			Measures implemented: Meas			
		f daily living (ADL) care		been taken to reduce staff tur			
	(Residents #9, #51, #	#74, and #80).		pay incentives on 4/24/2019.			
				unit manager is for improving			
		cord review, observation,		completion of showers and ca		1	

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DF DEFICIENCIES			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345293 B. WING			C 04/04/2019	
D PINES HEALTHCARE	AND REHABILITATION CENTE	[	HAMLET, NC 28345	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
and staff and family in provide physician orce weight loss (Residem residents reviewed for A resident council me 4/2/19 at 10:30 AM we residents (Residents #40, #45, #53, #57, # The residents reported had enough Nursing showers as scheduled and personal hygiened The residents stated working on this staffin period of time when it recently it had reapped An interview was com Nursing (DON) on 4/4 indicated that it was for facility have a sufficient meet the needs of the that this included have resident 's bathing p Activity of Daily Living physician ordered we interventions were im	nterview, the facility failed to lered interventions to prevent ts #51 and #60) for 2 of 3 or nutrition and hydration. The eting was conducted on with 16 alert and oriented #2, #3, #4, #6, #7, #30, #33, #67, #68, #69, #72, and #87). The the facility had not Assistants (NAs) to provide d and to provide bed baths a care on the weekends. That the facility had been ing issue and there was a t had improved, but that eared as a problem. The expectation that the ent number of nursing staff to e residents. She reported ring enough staff to honor a references, to provide g care, and to ensure eight loss prevention aplemented.		<ul> <li>4/8/2019. Auditing with the activities of daily living audit tool will identify resident that have not been given showers or cares. Shift to shift communication bool will alert evening shift residents requirin care.</li> <li>On 4/18/19 the director of nursing bega an in-service with nursing staff on providing proving assistance with activit of daily living including showers, nail cateating, personal hygiene, and bathing. This in-service was added to the orientation of new nursing staff on 4/18 by the staff facilitator on 4/18/19.</li> <li>Monitoring to maintain compliance: The unit manager, director of nursing, minimum data set nurse, or staff facilitation vill audit (by observation and documentation review) using the ADL audit tool 5 residents weekly (on randou shifts to include all shifts on random dato include all days) to ensure showers have been provided per schedule, assistance is being provided for eating, nail care has been provided, shaving, a personal hygiene has been provided. Issues will be reported to the director of nursing. The Director of Nursing will repute to the Quality Assurance/Performance Improvement committee the effectivener of the monitoring and identify any continuing issues.</li> <li>Corrective action compliance date: May 2019</li> </ul>	nts
	ROVIDER OR SUPPLIER <b>D PINES HEALTHCARE</b> SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page and staff and family in provide physician orco weight loss (Residen residents reviewed for A resident council me 4/2/19 at 10:30 AM w residents (Residents #40, #45, #53, #57, # The residents reported had enough Nursing showers as scheduled and personal hygiened The residents stated working on this staffing period of time when in recently it had reapped An interview was com Nursing (DON) on 4/4 indicated that it was for facility have a sufficient meet the needs of the that this included have resident 's bathing p Activity of Daily Living physician ordered we interventions were im Pharmacy Srvcs/Prove CFR(s): 483.45(a)(b)	345293	A BOULDING.         345293         B. WING	A BULLING           STREET ADDRESS, CITY, STATE, ZIP CODE           STREET ADDRESS, CITY, STATE, ZIP CODE           D PINES HEALTHCARE AND REHABILITATION CENTE           SUMMARY STATEMENT OF DEFICIENCES (EACH DECIDENT MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX         PROVIDER'S PLAN OF CORRECTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY (MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 725           Continued From page 95 and staff and family interview, the facility failed to provide physician ordered interventions to prevent weight loss (Residents #2, #3, #4, #6, #7, #30, #33, #40, #45, \$53, #57, #67, #68, #69, #72, and #87). The residents reported that the facility had not had enough Nursing Assistants (NAs) to provide showers as scheduled and to provide bed baths and personal hygiene care on the weekends. The resident stated that the facility had been working on this staffing issue and there was a period of time when it had improved, but that recently it had reappeared as a problem.         F 725           An interview was conducted with the Director of Nursing (DON) on 4/4/19 at 3:15 PM. She indicated that it was her expectation that the facility have a sufficient number of nursing staff to honor a resident 's bathing preferences, to provide Activity of Daily Living care, and to ensure physician ordered weight to sos prevention interventions were implemented.         Summa assistance of Nursing, personal hygiene has been provided shifts to include all shifts or nandrom using that this included having nough staff to honor a resident 's bathing preferences, to provide Activity of Daily Living care, and to ensure physician ordered weight toos sprevention int

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PRINTED: 05/09/2019 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345293	B. WING _				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		GHWAY 177 S BOX 1489 AMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 755	drugs and biologicals them under an agreen §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accura- dispensing, and admin biologicals) to meet th §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provisi- the facility. §483.45(b)(2) Establis- receipt and dispositio sufficient detail to ena- reconciliation; and §483.45(b)(3) Determ- order and that an acc- is maintained and per This REQUIREMENT by: Based on record revi-	ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident. Consultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of in of all controlled drugs in able an accurate hines that drug records are in count of all controlled drugs riodically reconciled. T is not met as evidenced iew and staff interview, the hister medication as ordered of 5 residents reviewed for	F 7	755	F755 For residents affected by the issue: Th residents medication has been refilled is currently receiving the medication as prescribed. The resident has not been without the proper dose since being refilled.	and	

Event ID: CYLY11

Facility ID: 923021

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
		345293	B. WING			C 04/2019
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b> - 1 -	STREET ADDRESS, CITY, STATE, ZIP CODE		04/2013
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 755		mitted on 9/10/12 with	F 755	Other potentially affected resident		
	diagnoses of dement disturbance, and bipo	lar disorder.		complete audit of all residents me availability was completed on two occasions since the issue, the late	est audit	
	Set dated 1/9/19 reve	#24's annual Minimum Data ealed the resident was rstands and her cognition gnoses were		<ul> <li>was 4/25/19. No other issues wer</li> <li>with the audit.</li> <li>On 4/18/19 the director of nursing</li> <li>an in-service for nursing staff on p</li> </ul>	initiated	
		entia, bipolar disorder, and		medications as ordered, and obta medications after hours and on weekends. This in-service was ad	ining	
	for Restoril (sleep aid	hysician order dated 2/12/19 ) 30 milligrams at bedtime.		orientation of new nursing staff or by the staff facilitator. Measures implemented: The unit		
		ation Record (MAR) ion that the resident was not		managers are completing activitie daily living audit tool 3 times a we assure no other resident medicati	ek to	
	at bedtime on March documented commer	ered Restoril 15 mg 2 tablets 16 - 20, 2019 (5 days). The its for omitted doses were der, and not available"		not been refilled. Monitoring to maintain compliance unit managers will be monitoring s week for adequate amount of med	5 times a	
	respectively.			for 5 residents, for 12 weeks and for an additional 3 months. The D	monthly	
	with Nurse #13 who w #24. Nurse #13 indic medications have a re	an interview was conducted vas assigned to Resident ated that all the resident's eminder to reorder when eft. The facility does not		Nursing will report to the Quality Assurance/Performance Improver committee the effectiveness of the monitoring and identify any contin issues.	e	
	stock Restoril. If the at 9:00 pm there wou the medication for that	It is the facility does not resident was out of Restoril Id be no resource to obtain at night. Each nurse who tion was expected to reorder		Corrective action compliance date 2019	e: May 1,	
	that medication when written reminder on th visible. The local pha	the count was low and the ne fourth to last dose was armacy provided backup not controlled substances,				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/09/2019 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345293	B. WING		_		C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				HIGHWAY 177 S BOX 1489			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		CTIVE ACTION SHOULD BE	1	COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		NCED TO THE APPROPRIA	TE	DATE
				I	DEFICIENCY)		
F 755	Continued From page	98	F 755	5			
	with Nurse #1 who sta	ated she was assigned					
		ent #24 on 3/16/19 and					
	-	s no Restoril to administer.					
		on 3/15/19 documented on					
		toril was reordered (first					
		rse #1 did not check to see					
	,	reordered. She checked for					
	the medication in the	medication cart and there					
	was none. The reside	ent was informed that the					
	Restoril was out but v	vas ordered. The resident					
	voiced no concern an	d had no behavior 3/16/19					
	and 3/17/19. The pro	cess for medication reorder					
		edication sticker with the					
	refill information hous	ed in the medication box					
	before you could acce	ess the next medication					
	dose when there are	three doses remaining. The					
	sticker would be place	ed on the reorder sheet and					
	faxed to the pharmac	y at the end of the shift.					
	The medication was ι	sually received by the next					
	day. Nurse #1 did no	t further check for the					
	delivery of Restoril be	cause the MAR					
	documented that it wa	as ordered.					
		an interview was conducted					
	with Medication Aide	(MA) #2 who stated she was					
		nedication to Resident #24					
		15/19. MA #2 stated she					
		s finished and informed the					
		l who) and was told that the					
	Restoril was ordered.	MA #2 stated she was not					
		Restoril for 3 doses/3days					
		being unavailable and					
		wrote on the MAR each day					
		l dose that the medication					
		stated she had not placed					
		al sticker on the reorder					
	form; she was require	ed to inform the nurse. MA					
		t she should have asked					
	about obtaining the m	edication if it was not					

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		MEDICAID SERVICES				<u>O. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		· · ·	E SURVEY PLETED
						С
		345293	B. WING			/04/2019
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COD	E	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IWAY 177 S BOX 1489 ILET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 755	1.0	e 99	F 755			
	available repeatedly. Drug Regimen Revie CFR(s): 483.45(c)(1)	w, Report Irregular, Act On (2)(4)(5)	F 756			5/1/19
		imen Review. ug regimen of each resident least once a month by a				
	§483.45(c)(2) This re of the resident's med	view must include a review ical chart.				
	<ul> <li>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</li> <li>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</li> <li>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</li> <li>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</li> </ul>					
	maintain policies and drug regimen review	cility must develop and procedures for the monthly that include, but are not s for the different steps in				

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	OF DEFICIENCIES	MEDICAID SERVICES	(V2) MILLI	רופי י	ECONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	
			A. BUILDI	NG_			С
		345293	B. WING			04/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	104/2013
					IIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		ŀ	HAMLET, NC 28345		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO DATE
F 756	Continued From page	e 100	F	756			
	the process and step	s the pharmacist must take					
		ifies an irregularity that					
		n to protect the resident.					
		Γ is not met as evidenced					
	by: Based on record rev			F756			
	family, Consultant Ph			For residents affected by the issue:			
		acist failed to notify the			Resident was scheduled for an		
		medication (Resident #22)			appointment with the oncologist for Ma	ay 6,	
	for 1 of 5 residents re	eviewed for unnecessary			2019 to evaluate the continuation of th	ne	
	medication.				medication or the discontinuing of the		
					medication.		
	Findings included:			Other potentially affected residents: N other resident is on this medication. If			
	Resident #22 was ad 5/15/18 with diagnose			resident were to be admitted with this	a		
	abnormalities of gait,			medication the facility will refer the			
	and history of breast			resident to their oncologist for clarifica	tion		
					on continuance of the medication. The		
		ole manufacturer information			facilities pharmacist reviewed all curre	nt	
		ion was prescribed to			residents' charts to assure no other		
		men with hormone receptor			resident is on an irregular medication.		
		er by an oncologist. The			other residents were found to be on ar these medications.	ny of	
		administration was 5 years as of a certain type and would			Measures implemented: On 4/18/19 th		
		oncologist to continue to 10			staff nurses were in-serviced by the		
	-	an cause osteoporosis and			director of nursing that residents on		
		en pathological fracture is			chemotherapy medications, including		
	present and would re	quire an annual bone			estrogen blockers, are to be referred to	0	
	density test.				the physician for continued use. This		
	Desident #00   .	hundrige and - fer			in-service was added to the orientation		
	Resident #22 had a p	ch day dated 5/15/18			new staff nurses on 4/18/19 by the sta facilitator.	uf	
	(hormone receptor bl	-			Monitoring to maintain compliance: Th	e	
	chemotherapy).				facility pharmacy consultant will compl		
					monthly audit to ensure appropriately		
	A review of Resident	#22 ' s annual Minimum			follow up for irregular medications. The	е	
		d 1/8/18 revealed the			pharmacy consultant will report any		
		ely impaired cognition. The			findings of this type of medication to th	ne	
	resident required exte	ensive assistance of 1 staff			director of nursing and to the Quality		

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	IDENTIFICATION NUMBER:	. ,		COMPLE	
				с	
	345293	B. WING		04/04	4/2019
ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
Continued From page	e 101	F 75	6		
for transfers, dressing, and toileting. There was no scheduled or prn pain medication. An interview was conducted on 4/2/19 at 10:45 am with the Resident 's family member who			committee.		
10 to 12 years ago and Anastrozole was started immediately afterwards. On 4/4/19 at 12:00 pm an interview was					
stated she had review medication and did no Anastrozole as an irre Consultant commente with Anastrozole but w required and was nor oncologist. The Cons Anastrozole did not h not know when the m Consultant stated that was on the Anastrozo would have recomme discontinue the medic	ved Resident #22's ot inform the physician of the egular medication. The ed that she was not familiar was aware a stop date was mally followed by an sultant stated that the ave a stop date and she did edication was started. The t if she knew the resident ole for 10 to 12 years she ended the physician cation. The consultant				
had severe osteopord fractures, including a facility, which would r recommended. The o was not aware of the class of drug but was was ordered by an or On 4/1/19 at 11:00 ar conducted with the re	bosis and pathological fracture of the arm in the make Anastrozole not consultant stated that she risk versus benefits for this aware that the medication ncologist. m an interview was esident who remembered				
	Continued From page for transfers, dressing no scheduled or pro- medication and did ne An interview was con am with the Resident provided the breast c 10 to 12 years ago ar immediately afterward On 4/4/19 at 12:00 pr conducted with the P stated she had review medication and did ne Anastrozole as an irre Consultant commente with Anastrozole but or oncologist. The Cons Anastrozole did not h not know when the m Consultant stated tha was on the Anastrozo would have recomme discontinue the medic commented that she had severe osteoporo fractures, including a facility, which would r recommended. The consultant 11:00 ar conducted with the re she has breast cance	OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345293         ROVIDER OR SUPPLIER         D PINES HEALTHCARE AND REHABILITATION CENTE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 101 for transfers, dressing, and toileting. There was no scheduled or prn pain medication.         An interview was conducted on 4/2/19 at 10:45 am with the Resident 's family member who provided the breast cancer history. Surgery was 10 to 12 years ago and Anastrozole was started immediately afterwards.         On 4/4/19 at 12:00 pm an interview was conducted with the Pharmacy Consultant who stated she had reviewed Resident #22's medication and did not inform the physician of the Anastrozole as an irregular medication. The Consultant commented that she was not familiar with Anastrozole but was aware a stop date was required and was normally followed by an oncologist. The Consultant stated that the Anastrozole did not have a stop date and she did not know when the medication was started. The Consultant stated that if she knew the resident was on the Anastrozole for 10 to 12 years she would have recommended the physician discontinue the medication. The consultant commented that she was not aware the resident had severe osteoporosis and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole not recommended. The consultant stated that she was not aware of the risk versus benefits for this class of drug but was aware that the medication was ordered by an oncologist.         On 4/1/19 at 11:00 am an interview was conducted with the resident who remembered she has breast cancer several years ago and	pF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIP         CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIP         A BUILDING       345293       B. WING         COVIDER OR SUPPLIER       DINES HEALTHCARE AND REHABILITATION CENTE       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 101       F 75         for transfers, dressing, and toileting. There was no scheduled or pm pain medication.       F 75         An interview was conducted on 4/2/19 at 10:45 am with the Resident 's family member who provided the breast cancer history. Surgery was 10 to 12 years ago and Anastrozole was started immediately afterwards.       F 75         On 4/4/19 at 12:00 pm an interview was conducted with the Pharmacy Consultant who stated she had reviewed Resident #22's medication and did not inform the physician of the Anastrozole but was aware a stop date was required and was normally followed by an oncologist. The Consultant stated that the Anastrozole did not have a stop date and she did not know when the medication was started. The Consultant stated that if she knew the resident was on the Anastrozole for 10 to 12 years she would have recommended the physician discontinue the medication. The consultant commented that she was not aware the resident had severe osteoproosis and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole not recommented. The consultant stated that she was not aware of the risk versus benefits for this class of drug but was aware that the medication was ordered by an onc	PERCIENCIES       (X1) PROVIDERSUPPLIENCLIA.       (X2) MULTIPLE CONSTRUCTION         A BUILDING	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COMPLET         345293       IN WING       COMPLET         DPINES HEALTHCARE AND REHABILITATION CENTE       STREET ADDRESS, CITY, STATE, ZP CODE       HIGHWAY 177 8 DOX 1489         MAMLET, NC 23345       STREET ADDRESS, CITY, STATE, ZP CODE       PROVIDER P NUM CORRECTION, TAGE       PRETX         REGULATORY OR LSC IDENTIFYING INFORMATION)       PRETX       PRETX       PRETX       PRETX         Continued From page 101       F 756       Assurance/Performance Improvement compliance date: May 1, 2019       Committee.         Continued From page 101       F 756       Assurance/Performance Improvement committee.       Corrective action compliance date: May 1, 2019         Conducted with the Resident 's family member who provided the breast cancer history. Surgery was 10 to 12 years ago and Anastrozole was started immedication. The Consultant stated that the was not familiar with Anastrozole but was aware a stop date and she did not know when the medication was started. The Consultant stated that the knew the resident was on taware of the risk versus benefits for this class of drug but was aware a stop date and she did not know whol make Anastrozole and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole and

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/09/2019 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING	B. WING			C / <b>04/2019</b>
	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 756	756 Continued From page 102 she was taking medication for breast cancer. On 4/2/19 at 9:45 am an interview was conducted		F	756	5		
	the resident had oster pathological fractures seen by an orthopedi familiar with Anastroz pharmacist to guide h The physician comme information was obtain timeframe administer history of pathological	physician who stated that oporosis with history of of the spine and had been st. The physician was not ole and expected the him with the administration. Ented after Anastrozole ned that because of the ed (10-12 years) and the I fractures, the medication or this resident and would					
F 757 SS=E	am with the Director of she expected the pha the resident 's medic physician and facility Drug Regimen is Free CFR(s): 483.45(d)(1)- §483.45(d) Unnecess	of irregular medication. e from Unnecessary Drugs -(6)	F	757	7		5/1/19
	unnecessary drugs. drug when used- §483.45(d)(1) In exce duplicate drug therap						
	§483.45(d)(2) For exe §483.45(d)(3) Withou	cessive duration; or t adequate monitoring; or					
	§483.45(d)(4) Withou use; or	t adequate indications for its					

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CENTER STATEMENT ( AND PLAN OF NAME OF PL	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345293	A. BUILDING	E CONSTRUCTION	PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 04/04/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	HAMLET, NC 28345 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 757	reduced or discontinu §483.45(d)(6) Any co stated in paragraphs section. This REQUIREMENT by: Based on record revi Consultant Pharmacis the facility failed to er receive unnecessary for 1 of 5 residents re medication. Findings included: Resident #22 was ad 5/15/18 with diagnose abnormalities of gait, and history of breast Resident #22 had a p Anastrozole 1 mg eac (hormone receptor ble chemotherapy). A review of Anastrozo revealed the medicati post-menopausal wo positive breast cance typical timeframe for a unless the cancer wa be determined by an years. Anastrozole c	eresence of adverse indicate the dose should be led; or mbinations of the reasons (d)(1) through (5) of this is not met as evidenced ew and resident, family, st, and physician interview, asure the resident did not medication (Resident #22) viewed for unnecessary mitted to the facility on es of unspecified age-related osteoporosis, cancer. hysician order for ch day dated 5/15/18 bocker used as a ele manufacturer information on was prescribed to men with hormone receptor r by an oncologist. The administration was 5 years s of a certain type and would oncologist to continue to 10 an cause osteoporosis and en pathological fracture is	F 757	F757 For residents affected by the issue: resident is scheduled for an appoint with their oncologist for May 6, 2019 to review whether t continue the medication. Other potentially affected residents: facility pharmacist completed 100% to identify other potentially unneces medications. The audit was comple 4/22/16. No other residents are on chemotherapeutic/ estrogen blockin medications. Measures implemented: The facility pharmacist will complete monthly ar identify unnecessary medications. Monitoring to maintain compliance: pharmacy consultant will report to the administrator and director of nursing findings of unnecessary medication Director of Nursing will communicate physician and discuss discontinuan identified medications. Director of n and pharmacy consultant will review auditing with the Quality Assurance/Performance Improvement committee. Corrective action compliance date: 2019	tment o The audit sary ted ng y udits to The he g any s. te with ce of ursing y ent

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING				04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	Set dated 1/8/19 reversion severely impaired cog	#22's annual Minimum Data aled the resident had a	F	757			
	she had breast cance surgery of her right bit that it was more than remember the date. she was taking medic An interview was con am with the Resident provided Resident #2 Surgery was 10 to 12 was started immediat had history of patholo The family believed th	n an interview was sident who remembered r several years ago and had reast. The resident stated 5 years ago but could not The resident was not aware tation for breast cancer. ducted on 4/2/19 at 10:45 s family member who 2's breast cancer history. years ago and Anastrozole ely afterwards. The resident ogical fractures of the spine. he resident was to remain on use the physician ordered					
	with Resident #22's p resident had osteopo pathological fractures seen by an orthopedi familiar with Anastroz medication the reside admission to the facil the pharmacist to guid administration. The p Anastrozole informati because of the timefr	of the spine and had been st. The physician was not ole and ordered all the nt was taking at home on ity. The physician expected de him with the Anastrozole ohysician commented after					

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/09/201 RM APPROVE IO. 0938-039
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		345293	B. WING		04	C 4/04/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757 F 761 SS=D	resident and would di routinely given for 5 y On 4/4/19 at 12:00 pr conducted with the P stated she had review medication and did no Anastrozole as an irro Consultant commente with Anastrozole but y required and was nor for 5 years, and follow Consultant stated that have a stop date and medication was started that if she knew the re Anastrozole for 10 to recommended the ph medication. The con- was not aware the re osteoporosis and pat a fracture of the arm Label/Store Drugs an CFR(s): 483.45(g) Labeling o Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the o \$483.45(h) Storage o \$483.45(h)(1) In accordance pation accordance of states and the states of the arm of applicable.	ot appropriate for this iscontinue. Anastrozole was years. m an interview was harmacy Consultant who yed Resident #22's ot inform the physician of the egular medication. The ed that she was not familiar was aware a stop date was mally ordered, administered wed by an oncologist. The it the Anastrozole did not she did not know when the ed. The Consultant stated esident was on the 12 years she would have hysician discontinue the sultant commented that she sident had severe hological fractures, including while in the facility. Id Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be e with currently accepted is, and include the y and cautionary	F 7			5/9/19

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
RICHMON	D PINES HEAT THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
	D FINES HEALINGARE			HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIN TO THE APPROPRIATE DATE CIENCY)
F 761	Continued From page	e 106	F 76	51	
		compartments under proper			
		, and permit only authorized			
		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			
	-	ution systems in which the			
		nimal and a missing dose can			
	be readily detected.	-			
	This REQUIREMENT	Γ is not met as evidenced			
	by:				
		ons and staff interviews, the		F761	
	-	multi dose medications		For residents affected I	-
		) for 3 of 4 medication carts		4/4/2019 the undated in	•
		ion storage (100, 200 and		were discard based on	pharmacy policy
	400 halls).			by the unit manager.	
	The findings includes	1.		Other potentially affect	
	The findings included	1.		licensed nurses, unit m	•
	Δ review of the facility	y policy titled Medication		facilitator completed a medication carts for ex	
		dated 11/1/17, read in part		4/4/2019. No other me	
		ation dates shall be observed		to be expired. All media	
		ny and all medications.		reviewed for appropriat	
	-	ndix for a summary of		opening and that they	0
	common medications	•		Measures implemented	-
		idelines. The appendix		were in-serviced on 4/1	18/19 through
	summary from Neil N	ledical Group indicated		4/29/19 on medication	storage policy
		ed to treat asthma and		including dating and lal	-
		ulmonary disease-COPD)		vials by the director of	
		30 days after opening,		in-service was added to	
		naler used to treat COPD)		new staff nurses on 4/1	18/19 by the staff
		6 weeks after opening the		facilitator.	
		a (an inhaler used to treat		Monitoring to maintain	-
		carded 6 weeks after		Weekly the unit manag	•
	opening the foil tray a	and Prostat ( a nutritional		medication storage aud	alt for 12 weeks

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/09/2019 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _				C / <b>04/2019</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	opening. 1) On 4/3/19 at 2:25p medication cart for 20 Unit Manager #2. Items *Incruse Ellipta 6 Resident #70 was op was present on t weeks after opening. *Advair 250/50m opened and undated *Incruse Ellipta 6 opened and undated box that reac opening. In an interview on 4/3 Manager #2 stated th dated when opened a cart. The Unit Manag the box stating it sho weeks after being op the responsibility of th medication to date th During an interview of Unit Manager #2, he medication carts nigh undated medications for all nurses to date when opening and di guidelines.	be discarded 3 months after om, an observation of the 20 hall was conducted with discovered included: 52.5 milligrams (mg) for bened and undated. A label the box that read to discard 6 and for Resident #70 was 52.5mg for Resident #87 was . A label was present on the d to discard 6 weeks after 8/19 at 2:25pm, Unit he inhalers should have been and were removed from the ter referred to the label on uid be discarded after 6 ened. He stated that it was he nurse that opened the e medication. on 4/4/19 at 1:40pm with the stated third shift checks the htly for any expired and , however the expectation is medications as appropriate scard per the manufacturer	F7	761	using the medication cart/medication room audit tool and report adverse findings to the director of nursing. The director of nursing will report compliant to the Quality Assurance/Performance Improvement committee. Corrective action compliance date: Me 2019	ice e	

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CENTERS FOR MEDICARE & MEDI	JMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) F	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
	345293	B. WING			C 04/04/2019	
NAME OF PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMOND PINES HEALTHCARE AND I	REHABILITATION CENTE			GHWAY 177 S BOX 1489		
			HA	MLET, NC 28345		
PREFIX (EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD AG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
<ul> <li>F 761 Continued From page 108 opened. She explained that opened the medication was and anyone who found the should contact the pharma 2. On 4/3/19 at 2:58 PM, the cart was observed. There Ellipta inhaler observed in drawers with no date of op the box of the Anoro Ellipta after opening foil tray".</li> <li>An interview was conducted Aide (Med Aide) #1 on 4/3/10 Med Aide stated that Anoro have been dated by the nut foil tray. The Med Aide had inhaler was not dated when the limit of the Assistant Di (ADON) and the night shift to be checking the medicated and undated multi dose mealso indicated that she exp medications including the i when opened and to follow the manufacturer's specific dates.</li> <li>3. On 4/3/19 at 2:49 PM, the cart was observed. There of Pro-Stat (protein supple) date of opening. The label Pro-Stat read to discard 3 means the pro-Stat read to discard 3 means the provide with Nurse #4 4/3/19 at 2:52 PM. Nurse 1000000000000000000000000000000000000</li></ul>	s responsible for dating medication undated cy and discard. he 400 hall medication was a used Anoro one of the medication ening. The label on a read "discard 6 weeks ed with the Medication (19 at 3:00 PM. The b Ellipta inhaler should urse who opened the d verified that the used n opened. tor of Nursing (DON) at 11:30 AM. The DON irector of Nursing nurses were supposed tion carts for expired edication. The DON bected the multi dose nhalers to be dated of the facility's policy and cation on expiration the 100 hall medication was an opened bottle ment), 1/4 full, with no on the bottle of months after opening.	F 7	761			

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		MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345293		B. WING		C 04/04/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC TE APPROPRIATE DATE	
F 761	Continued From page	e 109	F 76	51		
	should have been da					
		urse #4 had verified that the				
		Director of Nursing (DON) 4/19 at 11:30 AM. The DON				
		ant Director of Nursing				
		t shift nurses were supposed				
	•	edication carts for expired				
		se medication. The DON e expected the multi dose				
		Pro-Stat to be dated when				
	•	the facility's policy and the				
F 825	-	fication on expiration dates. alized Rehab Services	F 82	05	5/9/19	
SS=D	CFR(s): 483.65(a)(1)		1 02		3/9/19	
		rehabilitative services.				
	§483.65(a) Provision	of services. tative services such as but				
		I therapy, speech-language				
	pathology, occupation	nal therapy, respiratory				
		ative services for mental				
		al disability or services of a t forth at §483.120(c), are				
	-	nt's comprehensive plan of				
	care, the facility must	-				
	§483.65(a)(1) Provide	e the required services; or				
		ordance with §483.70(g),				
		ervices from an outside				
	resource that is a pro	vider of specialized s and is not excluded from				
		deral or state health care				
	programs pursuant to	section 1128 and 1156 of				
	the Act.	is not met as evidenced				
	This REQUIREMENT	is not met as evidenced				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE ICIENCY)
F 825	by: Based on record rev interview, the facility f physician's order for a evaluation for 1 of 4 r reviewed for position/ The findings included Resident #9 was adm 8/12/09 with diagnose The quarterly Minimu assessment dated 1/2 cognition was severe dependent on 2 or me transfers, dressing, a Resident #9 was dep on the unit, eating, to extensive assistance mobility. A physician's order da Nurse #7 indicated an (OT) evaluation for R clenching of her fists. An observation was co 3/31/19 at 6:05 PM. she was observed with ands. An interview was con Manager on 4/3/19 at that when a physiciar OT evaluation the nu- needed to complete a Electronic Medical Re	iew, observation, and staff failed to follow the an Occupational Therapy esidents (Resident #9) 'mobility. : : itted to the facility on es that included dementia. m Data Set (MDS) 2/19 indicated Resident #9's ly impaired. She was ore for assistance with nd personal hygiene. endent on 1 for locomotion ileting and she required the of 2 or more for bed ated 3/7/19 received by n Occupational Therapy esident #9 to address the conducted of Resident #9 on She was lying in bed and th clenched fists on both ducted with the Therapy to 12:15 PM. She reported n's order was written for an rse who received the order	F 8	F825 For residents affected affected resident was occupational therapy of 4/3/2019. The therapis resident and did not re- splinting due to the re- open and close hands Other potentially affect facility is auditing for t assure orders or refer care were implemented on 4/25/2019 by the u- negative findings were Measures implemente completed 100% audi days for therapy refer other issues were ide Monitoring to maintair orders are reviewed b for appropriate transcri- implementation on 5 r a week for 12 weeks u- chart audit tool. Any in transcription will be co- reported to the director director of nursing will to the Quality Assurar Improvement committ Corrective action com 2019	referred to for an evaluation on st assessed the ecommend any sidents ability to a fully on 4/3/2019. ted residents: The he past 30 days to rals for resident ed, Including therapy init managers. No e noted. ed: The facility t for the past 14 ral screenings. No ntified. n compliance: Daily by the unit managers ription and esidents for 5 times using the 24 hour haccurate prected and or of nursing. The report compliance ee.

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	G	C		
		345293	B. WING		04	/04/2019	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE		
F 825	evaluation for Reside Rehabilitation Directo then reviewed the EM revealed a referral for by the nurse. She sta to indicate an OT eva for Resident #9 after for A follow up interview for Therapy Manager on verified an OT evalua conducted for Reside physician's order. Sh Resident #9 today (4/ believed the hand cle had not required OT i A phone interview wa on 4/3/19 at 2:43 PM. Therapy Manager's in received the physician evaluation was suppor in the EMR to alert th new evaluation order. 3/7/19 for an OT eval reviewed with Nurse at that no referral was p this 3/7/19 order for F unable to explain why referral form in the EM received the 3/7/19 or An interview was con	<ul> <li>dated 3/7/19 for an OT</li> <li>nt #9 was reviewed with the</li> <li>r. The Therapy Manager</li> <li>IR for Resident #9 and</li> <li>m had not been completed</li> <li>ated that she had no record</li> <li>luation had been conducted</li> <li>the 3/7/19 physician's order.</li> <li>was conducted with the</li> <li>4/3/19 at 2:15 PM. She</li> <li>tion had not been</li> <li>nt #9 after the 3/7/19</li> <li>e reported she evaluated</li> <li>3/19) and indicated that she</li> <li>nching was a behavior and</li> <li>ntervention.</li> <li>s conducted with Nurse #7</li> <li>Nurse #7 confirmed the</li> <li>nterview that the nurse who</li> <li>n's order for an OT</li> <li>sed to enter a referral form</li> <li>e rehabilitation staff of the</li> <li>The physician's order dated</li> <li>uation for Resident #9 was</li> <li>#7. Nurse #7 was informed</li> <li>resent in the EMR related to</li> <li>Resident #9. Nurse #7 was</li> <li>y she had not completed a</li> <li>MR for Resident #9 after she</li> <li>rder for an OT evaluation.</li> </ul>	F 82				
F 842	evaluations to be follo Resident Records - Io	owed.	F 84	42		5/1/19	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/09/2019 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE		
		345293	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE				HGHWAY 177 S BOX 1489			
	1			ŀ	IAMLET, NC 28345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	112	F	842			
SS=B	CFR(s): 483.20(f)(5),	483.70(i)(1)-(5)					
	§483.20(f)(5) Resider (i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co- agrees not to use or co- except to the extent th to do so. §483.70(i) Medical re- §483.70(i)(1) In accor professional standard must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The faci all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitti with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p	At-identifiable information. Elease information that is the public. Lease information that is the public. Lease information that is the agent only in Intract under which the agent disclose the information the facility itself is permitted cords. dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance factivities, reporting of abuse, violence, health oversight administrative proceedings,					

Facility ID: 923021

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	MENT OF HEALTH AN				PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0
RICHMON	ND PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489 IAMLET, NC 28345	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 842	a serious threat to he by and in compliance §483.70(i)(3) The fact record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The me (i) Sufficient informatii (ii) A record of the res (iii) The comprehensity provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on record revi facility failed to mainta for 4 of 22 residents r #71, #80 and #67). 1) Resident #11 was 8/29/08 with diagnose paralysis, aphasia (pa	alth or safety as permitted with 45 CFR 164.512. ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and icted by the State; 's, and other licensed	F 842	F842 The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/1/2019 the splint for resident # ' was discontinued by director of nursir and removed from the medication administration record.	

Event ID: CYLY11

Facility ID: 923021

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/20 FORM APPROV OMB NO. 0938-03
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293			C 04/04/2019
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
				HIGHWAY 177 S BOX 1489	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 842	Continued From page	e 114	F 84	12	
-				was discontinued by direct	ctor of nursing
	The most recent Mini	imum Data Set (MDS) coded		and removed from the me	
		ment and dated 1/8/19		administration record.	
		nt with severe cognitive		From 4/1/2019 through 4/	/4/2019 the
		d to have limited range of		director of nursing (DON)	
	motion (ROM) to one	•		and unit managers search	
	required total assista			charts, nurse's station and	
Activities of Review of th	Activities of Daily Livi			records and were unable	to locate the
				missing page of the medie	cation
	Review of the Rehab	Communication to Nursing,		administration record. On	4/4/2019 the
	dated 3/13/19 indicat	ed the resident was to		director of nursing notified	d the medical
	receive Restorative N	Nursing for passive ROM		director of the medical rec	cord error, with
		his right shoulder, elbow		no new orders received.	
		t application to the right		On 4/3/2019 resident #28	
		hours a day, beginning on		set (MDS) assessment wa	
	3/15/19.			submitted to the national MDS nurse on 4/3/2019.	
		nt care plan showed a care		From 4/25/19 through 4/2	
		ssistance and risk for further		consultant completed an	
		ntions included PROM 7		assessments completed i	-
		ight arm and hand, apply		ensure coding accurate for	
	-	splint on for 4 hours per day		including injections with n	io negative
		ogram as well as monitor the		findings.	/10 the unit
	skin integrity under th	ie spillits dally.		From 4/25/19 through 5/1 managers completed an a	
	Review of the restore	ative nursing flow record		medication administration	
		19 revealed documentation		ensure present with no ne	
		ne 16 days for passive ROM,		On 4/5/2019 through 4/9/2	<b>u</b>
		l skin monitoring (3/20/19,		managers audited resider	
		6/19, 3/27/19, 3/29/19 and		orders to ensure the device	•
	4/1/19).			and documented as order findings.	-
	On 3/31/19 at 3:05pn	n Resident #11 was		On 4/18/19 the director of	f nursing initiated
		is bed. He was not wearing		an in-service with nursing	
		at arm or hand and no splints		following physician orders	
	were observed in his			splints, medications as or	-
				records must be complete	
	On 4/2/19 at 8:45am	the resident was observed		medication administration	-
		no splints present to his right		was added to the orientat	

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			()(0)			NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		OATE SURVEY
					С	
		345293	B. WING			04/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG			PREFIX	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIOI DATE
F 842	Continued From page	e 115	F 84	2		
	arm or hand.			nursing staff by the st	taff facilitator on	
				4/18/19.		
		Resident #11 was observed		On 4/17/19 and 4/18/		
	lying in his bed with n arm or hand.	no splints present to his right		were in-services by th reimbursement audito		
				of the MDS assessme	•	
	An interview occurred	d with Nurse Aide #6 on		resident assessment		
	4/2/19 at 9:50am. Sh	ne indicated that she was		manual. This in-servio		
		aide and normally applied		any new MDS nurse I	-	
	-	ath. She stated that she was		The monitoring proce		
		ne passive ROM exercises be worn for 4 hours a day		the plan of correction specific deficiency cite		
	· ·	he passive ROM or the		and/or in compliance		
		nt because she didn't have		requirements	,	
		n in the Electronic Medical				
	Record System (EMF	२).		Auditing will be comp		
	On 4/2/19 at 10:15an	n an interview was		week on 5 residents t set nurse, the director		
		irector of Nursing (DON).		facilitator and/or unit	0.	
	She stated in Februa			activities of daily living		
		tion and removal of splints to		data set audit tool and	d intervention audit	
		further explained that on		tool weekly for 12 we		
		ervice with all the aides		correctness of the me		
		ations for splints. The DON aides had access to the		including MDS accura medication administra		
		s in the EMR system and		splint application. The		
		d not verify splints were		will report compliance		
		ered unless they were		Assurance/Performar	nce Improvement	
	documented.			committee.		
	On 1/2/10 at 10:20	a an intonviou was		The monthly QI comm		
	On 4/2/19 at 10:30an conducted with the T	herapy Manager. She		results of the F842 au months for identificati		
		11 was evaluated and		taken, and to determi		
		nal Therapy from 2/12/19 to		and/or frequency of c		
		re of the right elbow and		and make recommen		
		ed to the nursing restorative		monitoring for continu	-	
		She further stated she ne staff on how to correctly		administrator and/or I findings and recommo	-	
		xercises and apply the		monthly QI committee		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 04/04/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, Z HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 842	splints and monitored ensure the technique Nurse Aide #6 was of exercises and applica #11's right elbow and An interview occurred 4/4/19 at 2:00pm. Sh shift restorative cham any questions regard program. She stated responsible for apply had access to the sed documentation. On 4/4/19 at 2:15pm resting in his bed with on. On 4/4/19 at 3:20pm DON, she stated her to document when sp 2) Resident #71 was 10/10/18 with diagnos injury, traumatic hem diabetes mellitus and The most recent MDS assessment and date #71 with severe cogn extensive to total ass was noted with limited extremity. Review of the active of	I them for a few days to s were performed correctly. Deserved performing PROM ation of splints to Resident hand on 4/2/19 at 10:40am. If with Nurse Aide #7 on the indicated she was the first upion for staff to come to with ing the restorative nursing the floor aides were ing the splints and they all ction on the EMR for Resident #11 was observed in right arm and hand splint during an interview with the expectation was for the staff blints were applied. admitted to the facility on ses that included intracranial orrhage of cerebrum, gout. S coded as a quarterly ed 3/1/19 assessed Resident itive deficits and he required istance with all ADL's. He	F 84	42 executive QA committee recommendations and o The title of the person re implementing the accep correction. The Director of nursing i implementing the accep correction. Corrective action compli 2019	oversight. esponsible for table plan of is responsible for table plan of

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345293	B. WING _			C 04/04/2019	
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG			ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 117	F	342			
	Review of the monthly Medication Administration Records (MAR) for January 2019, February 2019 and March 2019 revealed, to remove bilateral foot drop splints on 3-11 shift.						
		n 2019 physician orders bilateral foot drop splints on gn off on MAR.					
		the resident was observed oot drop splints present.					
	with Nurse #6. She s	an interview was conducted stated that she was familiar has never taken foot drop					
	On 4/2/19 at 4:30pm an interview occurred with Unit Manager #1. She explained that the resident was part of the evacuees taken in from the Hurricane in September 2018 and did not recall him having foot drop splints.						
	Resident #71 was pa from the Hurricane in not recall him having	9 at 10:25am. He explained rt of the evacuees taken in September 2018 and did foot drop splints. He was information or orders stating					
	On 4/3/19 at 10:40an observed lying in his foot drop splints on.	n Resident #71 was bed, watching TV without					
	Nurse Aide #7. She ir	n an interview occurred with ndicated she has not applied wearing bilateral foot drop					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345293	B. WING		04/04/2019		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 842	on 4/3/19 at 11:15am had been screened at therapy after admission were not recommend. Nurse #5 was identified the bilateral foot drop interviewed via phone indicated that she nor and was familiar with previous and current she knew he had som when at the previous were heel protectors. She further stated that evacuated to this facil to the hurricane in Se have his full medical in foot drop splint becaut type of device to his facil to the hurricane in Se have his full medical in foot drop splint becaut type of device to his facilit clarify whether they w protectors. Nurse #5 carrying over the rem from MAR to MAR at never questioned whe why there was no me drop splints. Nurse #5 splints should not hav without an order or re During an interview w on 4/3/19 at 11:30 should he	I with the therapy manager . She stated the resident ind evaluated by physical on, but foot drop splints ed or ordered. ed as the nurse that initiated splint on the MARs and was a on 4/3/19 at 11:20am. She mally worked the 3rd shift the resident both at his facility. She explained that he type of device on his feet facility and thought they at when the resident was lity (due to flooding related ptember 2018) he did not record and she added the ise she knew he wore some eet. She was unable to vere splints or heel stated that she kept oval of the foot drop splints the end of the month but ether he used any splints or ntion of applying the foot 5 stated that the foot drop ve been placed on the MAR	F 84				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/09/2019 APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		345293	B. WING					04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE					IIGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 842	On 4/4/19 at 8:05am a with the Staff Develop who was the nurse th on the January 2019 she completed the M/ wrote in to remove the on the 3-11 shift as it She further explained working at the facility a bit overwhelmed at The SDC stated that a why there was no me and investigated furth they resident wore the On 4/4/19 at 3:20pm expectation for the me 3. Resident #80 was a 12/7/17 and was read multiple diagnoses in admission Minimum E dated 2/28/19 indicate impaired cognition an antidepressant and hy days during the asses Review of Resident # revealed that on 12/4, order for Risperdal (a milligrams (mgs) by m Risperdal 25 mgs sub weeks for dementia w there was an order to 12.5 mgs SQ every 2 Review of Resident #	an interview was conducted oment Coordinator (SDC) at completed the first check MAR. She stated that when AR check on 12/26/18 she e bilateral foot drop splints was on the December MAR. that she had started on 11/26/18 and was feeling the time of the MAR check. she should have questioned ntion of applying the splints er for an order or to see if em. the DON stated it was her edical record to be accurate. admitted to the facility on lmitted on 2/21/19 with cluding dementia. The Data Set (MDS) assessment ed that Resident #80 had d had received antianxiety, ypnotic medication for 7 asment period. 80's doctor's orders /18, Resident #80 had an ntipsychotic drug) 2 nouth twice a day and ocutaneously (SQ) every 2 vith behaviors. On 2/13/19, decrease the Risperdal to	F	842				

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 05/09/2019 FORM APPROVED MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345293	B. WING _				C 04/04/2019		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		HIGH	EET ADDRESS, CITY, STATE, ZIP CODE IWAY 177 S BOX 1489 ILET, NC 28345	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842	Resident #80's Media Records (MARs) for I reviewed. The MARs Risperdal was admin February 1-18, 2019. An interview with the conducted on 4/2/19 Records staff stated f February 2019 MARs missing and she coul indicated that at the e MARs were left in a b review. After the pha with the MARs was g managers to be filed record. The Medical times the book was n she was behind with that she didn't know f were missing. Interview with the Un conducted on 4/2/19 that Risperdal was ad prior to his discharge The UM was unable f that Risperdal was ad from February 1-18, 2 Interview with the Dir 4/3/19 at 8:50 AM was stated that Resident a Risperdal prior to his 2/18/19. The DON si Resident 80's Februar and the Medical Reco	cation Administration February 2019 were a did not indicate that istered to Resident #80 from Medical Records staff was at 4:31 PM. The Medical that 2-3 pages of the s for Resident #80 were d not find them. She end of each month, the book for the pharmacist to irmacist review, the book iven to her by the unit in the resident's medical Record staff reported that at ot given to her timely and so her filing. She also added now and why those MARs it Manager (UM) #1 was at 4:33 PM, The UM stated dministered to Resident #80 to the hospital on 2/18/19. to find the MARs to indicate dministered to Resident #80 2019. ector of Nursing (DON) on is conducted. The DON	F	342					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345293		345293	B. WING _			C 04/04/2019	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	accurate. 4. Resident #67 was a 10/1/18 with diagnose Mellitus (DM). A physician's order da discontinuation of Tru Resident #67. A physician's order da discontinuation Lever (insulin), and Glucotro Resident #67. The quarterly Minimul assessment dated 2/2 #67's cognition was in the active diagnosis of A nursing note dated Nurse #1 indicated Ref following medications Novolog, Glucotrol, al An interview was com- on 4/1/19 at 4:00 PM. that indicated Residen Novolog, Glucotrol, al with MDS Nurse #1. indicated Trulicity was and Levemir, Novolog discontinued on 1/24/ Nurse #1. She indicat her records to see wh note. A follow up interview was Nurse #1 on 4/1/19 at	admitted to the facility on as that included Diabetes ated 12/13/18 indicated the licity (DM medication) for ated 1/24/19 indicated the nir (insulin), Novolog of (DM medication) for m Data Set (MDS) 22/19 indicated Resident ntact. He was coded with f DM. 2/22/19 completed by MDS esident #28 received the related to DM: Levemir, nd Trulicity. ducted with MDS Nurse #1 The 2/22/19 nursing note nt #67 received Levemir, nd Trulicity was reviewed The physician s orders that a discontinued on 12/13/18 g, and Glucotrol were 19 were reviewed with MDS ted she needed to review y she wrote the 2/22/19 was conducted with MDS a 4:20 PM. She revealed	F	342			
	on 4/1/19 at 4:00 PM. that indicated Resider Novolog, Glucotrol, ar with MDS Nurse #1. indicated Trulicity was and Levemir, Novolog discontinued on 1/24/ Nurse #1. She indica her records to see wh note. A follow up interview Nurse #1 on 4/1/19 at	The 2/22/19 nursing note ht #67 received Levemir, hd Trulicity was reviewed The physician s orders that a discontinued on 12/13/18 g, and Glucotrol were 19 were reviewed with MDS ted she needed to review y she wrote the 2/22/19 was conducted with MDS					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/0 FORM APP OMB NO. 093	ROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/04/2019	
	345293		B. WING			
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	н	IREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	AMLET, NC 28345 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COM	(X5) PLETIO DATE
F 842	for Resident #67 was she had copied and p previous note into he verifying its accuracy An interview was con Nursing on 4/4/19 at	inaccurate. She reported basted the information from a r 2/22/19 note without	F 842			
F 865 SS=E	QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2) §483.75(a) Quality as improvement (QAPI) §483.75(a)(2) Presen	ssurance and performance program. It its QAPI plan to the State er than 1 year after the	F 865		5/1/1	9
	except in so far as su	ary may not require ords of such committee ich disclosure is related to ch committee with the				
	and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observatio interviews and record Quality Assessment a (QAA) failed to maint and monitor intervent	by the committee to identify ficiencies will not be used as		F 865 Quality Assurance/Performance Improvement Program/Plan The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/29/19 the facility Quality	æ	

Event ID: CYLY11

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/09/201 M APPROVE D. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345293	B. WING			C / <b>04/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 865	Continued From page	e 123	F 86	5			
F 003	dated 10/18/18. This deficiencies in the are F561- not providing s Accuracy of Assessm Minimum Data Set (M Provided Meet Profes not administering psy ordered; Activities of Provided for Depende providing nail care to Nutrition/Hydration Si not implementing intel loss and Label/Store not dating multi- dose previously cited on 10 failure of the facility d record showed a patt sustain an effective G The findings included This citation is cross 1a. F561- Based on r interview, and staff in provide showers as s (Resident #74) review During the recertificat facility was cited for fa scheduled for 1 of 2 r choices (Resident #5	was for six recited eas of Self Determination at howers as scheduled; eents at F641- not coding the MDS) accurately; Services asional Standards at F658- rechotropic medications as Daily Living (ADL) Care ent Residents at F677- not a dependent resident; tatus Maintenance at F692- erventions to prevent weight Drugs & Biologicals at F761- e medications which were D/18/18. The continued uring two federal surveys of ern of the facility's inability to DAA program. I: referenced to: record review, resident terview, the facility failed to cheduled for 1 of 2 residents ved for choices. tion survey of 10/18/18 the ailing to provide showers as residents reviewed for 4).	F 86	Assurance/Performance Improv (QAPI) Committee held a meeti review the purpose and function QAPI committee and review on- compliance issues. The Medica Administrator, Director of Nursin Minimum Data Set (MDS) nurse Manager, maintenance director records, and housekeeping sup attend QAPI Committee Meeting ongoing basis and will assign at team members as appropriate. On 4/29/19 the corporate facility consultant in-serviced the facilit administrator, director of nursing nurse, admissions, activities din maintenance director, dietary m medical records, therapy directo housekeeping supervisor relate appropriate functioning of the Q Committee and the purpose of t committee to include identify iss correct repeat deficiencies relatt F641, F658, F677, F692, and F As of 4/29/19 after the facility con in-service, the facility QAPI Com begin identifying other areas of concern through the QAPI revie process, for example: review of tools, review of work orders, rev Point Click Care (Electronic Mer Record), review of resident cour minutes, review of resident cour	ing to n of the -going I Director, ng, e, Dietary r, medical pervisor will gs on an dditional y y g, MDS ector, hanager, or, and d to the API the sues and red F561, 761. onsultant nmittee will quality w riew of dical ncil cern logs,		
	resident interview, an failed to code the Min assessment accurate medications (Resider	ecord review, observation, ad staff interview, the facility nimum Data Set (MDS) ely in the areas of nts #28, #67, and #75), falls ties of daily living (Resident		review of pharmacy reports, rev audits related to the plan of com review of regional facility consult recommendations. The Facility QAPI Committee w a minimum of monthly and Exec	view of rection and Itant ill meet at		

Facility ID: 923021

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	ECONSTRUCTION	· /	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		345293	B. WING			C / <b>04/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	04/2013
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 865	Continued From page	e 124	F 865			
	<ul> <li>F 865 Continued From page 124 #28), tracheostomy care (Resident #34), active diagnoses (Resident #22), tube feeding (Resident #52), and pain (Resident #51) for 7 of 22 sampled residents.</li> <li>During the recertification survey of 10/18/18 the facility was cited for failing to code the Minimum Data Set (MDS) assessments accurately in the areas of hospice care (Resident #44), medications (Resident # 280), diagnoses (Residents #280 &amp; #11) and nutrition (Resident #30) for 4 of 20 sampled residents whose MDS assessments were reviewed.</li> <li>1c. F658- Based on record reviews, observations and staff interviews, the facility failed to accurately transcribe physician orders for an antianxiety medication ordered by the physician for 1 of 6 resident #53).</li> <li>During the recertification survey of 10/18/18 the facility was cited for failing facility to administer</li> </ul>			QAPI committee meeting a minin quarterly to identify issues related quality assessment and assurand activities as needed and will deve implementing appropriate plans of for identified facility concerns. Corrective action has been taken identified concerns related to rep deficiencies.	d to ce elop and of action for the	
	residents reviewed for (Resident #8). 1d. F677- Based on r resident interview, an failed to provide assis required extensive to bathing, showers, per care for 4 of 6 residen	f daily living (ADL) care				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345293	B. WING			04/	04/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY	, STATE, ZIP CODE		
DICUMON		AND DELLABILITATION CENTE		HIGHWAY 177 S BOX 14	189		
	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	care for one of two de for Activities of Daily I 1e. F692- Based on r and staff and family in provide physician ord weight loss (Resident residents reviewed for During the recertificat facility was cited for fa- interventions as orde loss for 1 of 3 sample nutrition (Resident # 1f. F761- Based on o interviews, the facility medications (inhalers medication carts revie (100, 200 and 400 ha During the recertificat facility was cited for fa- medications and to da in 2 of 2 medications			55			
	Administrator on 4/4/ the repeat citations co trying to change and too fast as well as the He added that as of r	ns were reviewed with the 19 at 2:55pm. He stated that ould be related to the facility implement new procedures e rapid turnover in the staff. ecently, the Medical Director yed with the monthly Quality					

Facility ID: 923021

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