	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED		
		345293	B. WING		0	5/12/2022	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
F 000	was found in complia	bugh 5/12/22. The facility nce with the requirement ncy Preparedness. Event	F 000				
		complaint investigation d from 5/9/22 to 5/12/22.					
	2 of the 7 complaint a substantiated resultin						
	NC00185587, NC001 NC00188719	87867, NC00188534,					
F 550	5/31/22 at tag F677.	iciencies was amended on	F 550			6/9/22	
SS=D			1 000			0/3/22	
	self-determination, ar access to persons an	ght to a dignified existence, nd communication with and					
	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					
	 DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 06/02/202	

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.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345293	B. WING		05/12/2022
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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 550	§483.10(a)(2) The fact access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless §483.10(b) Exercise of The resident has the rights as a resident o or resident of the Uni §483.10(b)(1) The fact resident can exercise interference, coercion from the facility. §483.10(b)(2) The re- free of interference, or reprisal from the facil rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on record rev and staff interviews, to dignity by not providin urinary drainage bag for dignity (Resident a The findings included Resident #34 was ad 9/28/21 with diagnosi urine.	cility must provide equal e regardless of diagnosis, or payment source. A facility iaintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen ted States. cility must ensure that the e his or her rights without n, discrimination, or reprisal sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this the facility failed to promote iew, observations, resident the facility failed to promote ng a privacy cover over a for 1 of 1 residents reviewed #34).	F 55	50 Richmond Pines Nursing and Rehabilitation Center acknowled receipt of the Statement of Defic and proposes this Plan of Corre the extent that the summary of f factually correct and to maintain compliance with applicable rules provisions of quality of care of re The Plan of Correction is submi written allegation of compliance Richmond Pines Nursing and Rehabilitation Center s respons Statement of Deficiencies does	ciencies ction to indings is s and esidents. tted as a e to this

Facility ID: 923021

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		IO. 0938-03 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G		COMPLETED	
		345293	B. WING		0	C 5/12/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETIO	
F 550	Continued From pag	e 2	F 5	50			
		/1/22 indicated Resident #34		denote agreement with the S	statement of		
		t. He required extensive		Deficiencies nor does it cons			
		for toileting needs and had		admission that any deficienc			
	an indwelling urinary	catheter.		Further, Richmond Pines Nu	-		
				Rehabilitation Center reserve	-		
	During an interview a			refute any of the deficiencies			
		0/22 at 10:22 AM, he was		Statement of Deficiencies thr	•		
		welling urinary catheter with ached to the right side of the		Informal Dispute Resolution, appeal procedure and/or any			
		ag did not have a privacy		administrative or legal proces			
		w urine in the drainage bag			cungo		
		om the hallway. Resident		On 5/9/22, during a recertific	ation and		
		the bag was visible from the		complaint survey at Richmor			
	hallway and to others	s and would prefer for it to be		Healthcare and Rehabilitation	n Center, the		
	covered.			survey team observed Resid			
				not have privacy/dignity bag	on his urinary		
		<i>I</i> , an observation was made		drainage bag.			
		the urinary drainage bag					
	attached to the right	side of the bed. The have a privacy cover, had		Resident #34 continues to re facility and continues to requ			
		ag, and could be seen from		a urinary drainage bag.	lie lie use of		
	the hallway.			On 5/29/22, Resident #34 wa	as asked by		
	and hairray.			nursing staff if he would like	•		
	An observation occu	rred of Resident #34 while he		privacy/dignity bag for urinar			
		5/10/22 at 11:09 AM. The		bag. Resident #34 stated he			
		was clipped to the right side		dignity/privacy bag. Nursing			
		privacy cover, and visible		dignity/privacy bag to Reside			
		n dark yellow urine in the		urinary drainage bag. This ta			
	drainage bag.			continue as Resident #34 all	ows.		
	On 5/11/22 at 10:28	AM, Resident #34 was		Root Cause: Resident #34 h	ad stated		
		in bed. The urinary drainage		upon admission, he did not v			
		urine, remained without a		dignity/privacy bag on his uri			
	privacy cover and wa	as visible from the doorway.		bag so he could observe his			
				Nursing staff did not docume			
		d with Nurse #1 on 5/11/22 at		plan this preference. Nursing			
		I all residents with urinary		revisit Resident #34 regardin	-		
	drainage bags. She	e a privacy cover on the		dignity/privacy bag on his uri	nary drainage		

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/09/2022 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345293	B. WING		05	C 5/12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 550	recently been to the E be the reason why he on the drainage bag. would make sure one #34. During an interview w Director of Nursing or both indicated it was staff to use a privacy	Emergency Room and could e didn't have a privacy cover Nurse #1 indicated she e was provided for Resident with the Administrator and n 5/12/22 at 1:14 PM, they their expectation for nursing cover for urinary drainage to state why Resident #34's	F 5	 All residents who have a drainage bag have the praffected by this alleged of To correct the deficient presidents will be included audits to ensure their right and care plans reflect the practice. On 5/17/22 through 5/20, of Nursing (DON), Assist Nursing (ADON), Staff D Coordinator (SDC) and a project department head completed 100% audit of urinary drainage bag beild dignity with a dignity/priveresident requesting not to privacy/dignity bag for urbag was documented an reflect this preference. The Staff Development C (SDC), Director of Nursing Cincal Nurse C begin education on 6/1/2 urinary drainage bag beild dignity with a dignity/priveresident completed 100% audit of urinary drainage bag beild dignity with a dignity/priveresident requesting not to privacy/dignity bag for urbag was documented an reflect this preference. The Staff Development C (SDC), Director of Nursing Assistant Director of Nursing Assistant Director of Nursing Assistant Director of Nursing Assistant Director of Nursing C begin education on 6/1/2 urinary drainage bag beild dignity with a dignity/prive education will be comple On 6/1/22, the SDC added to the new hire packet ar agency/contract staff pace On 6/9/22, the Staff Development equivalent and the completed an agency/Facili that had not completed ensuring resident urinary frame and the additional will mail educ Contracted Agency/Facili that had not completed ensuring resident urinary frame and the additional will be completed to the new hire packet an agency/Facili that had not completed ensuring resident urinary frame and additional will be completed to the new hire packet and agency/Facili that had not completed ensuring resident urinary frame and additional will be completed to the new hire packet and agency/Facili that had not completed ensuring resident urinary frame and additional will be completed and additional will be completed to the new hire packet and agency/Facili that had not completed ensuring resident urinary frame and additional will be	otential to be deficient practice. ractice, these d in the prescribed hts, preferences e corrective /22 the Director tant Director of evelopment assigned special began & f residents with ng covered for acy bag. Any o have a inary drainage d care planned to Coordinator ng (DON), sing (ADON), and Consultant will 22 on ensuring ng covered for acy bag. This ted on 6/8/22. ed this education nd cket. elopment ccation to any ity Nursing Staff education of	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/09/2022 MAPPROVED O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY IPLETED C
		345293	B. WING			05/12/2022	
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 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 550	Continued From page	≥ 4	F	550	 being covered for dignity with a dignity/privacy bag. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring resident urinary drainage bag being covered for dignity with a dignity/privacy bag. Beginning 6/9/22, the Director of Nurs Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) assigned special project department h will complete monitoring to ensure compliance of ensuring resident rights/exercise rights: urinary drainage bag being covered for dignity with a dignity/privacy bag. The Director of Nursing, the Unit Manager(s), and/or t assigned special project department h will observe six random residents 5x/v x 4 weeks, then 3x/week x 4 weeks, the 2x/week x 4 weeks to ensure compliar that resident rights/exercise rights: urin drainage bag being covered for dignity with a dignity/privacy bag Beginning 6/15/22 the Director of Nurs Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or assigned special project department for a dignity/privacy bag Beginning 6/15/22 the Director of Nurs Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or assigned special project department head will report the finding the monitoring that resident rights/exercise rights: urinary drainage bag being covered for dignity with a dignity/privacy bag to the members of Cardinal Intradisciplinary Team once weekly x3 months to ensure compliant 	ing, and ead he ead veek hen nce nary v sing, ys of the	

Event ID: J4MM11

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	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		ATE SURVEY DMPLETED
		345293	B. WING			05/12/2022
	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 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 550	Continued From page	e 5	F 55	50 and review for further recon and/or follow up as needed compliance.		
F 558 SS=D		odations Needs/Preferences	F 55	Date of completion 06/09/2	2022.	6/9/22
	services in the facility accommodation of re preferences except w endanger the health of other residents. This REQUIREMENT by: Based on observation interviews and record ensure an adaptive of resident's access. Th (Resident #38) review needs. The findings included Resident #38 was ad recently readmitted of contractures. Review of Resident # 9/17/21 read due to the	sident needs and /hen to do so would or safety of the resident or is not met as evidenced ms, staff and resident review, the facility failed to all light was positioned within is was for 1 of 1 resident ved for accommodation of !: mitted on 11/28/17and most n 11/4/21 with a diagnosis of 438's revised care plan dated he inability to use a regular actures, he required a soft		On 5/9/22, during a recerticomplaint survey at Richm Healthcare and Rehabilitat survey team observed Rest not have his alternative cal touch pad) within his reach Resident #38 continues to facility and continues to reac of an alternative call light. On 5/12/22 Resident #38 c attached to his gown (chest was within reach. Root Cause: Resident #38 clipped to an area outside while staff were performing	ond Pines ion Center, the ident #38 did I light (soft reside at the quire the uses call light was st area) and call light was of his reach	
		d ensuring the call light was		forgot to move the call light his reach before exiting Re room.	t back to within	

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 06/09/202 1 APPROVEI 0. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		05/) 12/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489	•	-
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	1	HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 558	was coded with impa (ROM) to his bilateral extremities. An interview and obs with Resident #38 on bilateral hand contract contracture. His adapt clipped to the right up He stated he could not the time, so he had to something. Resident arm and hand in an er but stated his arm wat often forgot to ask the was accessible becauter reach so much, he react An observation was con 10:51 AM of Residen light was observed cl of his fitted sheet. An interview was con AM with Nursing Assist was assigned Resider 5/10/22. She stated he light because of his co was uncertain if he ye his adaptive call light only happened on occ An interview was con PM with the ADON. So required an adaptive contractures and the	was cognitively intact and irment of range of motion I upper and lower ervation were completed 5/9/22 at 12:26 PM. He had ctures and a left elbow otive call light was observed oper top of his fitted sheet. of get to his call light most of o yell out when he needed #38 attempted to lift his right affort of reach the call light use it had been out of his sorted to yelling. completed on 5/10/22 at t #38's. His adaptive call ipped to the right upper top ducted on 5/11/22 at 8:20 stant (NA) #6 stated she ent #38 on 5/9/22 and he used a special soft call ontractures. She stated she elled out for assistance when was not in reach because it casion. pleted on 5/10/22 at 12:20 She stated Resident #38 call light due to his hand contracture of his left elbow.	F 558	 All residents have the potential to be affected by this alleged deficient prand will be included in the corrective audits utilized for the deficient prace. On 5/17/22 through 5/20/22 the Dirof Nursing (DON), Assistant Directed Nursing (ADON), Staff Development Coordinator (SDC) and assigned seproject department head began & completed 100% audit of residents lights being within reach. Any noted concerns of resident call lights out reach were corrected during this audit the Director of Nursing (DON), Assistant Director of Nursing (DON), Staff Development Coordinator (SDC) and assigned special project department head. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (DON), Assistant Director of Nursing (DON), Assistant Director of Nursing (ADO Regional Clinical Nurse Consultant begin education 6/1/22 on ensuring resident call lights are within resider reach. This education will be comp on 6/8/22. On 6/1/22, the Housekeeping Super placed clips on all resident call light for proper placement and ease of u each resident. On 6/1/22, the SDC added this edut to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator is a contracted Agency/Facility Nursing 	actice re tice. rector or of nt pecial call d of udit by istant nd nt r N), and will g ent leted ervisor t cords use by ucation	
	An observation was o	completed on 5/12/22 at		that had not completed education of		

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Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/09/2022 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING _				5/12/2022
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		HI	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 177 S BOX 1489 AMLET, NC 28345	1 -	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	10:05 AM of Residen clipped to the upper r He stated he was una asked anyone to mov An observation and in 5/12/22 at 10:40 AM present in the room. to the upper right side questioned about Re- light placement, NA # reach his call light wh the call light and clipp gown within his reach call light should alway An interview was con Administrator and the on 5/12/22 at 1:15 PM	t #38. His call light was ight side of his pillow case. able to reach it and had not ve it within his reach. hterview were completed on of Resident #38 with NA #8 His call light was still clipped e of his pillow case. When sident #38's adaptive call 48 stated he was unable to here it was, and she moved bed it to the chest area of his h. She stated Resident #38's ys be within his reach. hpleted with the e Director of Nursing (DON) M. The DON stated she 38's adaptive call light	F 5	558	ensuring resident call lights are within reach. After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring resident call lights are within reach. Beginning 6/9/22 the Director of Nurs Assistant Director of Nursing (ADON Staff Development Coordinator (SDC assigned special project department will complete monitoring to ensure compliance of ensuring residents rec services in the facility within reasonal accommodation for resident needs: ensure call lights are within resident reach. The Director of Nursing, the U Manager(s), and/or the assigned spe project department head will observe random residents 5x/week x 4 weeks then 3x/week x4weeks, then 2x/week weeks to ensure compliance that residents receive services in the facil within reasonable accommodation fo resident needs: ensure call lights are within resident reach. Beginning 6/15/22 the DON or ADON report the findings of the monitoring to resident needs: ensure call lights are within reasonable accommodation fo resident needs: ensure call lights are within resonable accommodation fo resident needs: ensure call lights are within resonable accommodation fo resident needs: ensure call lights are within resident reach to the members the Cardinal Intradisciplinary Team of weekly x3 months to ensure compliant and review for further recommendation and review for further recommendation and/or follow up as needed for contin	n sing,), 2) and head eive ble nit cial six six six six six r l will hat ity r	

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		MEDICAID SERVICES				938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUF COMPLET	
		345293	B. WING		C 05/12/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	(X5) OMPLETIO DATE
F 558	Continued From pag	e 8	F 55	8 compliance.		
				Beginning the month of July 2022 a continuing for 3 months, the DON of ADON will report the findings of the monitoring that residents receive se in the facility within reasonable accommodation for resident needs ensure call lights are within resident monthly Quality Improvement (QI) Committee meeting. The QI Comm will review for further recommendat for follow up as needed or continue compliance to determine the need frequency of the continued QI mon to ensure compliance is maintained	or ervices t reach ittee idons and/or toring	
F 641 SS=E	§483.20(g) Accuracy The assessment mu resident's status.	v of Assessments. st accurately reflect the	F 64	Date of completion 06/09/2022.	6/9	9/22
	by: Based on record rev interviews, the facilit Data Set (MDS) asso areas of restraints an #50, #59 and #67), b #78) and discharge of This was for 6 of 24 The findings included	T is not met as evidenced views, observations and staff y failed to code the Minimum essment accurately in the nd alarms (Residents #25, oladder and bowel (Resident disposition (Resident #89). resident records reviewed. d:		On 5/10/22, during a recertification complaint survey at Richmond Pine Healthcare and Rehabilitation Cent survey team observed Resident #2 Resident #50, Resident #59, and R #67, Minimum Data Set (MDS) Assessment was coded incorrectly most recent MDS assessment to re wander guard alarm. In addition, Resident #78 MDS assessment wa incorrectly coded for bladder and b	es er, the 5, esident on the flect a s	

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						NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	TE SURVEY MPLETED
		345293	B. WING		C 05/12/2022	
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 DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	je 9	F 64	1		
	12/17/20 with diagno with behavioral distu	oses that included dementia Irbance.		incontinence and Resident #89 assessment was incorrectly co discharge disposition.		
	hallways frequently whistory of wandering	progress note dated ident #25 ambulated in the with a walker. She has a and forgetfulness per family. t bracelet was applied to her		 Resident #25 continues to the facility with the use of a wa bracelet. Resident # 50 continues to the facility with the use of a wa bracelet. 	nder guard o reside in	
	The quarterly MDS assessment dated 2/2 indicated Resident #25 was able to under others and make herself understood. She independent with ambulation and was not for a wander/elopement alarm.	25 was able to understand rself understood. She was nbulation and was not coded		 Resident #59 continues to the facility with the use of a wa bracelet. Resident #67 continues to the facility with the use of a wa bracelet. 	nder guard reside in	
	5/10/22 at 2:25 PM, with her walker. A wa her ankle.	rrred of Resident #25 on ambulating in the hallways ander alarm was present to		 5. Resident #78 continues to the facility and remains inconti bladder and bowel. 6. Resident #89 no longer re facility. 	nent of	
	with the MDS Nurse assessment dated 2 wander/elopement a stated it was an over an alarm bracelet on An interview occurre on 5/12/22 at 1:14 P expectation for the M	PM, an interview occurred . She reviewed the MDS /22/22, confirmed the larm was not coded and rsight since Resident #25 had her ankle. In her ankle. In and indicated it was her MDS assessment to be coded		On 5/12/22 the MDS Assessm correctly coded Resident #25, #50, Resident #59, and Reside MDS Assessment to reflect the wander guard bracelet. On 5/12/22 the MDS Assessm correctly coded Resident #78 I Assessment to reflect bladder incontinence.	Resident ent #67, e use of a ent Nurse MDS	
		s originally admitted to the vith diagnoses that included		Root Cause: MDS Assessmen overlooked coding 4 residents wander guard bracelets and m one resident bladder and bowe incontinence and miscoded on discharge disposition in error.	with iscoded el	

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		. ,	E SURVEY IPLETED
			A. DOILDING			С
		345293	B. WING		0	5/12/2022
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, Z		
				HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	COMPLETIC
F 641	Continued From page	e 10	F 64	.1		
	revealed an order dat	ted 1/11/22 for a		All residents have the p	otential to be	
	wander-guard bracele	et.		affected by this alleged practice.	deficient coding	
		essment dated 3/15/22				
		50 had moderately impaired		On 6/1/22, the Regional		
	cognition and was no wander/elopement al			Consultant completed 1 residents requiring want		
				bracelets were coded co		
	On 5/9/22 at 10:15 Al	M, an observation occurred		On 6/1/22, the Regional	-	
		she was sitting in a chair in		Consultant completed a		
		der-alarm bracelet was		audit of discharged resid		
	visible to her right anl	kle.		that they were coded co	•	
	On E/12/22 at 12:26 [TM on interview accurred		On 6/2/22, the Regional		
		PM, an interview occurred She reviewed the MDS		Clinical Services comple of continent/incontinent		
		15/22 and confirmed the		ensure bowel and bladd		
		arm was not coded. She		continent/incontinent is		
	stated it was an overs	sight since Resident #50 had				
	an alarm bracelet on	her ankle.		On 6/1/22 the Regional		
				Consultant educated MI		
		d with the Director of Nursing A and indicated it was her		intradisciplinary team or Coding.	accuracy of MDS	
		DS assessment to be coded		County.		
	accurately.			Beginning 6/10/22 the A	ssistant Director	
	-			of Nursing, Regional Cli		
				Consultant, and Region		
		originally admitted to the		auditing 100% of MDS t	-	
	facility on 4/23/21 with dementia.	h diagnoses that included		of coding prior to MDS s This 100% audit will cov	-	
				since all could potential		
	A review of Resident	#59's active physician		regard to MDS coding a	-	
	orders revealed an or	der dated 4/27/21 for a			-	
	•	et for safety and to check		Beginning 6/17/22 the A		
	placement every shift			of Nursing will report the		
		essment dated 4/22/22		monitoring of MDS codi members of the Cardina		
		59 had severely impaired		Team once weekly x 3 n		
	cognition and was no	- · ·		compliance and review		
	wander/elopement al			recommendations and/c		

Event ID: J4MM11

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2022 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING				12/2022
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 177 S BOX 1489	<u> </u>	
				н	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	∋ 11	F	641			
	On 5/0/22 at 12:35 Pl	M an observation occurred			needed for continued compliance.		
	of Resident #59 while wander-alarm bracele On 5/12/22 at 12:26 F with the MDS Nurse. assessment dated 4/2 wander/elopement ala stated it was an overs an alarm bracelet on An interview occurred on 5/12/22 at 1:14 PM	M, an observation occurred e she was sitting with a et visible to her right ankle. PM, an interview occurred She reviewed the MDS 22/22 and confirmed the arm was not coded. She sight since Resident #59 had her ankle. d with the Director of Nursing A and indicated it was her DS assessment to be coded			Beginning the month of July 2022 and continuing for 3 months, the Assistant Director of Nursing will report the find of the monitoring of MDS coding accu to the monthly Quality Improvement (Committee meeting. The QI Committee will review for further recommendation for follow up as needed or continued compliance to determine the need an frequency of the continued QI monitor to ensure compliance is maintained. Date of completion 06/09/2022.	ાngs racy ૨૫) ૨૯ ૧૬	
	4/11/16 with diagnose A review of Resident orders revealed an or	admitted to the facility on es that included dementia. #67's active physician rder dated 4/4/22 to check nent to the ankle every shift.					
	A quarterly MDS asse indicated Resident #6 cognition and was no wander/elopement al	67 had severely impaired t coded for a					
	reviewed on 4/18/22, wandering and/or at r from the facility relate	#67's active care plan, last included a focus area for risk for unsupervised exits ed to impaired cognition. One ras for a wander-guard alarm iated on 6/12/19.					
		M, an observation occurred he was lying in bed with a					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2022 MAPPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDI	۹G			C
		345293	B. WING				12/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page wander-alarm bracele On 5/12/22 at 12:26 F with the MDS Nurse. assessment dated 4/4 wander/elopement ala stated it was an overs an alarm bracelet on An interview occurred on 5/12/22 at 1:14 PM expectation for the MI accurately. 5. Resident #78 was a diagnosis of a Cerebr Review of Resident # Minimum Data Sets (1 1/26/22 indicated he was cont Resident #78 was can revised 2/15/22 for to incontinence related to An interview was con Assistant (NA) #9 on stated that she had w and that he has been long as she could red An interview was con 5/11/22 at 5:05 PM. S incontinent of bowel f	A 12 e 12 et to his ankle. PM, an interview occurred She reviewed the MDS 4/22 and confirmed the arm was not coded. She sight since Resident #67 had his ankle. I with the Director of Nursing A and indicated it was her DS assessment to be coded admitted on 10/11/18 with a al Vascular Accident. 78's previous quarterly MDS) dated 12/3/21 and was incontinent of bowel. erly MDS dated 4/13/22 tinent of bowel. re planned 10/24/18 last fileting assistance due to o his left sided weakness. ducted with Nursing 5/11/22 at 5:00 PM. She orked with Resident #78 incontinent of bowel for as	TAG	641	CROSS-REFERENCED TO THE APPROPRIA		
	recall. An interview was con	ducted with the MDS Nurse					

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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		PLETED
		345293	B. WING				C 12/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 641	aware that she had in #78's bowel status an oversight. She explain modification to the qu on 5/11/22. An interview was com Administrator on 5/12 she expected Resider completed accurately 6. Resident #89 was a the acute hospital set Resident #89's discha (MDS) dated 2/15/202 was discharged to ac return was not anticip The discharge summary medications, physical recapitulation of stay discharge summary in discharge to home. The resident's medicar resident was discharg on 2/15/2022 with how Resident #89's medicar progress note by the 2/21/2022 that indicat made to the resident's health care was in pla physical therapy serv On 2/11/2022 at 2:11	M. She stated she was correctly noted Resident of this had been an ned she had completed a larterly MDS dated 4/13/22 hpleted with the 22 at 1:15 PM. She stated int #78's MDS to be admitted 12/15/2021 from ting. arge Minimum Data Set 22 indicated the resident ute hospital setting and bated. ary, dated 2/15/2022, with 1 therapy orders, and was reviewed. The indicated Resident #89 was al record indicated the ged home with her daughter me health services. cal record also contained a social worker dated ted a follow up call was s daughter to confirm home ace and resident received ices at home. PM and interview was DS nurse. She stated she	F	641			

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIE	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
					С
		345293	B. WING		05/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
	D PINES HEAL THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489	
	DTINEO NEAEMOARE			HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 641	Continued From page	e 14	F 64	41	
		ar. She reviewed Resident			
	#89's discharge MDS	dated 2/15/2022 and stated			
	the discharge was co				
		t anticipated. She reviewed ge summary and stated the			
		ror. The MDS should have			
		the resident was discharged			
	to home.				
		PM and interview was			
		irector of Nursing (DON).			
	accurately.	expectation MDS be coded			
F 677	-	or Dependent Residents	F 67	77	6/9/22
SS=E		-			0,0,
	out activities of daily l	ent who is unable to carry iving receives the necessary			
		good nutrition, grooming, and			
		giene; is not met as evidenced			
	by: Based on observatio	ns, staff, resident and family		On 5/12/22, during a recer	tification and
		I review, the facility failed to		complaint survey at Richme	
	provide shaving assis	stance for Resident #17 and		Healthcare and Rehabilitat	ion Center, the
		lent on assistance with		survey team noted the facil	-
		g (ADLs). The facility also care for ADL dependent		provide desired ADL care for	or the following:
	-	17, Resident #38, Resident		1. Resident #17 continue	es to reside in
	#78, Resident #34 an	d Resident #26). This was		the facility and continues to	
		eviewed for ADLs. The		assistance with ADLs: shaw	ving and nail
	finding included:			2. Resident #38 continue	es to reside in
	1. Resident #17 was	admitted on 6/26/21 and		the facility and continues to	
		2 with cumulative diagnoses		assistance with ADLs: nail	-
	of Peripheral Vascula	r Disease (PVD) and End		3. Resident #78 continue	es to reside in
	Stage Renal Disease	(ESRD).		the facility and continues to	o require

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/09/202 RM APPROVE O. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY IPLETED
		345293	B. WING		0	C 5/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				HIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	Continued From non	- 15	_			
F 0//	Continued From page		F 67			
		mum Data Set dated 2/26/22		4. Resident # 67 continues to		
		nitively intact, exhibited no		the facility and continues to req		
	behaviors and he req			assistance with ADLs: shaving care.	and hall	
	assistance with his po	ersonal hygiene.		5. Resident #26 continues to	rocido in	
	Pesident #17 was ca	re planned on 2/20/22 for		the facility and continues to req		
		DLs but the care plan did not		assistance with ADLs: nail care		
	include assistance wi	-			•	
				1. On 5/11/22 Resident #17 w	vas shaved.	
	An observation and ir	nterview was completed with		and nail care provided by facilit		
	Resident #17 on 5/9/2			staff	, ,	
	fingernails were obse	erved with a dark substance		2. On 5/10/22 Resident #38 v	vas	
	underneath and the r	nails extended past his		provided nail care by the Assist	ant	
	fingertips. Resident #	17's facial hair was		Director of Nursing (ADON).		
	-	extended down onto his		3. On 5/11/22 Resident #78 w		
		only preferred a mustache		provided nail care by facility nu		
	but not the beard. He			4. On 5/10/22 Resident #67 v		
		ne he had a shave or had his		(mustache remained as Reside		
	fingernails trimmed.			preference), and nail care provi	ided by	
	A 1 1			facility nursing staff.		
		completed on 5/10/22 at		5. On 5/10/22 Resident #26 v		
		eatment Nurse (TN) and the Nursing (ADON) providing		provided nail care by the assigr	ieu nurse.	
		and ADON did not mention		Root Cause: Nursing staff were	not	
		s fingernails or facial hair.		offering/performing ADL care (s		
		a myorriane or rabiar fiair.		assistance or nail care) per faci		
	An interview was con	npleted on 5/10/22 at 12:20		expectations for dependent res		
		She stated the aides provided		to staff unclear of facility expect		
		shaving during ADLs and it		assistance of ADL care for depe		
	should be done as ne			residents and staff role of assis		
				Shaving and/or nail care coincid	de with	
		npleted on 5/11/22 at 8:35		shower days and as needed. A		
	AM with Nursing Assi			aide, nurse and/or current Activ		
		ssigned Resident #17 on		is expected to provide this type		
		ut she did not notice his		care when the corrective audits	deem	
	-	air. NA #6 stated nail care		necessary.		
	-	npleted by the aides as				
	needed. She stated s refusals of assistance	she was not aware of any		All residents have the potential		
	relusais of assistance			affected by this alleged deficien	it practice.	

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/09/202 MAPPROVE O. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		345293	B. WING		05	C 5/12/2022
NAME OF PI	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From page	e 16	F 67	7		
	AM with the ADON. S not refuse assistance An interview and obs 5/11/22 at 11:13 AM. room with his wife pre- unshaven and his fing His wife stated Resid but only a mustache fingernails to extende stated he needed assist trimming his nails and aides had not assiste hygiene. An interview was com AM with NA #8. She completed Resident a	ervation was completed on Resident #17 was in his esent. He appeared gernails had not trimmed. lent #17 never wore a beard and he never allowed his ed past his fingertip. She sistance with shaving and d was uncertain why the ed him with his personal npleted on 5/11/22 at 11:22 stated the night shift aides #17's ADLs in order for him is but she would shave his		On 5/10/22 through 5/12/22 th of Nursing (DON), Assistant D Nursing (ADON), Staff Develop Coordinator (SDC) and assign project department head bega completed 100% audit of ADL care/assistance for dependent (shaving and nail care). Any ne concerns of residents requiring care/assistance for dependent (shaving and nail care) were c during this audit by the Director (DON), Assistant Director of N (ADON), Staff Development C (SDC), assigned special project department head, and nursing Additionally, all residents who shaving and/or nail care were care-planned for refusals by th Coordinator.	irector of pment ed special n & residents oted g ADL residents orrected or of Nursing ursing oordinator ct staff. refused	
	Attempts to contact N #17 third shift on 5/9/ were unsuccessful. An observation was of PM. Resident #17 ap for his mustache and trimmed and cleaned improved. An interview was con Administrator and the on 5/12/22 at 1:15 PM	VA #11 assigned Resident (22, 5/10/22 and 5/11/22 conducted on 5/11/22 at 5:07 peared clean shaven except his fingernails had been I. He stated he felt much npleted with the e Director of Nursing (DON) M. The DON stated she assist Resident #17 with	and 5/11/22Assistant Director of Nursing (ADON), a Regional Clinical Nurse Consultant will begin education on 6/1/22 on ensuring ADL care/assistance for dependent residents (shaving and nail care) is performed on shower days and as need by Certified Nursing Assistant (CNA), assigned nurse, or assigned departmen head. This education will be completed 6/8/22.the Nursing (DON) stated sheOn 6/1/22 the SDC added this education to the new hire packet and		DN), ADON), and ultant will ensuring ndent re) is d as needed (CNA), epartment ompleted on education	

Event ID: J4MM11

Facility ID: 923021

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OME	8 NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	DATE SURVEY	
		345293	B. WING			С	
		345293	B. WING	STREET ADDRESS, CITY, STATE, 2		05/12/2022	
NAME OF P	ROVIDER OR SUPPLIER				LIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLÉTIO DATE	
F 677	Continued From page	e 17	F 67	77			
				Contracted Agency/Fac	ility Nursing Staff		
	2. Resident #38 was	admitted on 11/28/17and		that had not completed			
	most recently readmi	tted on 11/4/21 with		ensuring ADL care/assi			
	cumulative diagnoses	s neurogenic bladder and		dependent residents (sl			
	contractures.			care) is performed on s	•		
				needed by Certified Nu	•		
		re planned on 10/4/18 last		(CNA), assigned nurse,	or assigned		
		otal assistance with his		department head.			
		e to his contracture to his left					
		was also care planned on		After 6/8/22, no Contrac			
		41/21 for resistance to care		Agency/Facility Nursing			
	and treatments and v			allowed to work until ed			
		nts and showers at times.		ensuring res ADL care/a			
	ADL routine to accor	d allowing flexibility in his		dependent residents (sl			
	ADL routine to accom	imodale his mood.		care) is performed on s	•		
	His quarterly Minimu	m Data Assessment dated		needed by Certified Nu (CNA), assigned nurse,			
	4/18/22 indicated he	was cognitively intact,		department head.	or assigned		
		care and coded for total					
		his activities of daily living		Beginning 6/9/22 the Di			
	(ADLs).			Assistant Director of Nu			
	An interview and cha	ervation was completed with		Staff Development Coo assigned special project			
		ervation was completed with 22 at 12:26 PM. He had		will complete monitoring			
		ctures and a left elbow		compliance of ensuring			
		eared fingernails jagged,		care/assistance for dep			
		fingertips and had a dark		(shaving and nail care)			
		ider the nails. He stated the		shower days and as ne			
		ngernails and could not		Nursing Assistant (CNA	•		
	recall when they were			or assigned department			
	,			Director of Nursing, the			
	An observation of wo	ound care was completed on		and /or the assigned sp			
		with the Treatment Nurse		department head will ob			
	(TN) and the Assistar	nt Director of Nursing		residents 5x/week x 4 w			
	,	TN nor the ADON noticed		3x/week x 4 weeks, the			
	the appearance of Re	esident #38's fingernails.		weeks to ensure compli			
				care/assistance for dep			
		npleted on 5/10/22 at 12:20		(shaving and nail care)			
	PM with the ADON. S	She stated the aides provided		shower days and as ne	eded by Certified		

Facility ID: 923021

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345293	B. WING		0	C 5/12/2022
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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 18	F 677			
		ing ADLs and it should be		Nursing Assistant (CNA), assigned department head.		
	AM with Nursing Ass was assigned Reside 5/10/22 but she did n his fingernails. She s Resident #38 to refus say his fingernails we who he allowed to tri ADON trimmed and o yesterday. An interview and obs 5/11/22 at 8:35 AM. N #38 with his breakfas trimmed his fingernail better because when long as they were ye sensitive. NA #7 state when needed. She st refuse nail care or per An interview was com Administrator and the on 5/12/22 at 1:15 Pl	aducted on 5/11/22 at 8:20 istant (NA) #6 stated she ent #38 on 5/9/22 and iot observe the condition of tated she had not known se his nail care but he would ere sensitive and picky about m them. NA #6 stated the cleaned his fingernails ervation was completed on NA #7 was assisting Resident st. He stated the ADON Is yesterday and they felt his fingernails grew out as sterday, they become very ed nail care should be done tated Resident #38 did not ersonal hygiene assistance. npleted with the e Director of Nursing (DON) M. The DON stated she assist Resident #38 with nail		Beginning 6/15/22 the Director Assistant Director of Nursing (Staff Development Coordinato assigned special project depar will report the findings of the m ADL care/assistance for deper residents (shaving and nail ca performed on shower days an needed, to the members of the Intradisciplinary Team once we months to ensure compliance for further recommendations a up as needed for continued co Beginning the month of July 20 continuing for 3 months, the D ADON will report the findings of monitoring that ADL care/assis dependent residents (shaving care) is performed on shower needed, monthly Quality Impro (QI) Committee meeting. The Committee will review for furth recommendations for follow up or continued compliance to de	ADON), r (SDC) and rtment head nonitoring ndent re) is d as e Cardinal eekly x3 and review ind/or follow ompliance. 022 and ON or of the stance for and nail days and as ovement QI er o as needed termine the	
	care as needed. 3. Resident #78 was admitted on 10/11/18 with a diagnosis of a Cerebral Vascular Accident. His quarterly Minimum Data Set (MDS) dated 4/13/22 indicated Resident #78 was cognitively intact, exhibited no behaviors and was coded for extensive staff assistance with his personal			need and/or frequency of the or monitoring to ensure complian maintained. Date of completion 06/09/2022	ice is	

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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	
		345293	B. WING				C 12/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTE		н	IGHWAY 177 S BOX 1489		
RICHWON	D FINES HEALTHCARE	AND REHABILITATION CENTE		н	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	9 19	F	677			
		re planned on 10/24/18 last assistance with his personal ded weakness.					
	5/09/22 1:36 PM with fingernails extended p appeared for have a o his fingernails. He sta	bast his fingertips and dark substance underneath ated he needed the staff to					
	PM. He was sitting in hall near the doorway	completed on 5/10/22 at 3:55 a wheelchair outside in the					
	PM with Nursing Assi Resident #78 was on	npleted on 5/11/22 at 5:00 stant (NA) #9. She stated ly known to refuse showers assistance with his personal					
	PM with NA #10. She	npleted on 5/11/22 at 5:05 stated Resident #78 was assistance but would agree him in his time.					
	on 5/12/22 at 1:15 PM expected the staff to a care as needed. 4. Resident #34 was	Director of Nursing (DON) <i>I</i> . The DON stated she assist Resident #78 with nail originally admitted to the h diagnoses that included					
	A quarterly Minimum assessment dated 3/	Data Set (MDS) 1/22, indicated Resident #34					

Facility ID: 923021

If continuation sheet Page 20 of 83

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				_			С
		345293	B. WING			05/	12/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 677	behaviors or refusal of extensive assistance bathing. A review of Resident reviewed 3/14/22, inc activities of daily living interventions included assistance with tasks shaving. A review of the nursin 12/31/21 to 5/9/22, re care or shaving assis An interview and obse Resident #34 on 5/9/2 sitting on the side of t thick, long beard and brown substance und Resident #34 stated i was shaved and norm Stated he would like t recall being offered. I stated "I've never kep They just cut my toen sure why they haven" On 5/10/22 at 11:09 A observed lying in bed offered to shave him of The Assistant Directo interviewed on 5/10/2 care was provided wh Resident #34 and stat to be cut and cleaned	and was coded with no of care. He required with personal hygiene and #34's active care plan, last luded a focus area for g/personal care. The d to provide extensive such as combing hair and ag progress notes from evealed no refusals of nail tance documented. ervation was made of 22 at 1:15 PM while he was he bed. He was noted with a long fingernails with a ter them to both hands. t had been awhile since he hally wore only a moustache. to be shaved but could not in addition, Resident #34 of my fingernails this long. hails not long ago, but not t done my fingernails. AM, Resident #34 was . He stated no one had or cut his fingernails. r of Nursing (ADON) was t2 at 3:15 PM and stated nail hen needed. She observed ted his fingernails did need to he was unable to state	F	677			
	Stated he would like t recall being offered. I stated "I've never kep They just cut my toen sure why they haven" On 5/10/22 at 11:09 A observed lying in bed offered to shave him of The Assistant Directo interviewed on 5/10/2 care was provided wh Resident #34 and sta	to be shaved but could not in addition, Resident #34 bit my fingernails this long. tails not long ago, but not it done my fingernails". AM, Resident #34 was . He stated no one had or cut his fingernails. r of Nursing (ADON) was 22 at 3:15 PM and stated nail then needed. She observed ted his fingernails did need I. She was unable to state					

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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	SURVEY PLETED
		345293	B. WING _				C 12/2022
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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	3:51 PM and explained assistance was comp needed or requested stated if a resident re- informed so a progres was unaware of any r Resident #34 was ob AM. His face was clear remaining and his fing- clean. Resident #34 sp prior evening and assis caring for his fingerna better". On 5/12/22 at 9:45 Al She indicated she was She explained nail cas should have occurred shower days and whe state why Resident # care or shaving assis The Director of Nursit on 5/12/22 at 1:15 PM expectation for NAs to nails during personal the resident was a dia Additionally, the DON expectation that Resi- unwanted facial hair a	during personal care vas interviewed on 5/10/22 at ed nail care and shaving bleted on shower days, when by the resident. She further fused the nurse would be ss note could be written. She refusals from Resident #34. served on 5/11/22 at 10:43 an shaven with a moustache gernails were short and stated someone came by the sisted with shaving and ails and added he felt "much M, NA #3 was interviewed. as familiar with Resident #34. the and shaving assistance d during personal care, en needed but was unable to 34 had not been offered nail tance prior to 5/10/22. mg (DON) was interviewed <i>A</i> and indicated it was her o monitor, clean and trim care, retrieving a nurse if abetic or refused. I stated it was her dent #34 be free of and expected NAs to offer uring his scheduled shower	F 6	577			
	5. Resident #26 was	admitted to the facility on					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/09/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345293	B. WING _			_		C 1 2/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page 12/21/2017 with diagr intellectual disabilities The resident's quarter (MDS) dated 2/22/202 was severely cognitiv The resident was dep activities of daily living toileting, and persona assessment period. R for moods or behavior during the assessment Resident #26's compr 3/9/2022 contained a related to having fragi himself. Interventions fingernails frequently trimmed and filed as r During an observation 5/10/2022 at 3:43 PM Nursing (ADON) and present. The Treatment had scratched his but a new area of broken incontinent brief was of removed. The bilaterat have blanchable redn had broken skin in lor ADON was asked to a	e 22 hosis that included s. rly Minimum Data Set 22 indicated Resident #26 ely impaired and nonverbal. bendent on staff for all g including eating, dressing, il hygiene during the Resident #26 was not coded rs and did not reject care int period. rehensive care plan dated focus for skin impairment ile skin and scratching included checking and keeping fingernails needed. In of wound care on I the Assistant Director of the Treatment nurse were ent nurse stated the resident tocks on 5/9/2022 and had skin. The resident's clean and dry when al buttocks were observed to bess and the right buttock ng linear patterns. The examine the resident's		577				
	observed to be long a under the nails. The r substance on the pair ADON stated the resi	. She further stated nail care						

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 05/12/2022	
	ROVIDER OR SUPPLIER D PINES HEALTHCARE	AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 677 F 684 SS=D	conducted with Nursi stated she was assig stated fingernails wer needed on shower da trimmed Resident #20 she did not know wha further stated she saw and hands were dirty hands and nails after resident's call bell. On 5/12/2022 at 1:14 conducted with the D stated she expected to and trim nails when th Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resid that residents received accordance with profe practice, the compret care plan, and the res This REQUIREMENT by: Based on record rev staff and physician in provide surgical wour	PM an interview was ng Assistant (NA) #1. She ned to Resident #26. She re checked and trimmed as ays. She stated she had not 6's fingernails recently and at day he got showers. She w that the resident's nails . She was going to clean his she answered another PM an interview was inctor of Nursing (DON). She the NAs to monitor, clean , ney provided personal care. Are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of nensive person-centered sidents' choices. T is not met as evidenced iews, observations, resident, terviews, the facility failed to nd care as ordered for 1 of 3 or non-pressure related t #40).	F 677		ines enter, the ed to	

Event ID: J4MM11

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	S FOR MEDICARE &		() (o) · · · · · - · - ·		OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345293	B. WING		05/12/2022
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIC
F 684	Continued From page	e 24	F 684		
	Resident #40 was ori on 1/3/22 with a read diagnoses included r soft tissue infection th abscess of the perine The nursing progress 1/3/22 to 5/8/22 and no episodes of refusa A physician progress Resident #40 had be abscess in the right p which was surgically necrotizing soft tissue A quarterly Minimum assessment dated 3/ #40 was cognitively i wounds present. Review of a Wound 0 3/25/22 revealed the measured 8.2 centim in width and 0.5cm in	iginally admitted to the facility mission date of 1/18/22. His necrotizing fasciitis (a severe nat is caused by bacteria), eum, and type 2 diabetes. Is notes were reviewed from indicated Resident #40 had al of wound care. Inote dated 1/21/22 indicated en hospitalized for an berineum and right buttock, debrided and consistent with e infection. Data Set (MDS) 17/22 indicated Resident intact and had surgical Clinic assessment dated perineal surgical wound leters (cm) in length, 0.5 cm in depth. There was tunnelling	F 004	 facility, continues to require to b the Wound Clinic for surgical wo healing and licensed provider or treatment. On 5/27/22 Resident #40 was se Wound Clinic with notes from th Care Provider of improvement to #40 wounds. Root Cause: Staff nurse not per wound care per licensed provide nor were the nurses reporting to on-coming nurse to provide the care per wound care providers of had not been completed on the shift. The staff nurse also did no document completion of ordered treatment on occasion. In addition staff nurse did not report to the for licensed provider of missed wou treatments for additional orders. All residents with wounds have for 	een at the e Wound o Resident forming er orders, wound orders that off-going t wound on, the acility d care ind care
	cm. The right buttock 1.8 cm in length, 0.3 depth. There was tur a maximum distance Resident #40's active 3/31/22, revealed a for for/actual skin integri diabetic/neuropathic ulcer to foot, left butto	e care plan, last reviewed ocus area for potential		 potential to be affected by this a deficient practice. On 5/17/22 through 5/20/22 the of Nursing (DON), Assistant Dire Nursing (ADON), Staff Developer Coordinator (SDC) and assigned project department head began completed 100% audit of resider requiring wound care to ensure were in place and being followed Licensed Providers and/or Would 	Director ector of nent d special & nts orders d. Facility

Facility ID: 923021

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/09/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		SURVEY
		345293	B. WING			C 12/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	5	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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 25	F 684			
	A review of a Wound 4/1/22 revealed Resi wound to the perineu 0.3 cm in width and 0	Clinic assessment dated dent #40's open surgical m measured 5 cm in length, 0.3 cm in depth. There was The right buttock open		followed. Any new orders for wo by the Facility/Wound Care Lice Providers were processed and a followed by the nursing staff.	nsed	
	surgical wound meas in width and 0.5 cm in at three o'clock with a	a maximum distance of 2.9 crotic (dead) tissue in the		The Staff Development Coordina (SDC), Director of Nursing (DON Assistant Director of Nursing (Al Regional Clinical Nurse Consult begin education on 6/1/22 on er resident wound care orders are	N), DON), and ant will nsuring	
	4/1/22: - Clean the perineal	ed the following orders dated wound with normal saline		followed. This education include informing nurses and medication on checking for omissions in EM prior to leaving for the shift or ac	ed ns aides IAR/ETAR ccepting	
	Calcium Alginate with gel-like covering to h	with clean gauze, apply n Silver (a highly absorbent elp maintain a moist motes wound healing) and		the cart for the on-coming shift. education will be completed by 6 On 6/1/22, the SDC added this 6 to the new hire packet and agency/contract staff packet.	6/9/22.	
	- Clean the right butt	ock wound with normal pat dry with clean gauze,		After 6/9/22, no Contracted		
	apply Calcium Algina every day.	te with Silver and secure		Agency/Facility Nursing Staff will allowed to work until education of ensuring resident wound care of	on	
	4/8/22 revealed Residue wound to the perineu 1 cm in width and 0.5	Clinic assessment dated dent #40's open surgical m measured 8 cm in length, 5 cm in depth. There was no 1e right buttock open surgical		being followed and checking for in EMAR/ETAR prior to leaving the shift or accepting the cart for the on-coming shift	for the	
	wound measured 1.5	cm in length, 0.5 cm in pth. There was no tunneling		Beginning 6/2/22, the Clinical Intradisciplinary Team/Nursing S will review the report for omissic EMAR/ETAR via the Medication	ons in	
	(TAR) was reviewed a surgical wound care a and right buttock wer	ment Administration Record and demonstrated the to Resident #40's perineum e not initialed as completed and 4/30/22 at 9:00 AM.		Administration Audit Report via t EMAR/ETAR system daily to en wound care is completed for all with wounds. Any concerns will corrected at that time. The Direct	the sure residents be	

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	S FOR MEDICARE &					<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		345293	B. WING		0	C 5/12/2022
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
				HIGHWAY 177 S BOX 1489		
	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 CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 684	Continued From page	e 26	F 68	4		
		5.20	1 00	Nursing, the Assistant	Director of Nursing	
	On 5/12/22 at 9:20 A	M an interview was		and /or the assigned s	•	
	completed with the S	-		department head will n		
	· ·	ho was assigned to Resident		Medication Administrat		
		explained nursing staff were		the EMAR/ETAR syste	•	
		d care when the treatment		to ensure compliance t	-	
	· ·	and normally the weekend		wound care orders are		
) completed the wound care		prescribed.	2011.g lonotiou do	
		e SDC further stated the		P		
		had been on medical leave		Beginning 6/2/22 the C	linical	
	-	d not returned to work yet.		Intradisciplinary Team/		
		esident #40's April 2022		will review the report for		
		didn't provide any wound		EMAR/ETAR via the M		
		e perineal or right buttock		Administration Audit Re		
		use she was "covering the		EMAR/ETAR system d		
	-	cart" and thought the		will be corrected at tha		
		I to 11:00 PM) nurse would		ADON will report the fin		
	complete the care.			monitoring that EMAR/	-	
				to ensure compliance t		
	A phone interview oc	curred with Nurse #6 on		care orders are being f		
		She was the nurse assigned		members of the Cardin		
		ne second shift on 4/24/22.		Team once weekly x3		
		peing told the wound care		compliance and review		
		ted that morning and stated		recommendations and		
	the electronic TAR di	d not show the wound care		needed for continued of	compliance.	
	was needed for her s	hift. Nurse #6 explained she				
	was asked by Reside	ent #40 to change the		Beginning the month o	f July 2022 and	
		eal wound, which she did,		continuing for 3 months	s, the DON or	
		was written, but she did not		ADON will report the fin	ndings of the	
		ock surgical wound dressing		monitoring that residen		
		e impression it had already		care as ordered: month		
	been completed on the	ne day shift as ordered.		Improvement (QI) Corr		
				The QI Committee will		
		progress note written by		recommendations for f	-	
		4/24/22, indicated per		or continued compliand		
	-	est the perineal surgical		need and/or frequency		
		and wound care was		monitoring to ensure co	ompliance is	
	provided.			maintained.		1

Facility ID: 923021

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/09/202 MAPPROVEI O. 0938-039	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING			C 05/12/2022		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		HIG	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	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 684	The May 2022 TAR w the surgical wound c perineum and right b completed on 5/1/22, On 5/11/22 at 2:50 P conducted with Nurse assigned to Resident She stated she could wound care for Resid buttock surgical woun had any wound order Multiple attempts we the survey to contact weekend supervisor; assigned to Resident #7, who was assigne and 5/8/22, without s A review of the Wour 5/6/22 indicated Resi wound to the perineu length, 0.4 cm in wid right buttock open su with all measuremen The Treatment Nurse at 3:45 PM and expla care dressing change the day shift (7:00 AM nursing staff were resi their own wound care evening shifts, if ther the weekend. Another interview occ Nurse on 5/11/22 at 4	vas reviewed and revealed are to Resident #40's uttock were not initialed as 5/7/22 or 5/8/22 at 9:00 AM. M, an interview was e #1, who had been #40 on 4/30/22 and 5/1/22. I not recall completing any lent #40's perineal or right nds and was unaware he rs. re made during the course of Nurse #4, who was the Nurse #5, who was #40 on 4/23/22; and Nurse d to Resident #40 on 5/7/22 uccess. d Clinic assessment dated ident #40's open surgical im measured 3.5cm in th and 0.1 cm in depth. The rgical wound was healed	F		Date of completion 06/09/2022.			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CC 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 COMPLETION HE APPROPRIATE DATE
F 684	weekend and stated the nursing supervise had been out for seve An observation of Re care occurred on 5/10 treatment nurse and (ADON). Resident #4 wound to the right po a small amount of bro dressing and minimal beefy red with no neo Wound care was corr surgical wound to the healed. An interview occurred 5/11/22 at 12:00 PM. wheelchair at bedside month or so" his surg been completed on the the week. Resident # wound care had occu weekend of 5/7/22 ar for someone to chang be told they would be On 5/12/22 at 1:15 P with the Director of N explained the facility from paper to electro DON stated she was care was not provide ordered. She expect report any wound car completed to the onc completed as well as	duty as well as on the normally on the weekends or completed wound care but eral weeks. sident #40's surgical wound 0/22 at 2:33 PM with the Assistant Director of Nursing 40 had an open surgical sterior perineal area that had own drainage on the 1 odor. The wound bed was crotic areas observed. npleted as ordered. The e right buttock area was d with Resident #40 on He was up in his e and stated that for the "last tical wound care had not ne weekend as it was during #40 indicated the lack of urred as recently as the nd 5/8/22. When he asked ge the dressings he would e there soon. M, an interview was held ursing (DON). She had recently transitioned nic TAR's on 4/19/22. The unaware surgical wound d to Resident #40 as ed the nurses on day shift to	F 68	34	

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/2 FORM APPRO OMB NO. 0938-0
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DICUMON				HIGHWAY 177 S BOX 1489	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
F 684		e 29 n needed to be put into nd care being missed as	F 68	4	
	2022 TARs were revisited he had not been wound care was not of days no initials were have expected nursing the second sec				
	Clinic during the cour unsuccessful.	to speak to the Wound se of the survey which were event/Heal Pressure Ulcer (i)(ii)	F 68	6	6/9/22
	resident, the facility n (i) A resident receives professional standard pressure ulcers and o ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, pre- new ulcers from deve	re ulcers. whensive assessment of a hust ensure that- is care, consistent with ls of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent hdards of practice, to vent infection and prevent			
	•	ns, staff and Medical		On 5/9/22, during a recertification ar	nd

Event ID: J4MM11

Facility ID: 923021

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	` '	G	COMPLETED		
		345293	B. WING _		C	C 5/12/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 686	Continued From page	e 30	F 6	86			
	Director (MD) intervie facility failed to ensur mattress was set acc resident (Resident #3 facility also failed to e mattress was implem	ews and record review, the re MD ordered specialty air cording to the weight of the 80 and Resident #38). The ensure the MD ordered air mented for Resident #26. This nts reviewed for pressure		complaint survey at Richmon Healthcare and Rehabilitatior survey team observed Reside Resident #38 Alternating Air (AAM) was not on the correct resident weight. Survey team Resident #26 AAM was not ir per Licensed Provider order.	n Center, the ent #30, and Mattress t settings per also noted		
	The findings included	l:		1. Resident #30 no longer res	sides at the		
	diagnoses of a Urina urinary retention and sacrum.	admitted 3/3/22 cumulative ry Tract Infection (UTI), a pressure ulcer to his um Data Set (MDS) dated		facility. 2. Resident #38 continues to facility and requires the use of 3. Resident #26 continues to facility and does not require t AAM.	of an AAM. reside at the		
	3/10/22 indicated he was coded for a urina pressure ulcers and o relieving device to his	was cognitively intact. He ary catheter, 2 stage one		On 5/12/22 Resident #38 AA were adjusted per Resident # per manufacture recommend these settings were added to be checked and adjusted eac needed by the assigned nurs aide.	\$38 weight as ations and the EMAR to ch shift as		
	risk of development of and the redness to his	re planned on 3/4/22 for the of further pressure ulcers is right and left buttocks. d ensuring the appropriate vices were in place.		On 5/12/22 Resident #26 AA removed from the EMAR per from the Licensed Provider. Root Cause: Resident #38 AA	clarification		
	Review of Resident #	#30's skin assessment dated stage 1 pressure ulcer to his		were not checked and adjust resident weight by nurses/me aides. Resident #26 was a tra error to EMAR from paper M/	ed per edication anscription		
	4/15/22 indicated the	/30's skin assessment dated area to his left buttock e 3 and his skin assessment		All residents have the potenti affected by this alleged defici			
		ed the area was unchanged.		On 5/17/22 through 5/20/22 t of Nursing (DON), Assistant I			

Event ID: J4MM11

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 06/09/2022 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345293	B. WING _			C 05/12/2022	
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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	The MD ordered Resident # 4/25/22. Review of Resident # 5/2/22 indicated the a described as his sacr and a new order for a (AAM). Review of a MD orde Resident #30 to be pl to validate AAM settin Tuesday. Resident #30's electr last weight for Reside 4/13/22. An interview was con 5/9/22 at 11:46 AM. H was added to his bed wound clinic appointr Observation of the AA set at 400 pounds. An observation of Re completed on 5/10/22 Treatment Nurse (TN noticed the AAM was pounds. He stated the be set accurately bas An interview was con Assistant (NA) #6 on stated the aides were up or checking the AA	ident #30 to be referred to to increased drainage on 30's wound consult dated area on his left buttock was rum. The area was debrided an alternating air mattress r dated 5/9/22 read for laced on an air mattress and ng range weekly on every onic medical record read the ent #30 was 182 pounds on ducted with Resident #30 on le stated the air mattress I while he was out for his ment earlier this morning. AM indicated the weight was esident #30's AAM was 2 at 10:35 AM. The I) was present but did not set for the weight of 400 at all ordered AAM's should sed on the resident's weight. ducted with Nursing 5/10/22 at 10:45 AM. She e not responsible for setting AM for function or settings. owledge, it was either the	F6	586	Nursing (ADON), Staff Development Coordinator (SDC) and assigned spec project department head began & completed 100% audit of resident mattress to ensure correct orders for specialty mattress were in place. The audits also included any specialty mattresses were correct on the EMAF and AAM settings were being checked each shift. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON) Regional Clinical Nurse Consultant wi begin education on 6/1/22 on ensuring orders for specialty mattresses are co on EMAR and AAM settings are check & corrected per resident weight as needed. This education will be comple on 6/8/22. On 6/1/22, the SDC added this educat to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing S that had not completed education of ensuring orders for specialty mattress are correct on EMAR and AAM setting are checked & corrected per resident weight as needed.	se a d , and II g rrect ked tion taff es gs es	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/09/202 MAPPROVE O. 0938-039		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED		
		345293	B. WING	B. WING			C 5/12/2022		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•			
				HI	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 686	Continued From page	e 32	F 68	86					
	Continuou i rom pag	0.02	100		weight as needed.				
	An interview was con	ducted with the Staff							
		nator (SDC) on 5/10/22 at			Beginning 6/9/22, the Director of Nu	rsing			
		d it was the responsibility of			(DON), Assistant Director of Nursing	U U			
		sure any AAM's function and			(ADON), Staff Development Coordin	ator			
	setting were accurate	9.			(SDC) and assigned special project				
	.				department head will complete moni	toring			
		ducted with Nurse #1 on She stated she was not sure			to ensure compliance of orders for				
		for ensuring AAM's were			specialty mattresses are correct on EMAR/ETAR and AAM settings are				
	-	and the air mattress pump			correct per resident weight/manufac	ure			
		te based on the resident's			recommendations. The DON, ADON				
	-	he was under the impression			SDC, and /or the assigned special p				
	that the TN and Assis	stant Director of Nursing			department head will observe 6 rand				
	(ADON) did it since the	hey did wound rounds			residents 5x/week x 4 weeks, then				
	together weekly.				3x/week x4weeks, then 2x/week x4				
					weeks to ensure compliance that or				
		ducted with the ADON on			for specialty mattresses are correct of	on			
		She confirmed she and the wound assessments. The			EMAR/ETAR and AAM settings are correct per resident weight/manufac	uro			
		the wound rounds, the AAM			recommendations. This corrective	uie			
	-	oper function and settings but			practice will be applied to any addition	nal			
		ity of the floor nurses to			residents who receive an order and				
	ensure the function a	nd setting were accurate			subsequent AAM to promote skin int	egrity.			
	daily.				Beginning 6/15/22 the Director of Nu	•			
		sident #30's AAM was			Assistant Director of Nursing (ADON				
		2 at 8:45 AM. The AAM was			Staff Development Coordinator (SDC	J)			
		f 400 pounds but he was not			and/or assigned special project	and of			
		stant Director of Nursing lent #30 was transferred to			department head will report the findi the monitoring that orders for specia	-			
	· · ·	y from the wound clinic.			mattresses are correct on EMAR/ET				
					and AAM settings are correct per res				
	An interview was con	iducted with the MD on			weight/manufacture recommendatio				
		He stated Resident #30 was			the members of the Cardinal	-			
	known to him and ha	d a previous stay in 2021.			Intradisciplinary Team once weekly >	(3			
		this most recent hospital			months to ensure compliance and re				
		equent admission to the			for further recommendations and/or				
	facility, Resident #30	's medical condition had			up as needed for continued complian	nce.			

Event ID: J4MM11

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	06/09/2022 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPLE	URVEY
		345293	B. WING		C 05/1	2/2022
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	 progressively decline AAM was ordered to weight and it was his set according to his a Another observation of completed on 5/11/22 been adjusted to the An interview with the 5/11/22 at 4:50 PM. Heabout the incorrect Avadjusted the setting in #30's weight. He starshould be set accurate weight. An interview was com 5/12/22 at 10:10 AM. understanding that all responsible for ensure setting of any resider An interview was com Administrator and the on 5/12/22 at 1:15 PM #30's AAM was to be recent weight of 182 pounds. 2. Resident #38 was recently readmitted or diagnoses neurogenii Peripheral Vascular Eulocational and the on and the on sight and the set of the set of	d. He stated Resident #30's be set according to his expectation that the AAM be citual weight of 182 pounds. of Resident #30's AAM was 2 at 4:45 PM. The AAM had proper weight setting. TN was completed on de stated the MD told him AM settings earlier and he in accordance with Resident ted that all ordered AAM tely based on the resident's inpleted with Nurse #2 on She stated it was her I the nurses and TN were ing proper function and it ordered an AAM. hpleted with the Director of Nursing (DON) A. The DON stated Resident set according to his most pounds and not at 400 admitted on 11/28/17and in 11/4/21 with cumulative c bladder, contractures, Disease (PVD) and pressure	F 68	 Beginning the month of Ji continuing for 3 months, the ADON will report the finding monitoring that orders for mattresses are correct or and AAM settings are conveight/manufacture recommonthly Quality Improvem Committee meeting. The will review for further recompliance to determine frequency of the continue to ensure compliance is more to ensure to ensure compliance is more to ensure to ensure compliance is more to ensure to ensure	the DON or ings of the specialty DEMAR/ETAR rect per resident mmendations, nent (QI) QI Committee ommendations r continued the need and/or ed QI monitoring naintained.	

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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>		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345293	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE						
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 686	left heel. He was care last revised 9/17/21 fc his lower extremities. ensuring the appropri devices were in place His quarterly Minimur 4/18/22 indicated he was coded for a urina pressure ulcer and 3 was recorded as 240 Review of Resident # dated 4/8/22 indicated acquired inhouse (dat of 4/22/22. He still wa his venous ulcers. An interview and obse Resident #38 on 5/9/2 lying on an alternating weight set at 340 pou significant history of p buttocks along with his Review of Resident # orders on 5/9/22 did r AAM. An observation and ir Nursing Assistant (NA AM. Resident #38's A She stated the aides setting up or checking settings. She stated to	 a planned on 1/26/21 and or bilateral arterial ulcers to Interventions included ate pressure relieving a. an Data Assessment dated was cognitively intact. He my catheter one stage 3 venous ulcers. His weight pounds. 38's wound ulcer flowsheet d his left heel pressure ulcer te unknown) was healed as is receiving wound care for ervation was completed with 22 at 12:26 PM. He was g air mattress (AAM) with the nds. He stated he had a pressures to his feet and is venous ulcers. 38's May 2022 on Physician not include an order for a heterview was conducted with A) #6 on 5/10/22 at 10:45 AM was set for 340 pounds. were not responsible for g the AAM for function or o her knowledge, it was ty of the floor nurses or the 	F	586				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/09/2022 MAPPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345293	B. WING			_	C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	10:47 AM. She stated the floor nurses to en- setting were accurate An interview was com 5/10/22 at 11:10 AM. who was responsible functioning properly a settings were accurat weight. She stated sh that the TN and Assis (ADON) did it since th together weekly. An interview was com 5/10/22 at 11:15 AM. TN performed weekly ADON stated during t was assessed for pro it was the responsibili ensure the function an daily. An observation of wor 5/10/22 at 11:20 AM of The area to Resident but noted were 3 verse lower extremities. The observed assessing of AAM setting. An observation was c AM. NA #7 was obser with breakfast. His AF NA #7 stated she was	hator (SDC) on 5/10/22 at I it was the responsibility of sure any AAM's function and ducted with Nurse #1 on She stated she was not sure for ensuring AAM's were nd the air mattress pump e based on the resident's ne was under the impression tant Director of Nursing ney did wound rounds ducted with the ADON on She confirmed she and the wound assessments. The he wound rounds, the AAM per function and settings but ty of the floor nurses to nd setting were accurate und care was completed on with the TN and the ADON. #38's left heel was healed ous ulcers to his bilateral e TN and ADON were not or adjusting Resident #38's ompleted on 5/11/22 at 8:35 rved assisting Resident #38 AM was set at 340 pounds. a not aware of who checked and settings. She stated she	F	686					

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	-	ID HUMAN SERVICES				FORM	APPROVED
			(X2) MUI			(X3) DATE	0. 0938-0391
		IDENTIFICATION NUMBER:	· ,				LETED
						(C
		345293	B. WING			05/	12/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE					
				F			
(X4) ID PREFIX				х		E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			ATE	DATE
F 686	Continued From page	<u>+</u> 36	F	686			
	A BULUMS A SOLUMS A BULUMS A BULUMS STREET ADDRESS, CITY, STATE, 2P COD RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE (74) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF COL (CACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) F 686 Continued From page 36 An interview was conducted with the MD on 5/11/22 at 19:50 AM. He stated Resident #38's AAM was ordered to be set according to his weight and it was his expectation that the AAM be set according to his actual weight of 240 pounds. F 686 An other observation was completed with Nurse #2 on 5/12/22 at 10:10 AM. She stated it was her understanding that all the nurses and the TN were responsible for ensuring proper function and setting of any resident ordered an AAM. An interview was completed with the TN on 5/12/22 at 1:10 AM. She stated the MD informed him of the inaccurate weight setting on Resident #38's AAM but he forgot to correct the setting until late yesterday afternoon. He stated that all ordered AAM's should be set accurately based on the resident's weight. An interview was completed with the Administrator and the Director of Nursing (DON) on 5/12/22 at 1:15 PM. The DON stated Resident #38's AAM was to be set according to his most recent weight of 240 pounds and not at 340 pounds.						
345293 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE PIX 1/20 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REALTHCARE AND REHABILITATION CENTE ID PREFIX REQUATORY OR LSC IDENTIFYING INFORMATION) PREFIX F 686 Continued From page 36 F 686 An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated Resident #38's AAM was ordered to be set according to his weight and it was his expectation that the AAM be set according to his actual weight of 240 pounds. F 686 An interview was completed on 5/11/22 at 5/05 PM. Resident #38's AAM was still set for a were responsible for ensuing proper function and setting of any resident ordered an AAM. An interview was completed with the TN on 5/12/22 at 1:010 AM. She stated the MD informed him of the inaccurate weight setting on Resident #38's AAM but he forgot to correct the setting until late yesterday afternoon. He stated that all ordered AAM's should be set accurately based on the resident's weight. An interview was completed with the Administrator and the Director of Nursing (DON)							
		5					
		•					
	Set according to his a						
		•					
	weight of 340 pounds						
	An interview was com	pleted with Nurse #2 on					
	5/12/22 at 10:10 AM.	She stated it was her					
	•						
	•						
	county recident						
		•					
		be set accurately based on					
	the resident's weight.						
	An interview was com	pleted with the					
	Administrator and the	Director of Nursing (DON)					
		Jounus and not at 540					
		admitted to the facility on					
	12/21/2017 with diagr	nosis that included					
	contractures.						
	The resident's quarter	rly Minimum Data Set					
	(MDS) dated 2/22/202	22 indicated Resident #26					
		ely impaired and nonverbal.					
	The resident was dep activities of daily living	endent on staff for all gincluding bed mobility,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345293	B. WING				C 12/2022
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 686	dressing, toileting, an the assessment perio as high risk for pressu pressure reducing de dressing applied durin Resident #26's compo- 3/9/2022 contained a breakdown or pressu included ensuring app devices and air mattre The resident's active physician's order for a with no end date. The development coordina On 5/10/2022 at 3:43 wound care by the tre Assistant Director of I was conducted. Resid have blanchable redm scrotum. When writer to characterize the wo stated it was a stage was observed to have pattern on his right bu the mattress, both the nurse stated the resid mattress, he was on a On 5/11/2022 at 11:40 conducted with the tre Resident #26's active not know the resident mattress.	d personal hygiene during d. Resident #26 was coded ure injuries and had vices and nonsurgical ng the assessment period. rehensive care plan dated focus for risk of skin re injuries. Interventions propriate pressure reducing ess were in place. orders revealed a air mattress dated 3/27/2022 e order was entered by staff ator (SDC). PM an observation of eatment nurse, with the Nursing (ADON) present, dent #26 was observed to ress to bilateral buttocks and asked the treatment nurse 1. Additionally, the resident e broken skin in a linear uttock. When asked about e ADON and the treatment lent was not on an air a wing mattress.	F	686			

Facility ID: 923021

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TATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345293	B. WING		05/12/2022	
NAME OF PF	ROVIDER OR SUPPLIER	•		REET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		GHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO	
F 686	Continued From page	e 38	F 686			
		acility recently transitioned	1 000			
		ecords to electronic medical				
		anscribed Resident #26's				
	resident had an order	per to electronic format, the				
		d the order over. She did not				
		was on an air mattress.				
F 688 SS=D	Increase/Prevent Dec CFR(s): 483.25(c)(1)	crease in ROM/Mobility -(3)	F 688		6/9/22	
	§483.25(c) Mobility.					
		cility must ensure that a				
		he facility without limited not experience reduction in				
		ss the resident's clinical				
	condition demonstrate	es that a reduction in range ble: and				
		ent with limited range of				
	motion receives appr					
		ange of motion and/or to				
	prevent further decre	ase in range of motion.				
	•	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 observatio	ns, staff and resident		On 5/9/22, 5/10, 5/11, and 5/12/22 d	lurina	
	interviews and record	I review, the facility failed to		a recertification and complaint surve		
	apply splints as order			Richmond Pines Healthcare and		
		ent #38). This was for 1 of 1 or range of motion (ROM).		Rehabilitation Center, the survey tea observed Resident #38 did not have		
	The findings included	- , ,		applied per therapy recommendation		
	Resident #38 was ad			Resident #38 continues to reside at t		

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Facility ID: 923021

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				E CONSTRUCTION		NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	. ,	ATE SURVEY
			A. BUILDING		-	С
		345293	B. WING			05/12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		03/12/2022
				HIGHWAY 177 S BOX 148		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER	'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC
F 688	Continued From page	ə 39	F 68	8		
	recently readmitted o	n 11/4/21 with cumulative		facility and continu	ues to require the use of	
	diagnoses neurogeni	c bladder and contractures.		bilateral hand spli	nts and left elbow splint.	
					ent #38 bilateral hand	
		38's revised care plan dated			oow splint was applied at	
		equired assistance to		-	Nursing Assistant (CNA)	
		s maximum potential and his present contractures.		resident tolerated	or Resident #38 as	
		d the application of a left			ent #38 bilateral hand	
		week for 4 hours each day.			bow splint was applied at	
				1459 by Certified		
	His quarterly Minimur	n Data Assessment dated		-	or Resident #38 as	
	4/18/22 indicated he	was cognitively intact and		resident tolerated		
		to his bilateral upper and				
	lower extremities.			-	orative Aide was on a	
	Deview of Devidental			resident assignme		
		38's April and May 2022 not include any orders for			taff applied Resident #38 nts and left elbow to	
	splinting to his contra	-			decrease in range of	
				motion/mobility.		
	Review of Resident #	38's restorative		,		
	documentation for Ap	ril and May 2022 indicated		All residents have	the potential to be	
		torative nursing for passive		affected by this al	leged deficient practice.	
	range of motion (PRC	•				
		right elbow, bilateral wrist		On 6/1/22, the As		
	week. Resident #38 v	on each hand 5 times each		÷ , , ,	and Therapy Director	
		r the application of a left		completed 100% a requiring splints/b		
	-	eral hand splints for 4 hours			decrease in Range of	
	a day for 6 times a w			Motion (ROM)/mo		
	-				/braces per Licensed	
	An interview and obs	ervation was completed with		Provider orders a		
		22 at 12:26 PM. He had			were added to EMAR	
		ctures and a left elbow		for nurses to ensu		
		as a folded pillow case		requiring splints/b		
		of his left elbow contracture			decrease in Range of	
	-	ateral hands. He stated at e staff were applying his		resident tolerates.	bility are in place as	
	-	and his left elbow splint but			and like residents, on	
	it had not been done	-			ant Director of Nursing	

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/09/2022 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING _				C / 12/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				Н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALI HUARE	AND REHABILITATION CENTE		H	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From page	e 40	F6	588			
					(ADON) and Therapy Director began		
	An observation was o	completed on 5/10/22 at			cross-training additional CNAs in app	lying	
		t #38's. There was a folded			splints/braces to increase/prevent	-	
		the crease of his left elbow			decrease in Range of Motion		
	contracture and nothi	ng to his bilateral hands.			(ROM)/mobility as resident tolerates.		
	An interview was con	ducted on 5/11/22 at 8:20			The Staff Development Coordinator		
		stant (NA) #6 stated she			(SDC), Director of Nursing (DON),		
	was assigned Reside			Assistant Director of Nursing (ADON)	, and		
		he did not apply Resident			Regional Clinical Nurse Consultant w		
	#38's splint because	he was on the restorative			begin education to facility department		
	nursing caseload.				heads and facility/agency nursing sta	ff on	
					6/1/22 on ensuring splints/braces are		
		completed on 5/12/22 at 9:40			being applied as per Licensed Provid		
		There were no observed			orders and/or Therapy recommendati	ons.	
	contractures.	eft elbow and bilateral hand			This education will be completed on 6/8/22.		
	contractures.				On 6/1/22, the SDC added this education	tion	
	An interview was com	npleted on 5/12/22 at 9:50			to the new hire packet and		
	AM with the Assistant				agency/contract staff packet.		
		she was over the restorative			On 6/9/22, the Staff Development		
		was questioned as to why			Coordinator will mail education to any		
	no splints were obser				Contracted Agency/Facility Nursing S		
		5/12/22, she was unable to			that had not completed education of c		
	provide an answer.				ensuring splints/braces are being app as per Licensed Provider orders and/		
	An interview was com	npleted on 5/12/22 at 11:45			Therapy recommendations.		
		ive Aide (RA). She stated					
		the floor all week and that			After 6/8/22, no Contracted		
		8 did not receive any PROM			Agency/Facility Nursing Staff will be		
	· •	ed the ADON was aware but			allowed to work until education on		
		ued to assign her to work on			ensuring splints/braces are being app		
	•	assisted her with splinting			as per Licensed Provider orders and/	or	
	when she was assign	ied to work the floor.			Therapy recommendations.		
		npleted on 5/12/22 at 12:03			Beginning 6/9/22 22 the Assistant Dir	ector	
	-	heduler. She stated the RA			of Nursing (ADON), Therapy Director		
		o work the floor today. She			and/or assigned special project thera		
	stated anytime she ne	eeded to pull the RA to work			staff member will complete monitoring	j to	

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		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 06/09/2022 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345293	B. WING		0	C 5/12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
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 C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 688	the floor she always in the Director of Nursin An interview was con Administrator and the PM. The DON stated	notified either the ADON or ng (DON).	F	 ensure compliance of ensisplints/braces are being a Licensed Provider orders recommendations. the As of Nursing (ADON), Ther and/or assigned special p staff member will observeres idents 5x/week x 4 we 3x/week x4,weeks, then a weeks to ensure complia splints/braces are being a Licensed Provider orders recommendations Beginning 6/15/22 the As of Nursing (ADON), Ther report the findings of the splints/braces are being a Licensed Provider orders recommendations to the Cardinal Intradisciplinary weekly x3 months to ensiand review for further recand/or follow up as needed compliance. Beginning the month of J continuing for 3 months, Therapy Director will report the monitoring that of ensisplints/braces are being a Licensed Provider orders recommendations to the Cardinal Intradisciplinary weekly x3 months to ensign and review for further recand/or follow up as needed compliance. 	suring applied as per s and/or Therapy ssistant Director apy Director project therapy e 6 random eeks, then 2x/week x4 ance of ensuring applied as per s and/or Therapy members of the ream once sure compliance commendations ed for continued July 2022 and ADON and/or ort the findings of suring applied as per s and/or Therapy members of the ream once sure compliance commendations ed for continued	

Event ID: J4MM11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/20 FORM APPROV OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 05/12/2022		
NAME OF PI	ROVIDER OR SUPPLIER	L	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC		
F 688	Continued From page	e 42	F 688	maintained.			
F 690	Bowel/Bladder Incont	inence Catheter LITI	F 690	Date of completion 06/09/2022	2. 6/9/22		
SS=E	resident who is contin admission receives s maintain continence of condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who en- indwelling catheter or is assessed for remo- as possible unless the demonstrates that cat	nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain. esident with urinary on the resident's ssment, the facility must ters the facility without an not catheterized unless the idition demonstrates that					
	receives appropriate prevent urinary tract i continence to the extension §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen	esident with fecal					

Facility ID: 923021

If continuation sheet Page 43 of 83

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 05/12/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0;	0/12/2022
		RE AND REHABILITATION CENTE	1	HIGHWAY 177 S BOX 1489		
				HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 690	Continued From pa	age 43	F 690			
	restore as much ne	ormal bowel function as				
	possible. This REQUIREME by:	NT is not met as evidenced				
		Based on observations, staff, resident and		On 5/9/22, during a recertification	and	
	· · ·	MD) interviews and record		complaint survey at Richmond Pine		
	· ·	failed to ensure Physician		Healthcare and Rehabilitation Cen		
		ed and implemented for the		survey team observed Resident #3		
		ent of residents with indwelling Resident #30, Resident #38		Resident #38, and Resident #74 di have Licensed Provider orders and		
		. The facility also failed to place		facility protocols in place for care a		
		ce for an indwelling urinary		assessment of indwelling urinary		
		#30). This was for 3 of 6		catheters.		
	residents reviewed	for urinary catheters. The				
	findings included:			1. Resident #30 no longer reside	s at the	
				facility.		
		as admitted 3/3/22 cumulative		2. Resident #38 continues to res		
	diagnoses of a Uri urinary retention.	nary Tract Infection (UTI) and		the facility and continues to require indwelling urinary catheter.	an	
	unnary retention.			3. Resident #74 continues to res	de at	
	His admission Min	imum Data Set (MDS) dated		the facility and continues to require		
		ne was cognitively intact,		indwelling urinary catheter.		
		staff assistance with his				
	activities of daily liv	ving (ADLs) and was coded for		On 5/10/22 Facility Management N		
	a urinary catheter.			obtained and implemented orders		
	D			EMAR/ETAR for care and assessm		
		e plan last revised 4/1/22 read		indwelling urinary catheter for Resi	aent	
		pattern of urinary elimination urinary catheter. Interventions		#38. On 5/10/22 Facility Management N	urses	
	-	care per the facility protocol,		obtained and implemented orders		
		er per MD orders and/or facility		EMAR/ETAR for care and assessme		
		an unobstructed urine flow and		indwelling urinary catheter for Resi		
	ensure the urinary	was below the level of the		#38.		
		s no intervention of a				
	securement device	2.		Root Cause: Nurses did not obtain		
	Deview of D			implement Licensed Provider order		
		nt #30's weekly electronic		and/or facility protocols for care an	a	
		sessments from admission completed by the facility		assessment of indwelling urinary catheters.		

PRINTED: 06/09/2022 FORM APPROVED

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/09/20 M APPROVE <u>D. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05/12/2022	
		345293	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	• • •	-
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 44	F	690			
1 000		l) and once by the Assistant	1	090			
		ADON) did not include any			All residents requiring and indwelling	I	
		ding the appearance of the			catheter have the potential to be affe		
	catheter insertion site	• • • •			by this alleged deficient practice. All		
					corrective practices applied to currer	nt	
		#30's May 2022 Physician			residents with catheters will be equa	•	
		e any orders for a urinary			implemented and audited for correction	ve	
		anges, assessment or the			orders and protocols.		
		rinary catheter. There were			On E/40/00 the Arcistent Director of		
		ow the facility protocol for			On 5/10/22 the Assistant Director of	and	
	urinary catheters.				Nursing (ADON), Treatment Nurse, a Quality Assurance & Improvement (C		
	Review of Resident #	#30's March, April and May			Nurse completed 100% audit of resid	,	
		inistration Records (TAR)			requiring indwelling urinary catheters		
		ocumented evidence of			On 5/10/22 the Assistant Director of		
	urinary catheter care				Nursing (ADON), Treatment Nurse, a	and	
	maintenance.				Quality Assurance & Improvement N		
					obtained and implemented orders for	r	
		note dated 5/9/22 at 11:05			residents requiring indwelling urinary	,	
		oted some blood around his			catheter care and assessment.		
		e and she notified the MD.					
	There were no new c	orders.			The Staff Development Coordinator		
					(SDC), Director of Nursing (DON),)	
		ervation were conducted 5/9/22 at 11:46 AM. He			Assistant Director of Nursing (ADON Regional Clinical Nurse Consultant v		
		heter insertion site was			begin education to facility department		
		be was tugging on the			heads and facility/agency nursing sta		
		ed back his top sheet to			6/1/22 on ensuring obtaining and		
		securement device attached			implementing orders for residents		
		ated when he was first			requiring indwelling urinary catheter	care	
		t some sort of device that			and assessment. This education also		
		eter in place. He stated they			included notifying licensed provider of		
	stopped using it seve	eral weeks ago.			changes to the indwelling urinary cat		
	An abarmenti CD	eident #201a series and the f			site for additional orders and ensurin	•	
		sident #30's urinary catheter			securement device is in place to prev		
		mpleted on 5/10/22 at 10:35 ident #30 stated his urinary			pulling or tugging that may lead to tra	auma.	
		pulling, tugging and the			This education will be completed on 6/8/22.		
		e was stinging. The TN			On 6/1/22 the SDC added this education	ation	

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	-	ID HUMAN SERVICES MEDICAID SERVICES					/ APPROV). 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING				C)5/12/2022	
NAME OF PI	ROVIDER OR SUPPLIER	·		STR	REET 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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETIC DATE	
F 690	Continued From page	e 45	F	690				
	pulled back the top sl				to the new hire packet and			
		He stated the stat locks (a			agency/contract staff packet.			
		lization device used for			On 6/9/22 the Staff Development			
		place to prevent pulling and			Coordinator will mail education to any			
		back order for a couple of			Contracted Agency/Facility Nursing Sta	aff		
	,	ed there should be some sort			that had not completed education of or			
		e even if the stat locks were			ensuring obtaining and implementing			
	·	ated it could be stabilized			orders for residents requiring indwelling	g		
	with tape or a leg stra	ap. The TN removed			urinary catheter care, assessment, and			
	Resident #30's brief t	o reveal dried blood to the			notifying licensed provider of changes	to		
	inside of his brief. The	ere was also observed of			the indwelling urinary catheter site			
	dark red blood at the	catheter insertion site. The			ensuring a securement device is in pla	ce		
	TN stated he was not	aware of the observed			to prevent pulling or tugging that may I	ead		
		would clean the area and			to trauma.			
		device was placed. The TN						
		the impression there was a			After 6/8/22, no Contracted			
	· ·	ocol on his Physician orders.			Agency/Facility Nursing Staff will be			
		s not aware of where to			allowed to work until education on			
	locate the facility's ur	inary catheter protocol.			ensuring obtaining and implementing			
					orders for residents requiring indwelling			
	An interview was con				urinary catheter care and assessment.			
		5/10/22 at 10:45 AM. She			This education also included notifying			
		e allowed the clean around			licensed provider of changes to the			
	allowed to place a se	nsertions sites but not			indwelling urinary catheter site for additional orders and ensuring a			
		she stated the TN, or the			securement device is in place to preve	nt		
		NA #6 stated she did not			pulling or tugging that may lead to trau			
		of trauma or blood during his			paining of tagging that may load to that			
	ADL care on 5/9/22.				Beginning 6/9/22 22 the SDC, DON,			
					ADON, Treatment Nurse, QA&I Nurse,			
	An interview was con	ducted with Nurse #1 on			and/or assigned special project			
		She stated it was her			department head will complete monitor	ring		
		e TN changed the urinary			to ensure compliance of obtaining and	-		
		ne stated she was not aware			implementing orders for residents			
	that Resident #30 did	l not have a securement			requiring indwelling urinary catheter ca	are,		
	device in place or abo	out the observed trauma at			assessment, securement device is in			
	the urinary catheter in				place, and notifying licensed provider of	of		
					changes to the indwelling urinary cathe			
	An interview was con	ducted with the Assistant			site. the SDC, DON, ADON, Treatmen	t		

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/09/20 M APPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		345293	B. WING		05	C / 12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489		
	DTINEO NEAEMOARE			HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 46	F 69	0		
		DON) on 5/10/22 at 11:15	1 03	Nurse, QA&I Nurse, and/or as	signed	
		and the TN performed weekly		special project department he		
		er. She stated normally if the		observe 6 random residents 5		
	resident had a wound	d and a urinary catheter, the		weeks, then 3x/week x4weeks	s, then	
	catheter was part of t	he weekly assessment as		2x/week x4 weeks ensure con		
	well.			obtaining and implementing of		
		anlatad an 5/10/22 at 1:00		residents requiring indwelling		
		npleted on 5/10/22 at 4:00 she observed blood in		catheter care, assessment, se device is in place, and notifyin		
		yesterday and she notified		provider of changes to the ind	-	
		e no orders were given.		urinary catheter site	i olinig	
		could not recall if there was				
	a urinary securement	t device in place on 5/10/22.		Beginning 6/15/22 ADON, DO QA&I nurse will report the find		
	An interview was con	ducted with the MD on		monitoring: obtaining and imp	-	
		He stated he was under the		orders for residents requiring		
	-	acility had a protocol for the		urinary catheter care, assessr		
		n urinary catheters and was e no orders for the care and		securement device is in place notifying licensed provider of o		
		ent #30's urinary catheter.		the indwelling urinary catheter		
		30's catheter should always		members of the Cardinal Intra		
		levice in place to prevent		Team once weekly x3 months		
		removal of his urinary		compliance and review for fur		
		ted the nurses, or the TN		recommendations and/or follo	•	
		monthly Physician orders		needed for continued complia	nce.	
		inary catheter, assessed and		Designing the menth of luty 0	022 and	
	cleaned his unnary c	atheter insertion site daily.		Beginning the month of July 2 continuing for 3 months, ADO		
	An interview was con	npleted with the		and/or QA&I nurse will report		
		Director of Nursing (DON)		of the monitoring that of obtain	-	
		M. The DON stated there		implementing orders for reside		
	should be Physician	orders for his urinary		requiring indwelling urinary ca		
	catheter, be secured	and assessed daily.		assessment, securement devi		
				place, and notifying licensed p		
		admitted on 11/28/17and		changes to the indwelling urin		
	most recently readmi			site monthly Quality Improvem Committee meeting. The QI C		
	contractures.	s neurogenic bladder and		will review for further recomme		
	somulatures.			for follow up as needed or cor		

Facility ID: 923021

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	S FOR MEDICARE &					NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	()	ATE SURVEY OMPLETED
		0.45000				С
		345293	B. WING	STREET ADDRESS, CITY, STATE,		05/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			HIGHWAY 177 S BOX 1489	ZIP CODE	
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 CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 690	Continued From page	o 17	F 69	0		
F 690		plan last revised 9/17/21	F 09	compliance to determin	no the need and/or	
	read he had an altere			frequency of the contin		
		prapubic urinary catheter (a		to ensure compliance i	•	
		n urine from the bladder).				
		d catheter care per the ge the catheter per MD		Date of completion 06/	09/2022.	
	orders and/or facility					
		ow, ensure the urinary was				
		bladder and the catheter				
	secured with an anch	noring device.				
		m Data Assessment dated				
		was cognitively intact, atheter and total assistance				
	with all his activities of					
		438's May 2022 Physician				
		e any orders for a suprapubic				
		anges, assessment or rinary catheter. There were				
		e facility protocol for urinary				
	catheters.					
	Review of Resident #	438's April and May 2022				
		ation Record (TAR) did not				
	•	nted evidence of urinary				
		sment or maintenance.				
		438's nursing notes dated				
		6/22, 3/23/22, 4/9/22 and				
		documentation regarding ter sliding out or leaking.				
		ervation were completed				
		5/9/22 at 12:26 PM. He				
		d about the hole in his ed he was describing his				
			1	1		1

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	SURVEY PLETED
		345293	B. WING _				C 12/2022
NAME OF P	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	An observation and ir with Nursing Assistan 10:45 AM. She was ir Resident #38's morni abdominal fold to reve site with an open area site with bright red blo was in place. NA #6 s appear that way on 5 have reported it to the An observation and ir with the Staff Develop 5/10/22 at 10:47 AM. aware Resident #38' looked the way it did. nurses and the aides the Treatment (TN) a Nursing (ADON) asse sites weekly. An interview was con 5/10/22 at 11:10 AM. floor nurses, or the TI Resident #38's supra She stated she had n assessment of Reside or 5/10/22 at 11:20 AM w the insertion site. An observation and ir 5/10/22 at 11:20 AM w Both assessed Resid insertion site and stat that way when assess proceeded to clean the blood observed. The notify the MD of the a	Atterview were conducted the trian the process of providing ing ADLs. The aide lifted his eal a suprapubic insertion a to the right of the insertion bod. His securement device stated the area did not /9/22 because she would e nurse. Atterview were conducted boment Coordinator (SDC) on She stated she was not is catheter insertion site The SDC stated the floor provided catheter care but not the Assistant Director of essed the catheter insertion ducted with Nurse #1 on She stated she thought the N assessed and cleaned pubic insertion site daily. ot completed care or ent #38's catheter on 5/9/22 as not aware of bleeding at therview were completed on with the TN and the ADON.	F	590			

Facility ID: 923021

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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:	· ,		NSTRUCTION	(X3) DATE	
		345293	B. WING _			7 177 S BOX 1489	
NAME OF P	ROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			WAY 177 S BOX 1489 ILET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 690	stated he was under i suprapubic catheter p orders. The TN stated to locate the facility's protocol. An interview was con 5/11/22 at 9:50 AM. H impression that the fac care of residents with was not aware that the care and assessment suprapubic catheter. contacted him on 5/10 appearance of his cat stated he gave new of The MD stated the nu obtained monthly Phy suprapubic site daily. Review of Resident # included an order dat needed cleaning of hi using normal saline a gauze, cover site the snug fit sponge desig from the catheter site with tape for wound h An interview was com Administrator and the on 5/12/22 at 1:15 PM DON stated there sho Resident #38's supra 3. Resident #74's quarter	the impression there was a protocol on his Physician d he was not aware of where suprapubic catheter ducted with the MD on the stated he was under the acility had a protocol for the suprapubic catheters and here were no orders for the c of Resident #38's He stated the ADON 0/22 and notified of the theter insertion site. He orders to clean the area daily. Urses, or the TN should have visician orders for his assessed and cleaned his 38's Physician orders ed 5/11/22 for daily and as is suprapubic catheter site nd gauze, pat dry with with a T-Sponge (a precut, ned to wick moisture away) and secure the sponge lealing.	F 6	390			

Facility ID: 923021

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	-	ID HUMAN SERVICES				FORM	M APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG			PLETED
		345293	B. WING _				C / 12/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RICHMON	D PINES HEAI THCARE	AND REHABILITATION CENTE		н	IGHWAY 177 S BOX 1489		
				н	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	had an indwelling urin Resident #74's compo- revised on 3/16/2022 pattern or urinary elim urinary catheter. Inter- care per physician's of catheter changes per protocol, maintain und ensure the urinary was bladder and the cather anchoring device. Resident #74 had a p 4/22/2022 for reinsert wound healing. The of ADON. Resident #74's May 2 not include orders for maintenance of his ur The facility's protocol catheters did not addl of a urinary catheters Resident #74's April a Administration Record documented evidence assessment or mainter An interview was con 5/11/2022 at 2:05 PM cleaned her urinary catheters	r impaired, required ties of daily living (ADL), and harry catheter. rehensive care plan, last , included a focus for altered hination related to indwelling ventions included catheter order or the facility protocol, MD orders and/or facility obstructed urine flow, as below the level of the eter secured with an hysician's order dated tion of urinary catheter for order was entered by the 2022 Physician orders did changes, assessments, or rinary catheter. for indwelling urinary ress care and maintenance and May 2022 Treatment d (TAR) did not include any e of urinary catheter care, enance. ducted with Resident #74 on . She stated the staff	F	690			

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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 ABUILDING		MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
345293 B. WING 05/12/2022 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 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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 ID PROVIDER'S PLAN OF CORRECTION (x4) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 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 (X4) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT	NAME OF PI	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT	RICHMON	ND PINES HEALTHCARE	AND REHABILITATION CENTE					
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 690 Continued From page 51 the order for Resident #74's indwelling urinary catheter. She further stated the urinary catheter was placed for wound healing. The ADON stated she should have put in catheter care orders but she did not. F 690 On 5/11/2022 at 4:11 PM an interview was conducted with Nurse #9. She stated she was assigned to Resident #74 and she provided urinary catheter care to the resident every shift. Nurse #9 reviewed Resident #74's melical record and stated she could not find urinary catheter care orders for the resident every shift. Nurse #9 reviewed Resident #74's melical record and stated she could not find urinary catheter care orders for the resident. An interview was conducted with the MD on 5/11/22 at 9:50 AM. He stated he thought the facility had a protocol for the care of residents with indwelling urinary catheters. He further stated he was not aware there were no orders for the care and assessment of Resident #74's indwelling urinary catheter. F 694 An interview was completed with the Administrator and the Director of Nursing (DON) on 51/2122 at 1:15 PM. The DON stated there should be Physician orders for daily care an maintenance of Resident #74's urinary catheter. F 694 F 694 Seed CFR(s): 483.25(h) F 694 § 433.26(h) Parenteral Fluids. Parenteral fluids. Narenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centred care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 694	the order for Residen catheter. She further was placed for wound she should have put is she did not. On 5/11/2022 at 4:11 conducted with Nurse assigned to Resident urinary catheter care Nurse #9 reviewed R and stated she could care orders for the re An interview was con 5/11/22 at 9:50 AM. H facility had a protocol with indwelling urinary stated he was not aw the care and assess indwelling urinary cat An interview was com Administrator and the on 5/12/22 at 1:15 PM should be Physician of maintenance of Resid Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parentera Parenteral fluids mus with professional star accordance with physic comprehensive person the resident's goals a This REQUIREMENT	t #74's indwelling urinary stated the urinary catheter d healing. The ADON stated in catheter care orders but PM an interview was #9. She stated she was #74 and she provided to the resident every shift. esident #74's medical record not find urinary catheter sident. ducted with the MD on le stated he thought the for the care of residents y catheters. He further are there were no orders for nent of Resident #74's heter. heter. heter. heter. al Fluids. t be administered consistent dards of practice and in sician orders, the on-centered care plan, and nd preferences.					6/9/22

Event ID: J4MM11

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		ID HUMAN SERVICES				FOR	D: 06/09/202 MAPPROVE
STATEMENT C	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345293	B. WING _			05	C / 12/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				н	IGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		н	AMLET, NC 28345		
(X4) ID 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 694	Continued From page	52		694			
1 034				094	to any abaam (ad Daaidant #72 did not		
		ns, resident, staff, Vascular			team observed Resident #73 did not		
		irector (MD) interviews, the le a dressing change to a			provide dressing changes and care for Peripherally Inserted Central Cathete		
		Central Catheter (PICC) line			(PICC) per licensed provider orders	1	
		for 1 (Resident #73) of 1			and/or facility protocol.		
		r infections. The findings					
	included	C C			Resident #73 continues to reside at the	he	
	Resident #73 was ad	mitted on 2/14/19 and			facility and no longer requires the use	e of a	
	readmitted 4/28/22 w	ith a diagnosis of Urosepsis.			PICC.		
					On 5/10/22 Resident #73 dressing ch	-	
		m Data Set dated 4/6/22			was completed by Staff Development	t	
		gnitively intact and she			Coordinator (SDC).		
	exhibited no behavior	ſS.			On 5/11/22 SDC obtained an order fr licensed provider to remove the PICC		
	Review of Resident #	73's hospital discharge			due to no longer needed.		
		22 read a PICC line was			On 5/11/22 Vascular Wellness nurse	in	
		d she was to continue to			the facility to remove PICC line per		
		us (IV) antibiotic for another			licensed provider order.		
					Root Cause: Nursing staff did not obt		
		73's readmission Physician			and/or implement PICC line orders from		
		read she was to receive an			licensed provider and/or facility proto	col	
	•	nours for 9 days. The er IV antibiotic was 5/7/22.			for dressing changes, care, and assessment.		
	Resident #73 was ca	re planned on 5/3/22 for an			All residents with new or existing PIC	С	
	actual urinary tract in				lines have the potential to be affected	l by	
		of the PICC line for signs of			this alleged deficient practice. The		
		e MD, PICC line site care,			corrective actions set forth will be util		
		ne per the facility protocol or			for any residents found to be in a sim	llar	
	as ordered by the Ph	ysician.			situation as Resident #73.		
	The Administrator pro	ovided a copy of the facility's			On 5/10/22, Staff Development		
		et dated June 2020 from a			Coordinator (SDC), began 100% aud	it of	
		The transparent dressing			residents with PICC lines to ensure		
	-	t least every 7 days or			Residents with PICC lines had orders	6	
	immediately when the				from a licensed provider and/or facilit	у	
	compromised.				protocol for dressing changes, care, a		
					assessment. This audit also included		

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/09/2022 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345293	B. WING _			0	C 5/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 694	orders included an or PICC line site care per ordered by the Physic order was dated 5/11 Review of Resident # Medication Administra any documented evic dressing change to h An interview and obs 5/9/22 at 11:06 AM w was observed to her a dressing in place the around the edges but site. Resident #73 sta IV antibiotics and she dressing was the sam from the hospital with An observation was of 10:45 AM. The same Resident #73's PICC An interview was com Director of nursing (A AM. She stated it was change the dressing An observation and in 5/11/22 8:50 AM with She stated she was t #73's PICC line. The been changed on 5/1	 F73's May 2022 Physician der dated 5/3/22 provide er the facility's protocol or as cian. Another Physician //22 to pull out the PICC line. F73's April and May 2022 ation Records and tion Records and tion Records did not include lence of Resident #73's er PICC line for 13 days. ervation was completed on the Resident #73. The PICC right upper arm. There was hat appeared rolled up to still intact at the insertion ated she just completed her e thought the PICC line he one she was discharged here. completed on 5/10/22 at dressing was still in place to line. ducted with the Assistant DON) on 5/10/22 at 11:15 is the facility's protocol to to a PICC line every 7 days. herview was completed on the Vascular Nurse (VN). here to remove Resident PICC line dressing had 0/22 by the Staff 	F	594	checking care plans to ensure reside with PICC lines had a care plan to re PICC line care. This audit was compl on 5/18/22. The Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON Regional Clinical Nurse Consultant w begin education on 6/1/22 on ensurin residents with PICC lines have order from a licensed provider and/or facilit protocol for dressing changes, care, assessment, and care plan. This education will be completed on 6/8/2 On 6/1/22 the SDC added this educat to the new hire packet and agency/contract staff packet. On 6/9/22 the Staff Development Coordinator will mail education to an Contracted Agency/Facility Nursing S that had not completed education of ensuring residents with PICC lines has orders from a licensed provider and/of facility protocol for dressing changes care, assessment, and care plan After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring residents with PICC lines has orders from a licensed provider and/of facility protocol for dressing changes care, assessment, and care plan After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on ensuring residents with PICC lines has orders from a licensed provider and/of facility protocol for dressing changes care, assessment, and care plan	flect eted), and /ill ng s y 2. tion y Staff ave pr , ave pr , sing,	
	was not familiar with	hator (SDC). She stated she the facility's policy on PICC the dressing changes to the			Assistant Director of Nursing (ADON Staff Development Coordinator (SDC assigned special project department) and	

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/09/2022 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345293	B. WING				C / 12/2022
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		
				H	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 694	Continued From page	2 54	F 6	94			
	and as needed. An interview was com AM with the SDC. Sh noticed Resident #73 not been changed sir did it. The SDC states changes were done of She stated she was u PICC line dressing w her readmission on 4 An interview was com AM with the MD. He st that Resident #73's P changed every 7 days An interview was com Administrator and the PM. The DON stated	every 7 days and as needed. Insure why Resident #73's as not changed 7 days after /28/22. Inpleted on 5/11/22 at 9:50 stated it was his expectation PICC line dressing to be s. Inpleted with the DON on 5/12/22 at 1:15 Resident #73's PICC line been changed last week on			will complete monitoring to ensure compliance of ensuring residents with PICC lines have orders from a license provider and/or facility protocol for dressing changes, care, assessment, care plan. The Director of Nursing, the Unit Manager(s), and /or the assigned special project department head will observe 6 random residents 5x/week weeks, then 3x/week x4weeks, then 2x/week x4 weeks to ensure complian that residents with PICC lines have or from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan Beginning 6/15/22 the Director of Nur Assistant Director of Nursing (ADON) Staff Development Coordinator (SDC and/or assigned special project department head will report the finding the monitoring residents with PICC line have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan, to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and rew for further recommendations and/or for	ed and e x 4 nce ders / sing, ,) gs of es } iew bllow	
					Beginning the month of July 2022 and continuing for 3 months, the DON or ADON will report the findings of the monitoring that residents with PICC lin have orders from a licensed provider and/or facility protocol for dressing changes, care, assessment, and care plan monthly Quality Improvement (Q	nes	

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Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/20 FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345293	B. WING		05/12/2022	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IGHWAY 177 S BOX 1489 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIC	
F 694	Continued From page	e 55	F 694	Committee meeting. The QI Commi will review for further recommendat for follow up as needed or continue compliance to determine the need a frequency of the continued QI moni to ensure compliance is maintained	ions d and/or toring	
F 695 SS=D	Respiratory/Tracheos CFR(s): 483.25(i)	stomy Care and Suctioning	F 695	Date of completion 06/09/2022.	6/9/22	
	The facility must ensure needs respiratory car care and tracheal suc care, consistent with practice, the compret care plan, the resider and 483.65 of this su This REQUIREMENT by: Based on observatio Director (MD) intervie facility failed to admir the prescribed rate (F #80). This was for 2 of respiratory care. The 1. Resident #73 was readmitted 4/28/22 w Obstructive Pulmonal	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart. T is not met as evidenced ans, staff and Medical ews and record review, the nister continuous oxygen at Resident #73 and Resident of 3 residents reviewed for findings included: admitted on 2/14/19 and ith a diagnosis of Chronic		On 5/9/22, during a recertification a complaint survey at Richmond Pine Healthcare and Rehabilitation Cente survey team observed Resident #73 Resident #80 were not getting conti oxygen (O2) therapy per the prescr rate as per licensed provider orders 1. Resident #73 continues to resid the facility and continues to require continuous O2 at 2L/Min via nasal cannula. 2. Resident #80 continues to resid	er, the 3, and inuous ibed s. de at	
	Resident #73 was ca	re planned for ineffective ited to COPD. This care plan		the facility and continues to require continuous O2 at 2L/Min via nasal cannula.		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 695	intervention of oxygen cannula as ordered. Review of Resident # orders dated 4/28/22 continuous oxygen at due to COPD. This of Review of Resident # Administration Record documentation that th Resident #73's oxyge hospital transfer on 4 continued after her ref Review of Resident # include any document prescribed oxygen. An interview and obs 5/9/22 at 11:06 AM w wearing her oxygen v at 3.5 L/Min. Resident oxygen at all times du An observation was con Director of nursing (A AM. She stated the flic concentrators setting prescribed continuous An observation was con	 /11/22 and included the in therapy 2L/Min via nasal 473's readmission Physician included an order for t 2 liter per minute (L/Min) rder was dated 10/12/21. 473's April 2022 Medication ds (MAR) included the nurses were assessing en rate every shift prior to her /24/22 but it was not eadmission on 4/28/22. 473's May 2022 MAR did not attaion regarding her ervation was completed on with Resident #73. She was with the concentrator rate set at #73 stated she required ue to her COPD. completed on 5/10/22 at #73 was wearing her oxygen rate set at 3.5 L/Min. npleted with the Assistant ADON) on 5/10/22 at 11:15 oor nurses check the oxygen s every shift on the residents s oxygen. 	F 695	 On 5/12/22, Resident #73 O2 flow was adjusted to 2L/Min via nasal c On 5/27/22 Resident #73 EMAR w corrected to reflect continuous O2 2L/Min via nasal cannula per licens provider clarification. On 5/12/22, Resident # 80 flow O2 rate was adjusted to 2L/Min via na cannula. Root Cause: Nursing staff did cheer flow rate every shift to ensure O2 w being administered per licensed prorder. Nurse did not transcribe O2 for continuous O2 on resident #73 other nurse initiated or implementer Resident #73 continuous O2 order All residents requiring O2 have the potential to be affected by this alleged efficient practice. The corrective a set forth will be utilized for any resifound to be in a similar situation as Resident #73 and #80. On 5/18/22 Assistant Director of N completed 100% audit of residents ensure any resident requiring O2 have the protential to be affected by this alleged flow rate orders and flow rates trans to the EMAR and concentrators/O2 cylinders regulators reflect the order flow rate. In addition, the audit incluaccurate O2 care plan and intervent This audit was completed 5/27/22. 	annula. as at sed flow sal flow sal ck O2 was rovider order and no ed cions idents ursing to nad nscribed 2 ered uded ntions.
	AM. Resident #73 wathe concentrator set a	as wearing her oxygen with at 4.5 L/Min.		(SDC), Director of Nursing (DON), Assistant Director of Nursing (ADC	

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345293	B. WING				C 1 2/2022
NAME OF PF	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DICUMON		AND DELLADU ITATION CENTE		HI	GHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		H	AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 57	F 6	95			
					Regional Clinical Nurse Consultant will		
		npleted on 5/11/22 at 9:00			begin education on 6/1/22 on ensuring		
		ne stated Resident #73 was			resident requiring O2 had accurate ord		
		s oxygen and she was very			and flow rates transcribed to the EMAF	R	
	-	ring it. Nurse #3 stated the			per licensed provider orders,		
	nurses check Resider				concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care a	nd	
	setting was at the pre	every shift to make sure the			assessment per facility protocol, and	na	
	setting was at the pre	scribed rate.			accurate O2 care plan and intervention	s	
	An interview was com	npleted on 5/11/22 at 9:50			This education will be completed on		
		stated it was his expectation			6/8/22.		
	that Resident #73's c	•			On 6/1/22 the SDC added this education	on	
	administrated at the c	ordered rate of 2 L/Min			to the new hire packet and		
	unless otherwise indi	cated.			agency/contract staff packet.		
					On 6/9/22 the Staff Development		
	An interview was com	•			Coordinator will mail education to any		
		DON on 5/12/22 at 1:15			Contracted Agency/Facility Nursing Sta	aff	
		Resident #73's oxygen			that had not completed education		
	L/Min.	ed at the ordered rate of 2			ensuring resident requiring O2 had accurate orders and flow rates transcri	hod	
		admitted on 12/21/2015 with			to the EMAR per licensed provider order		
		ed chronic obstructive			concentrators/O2 cylinders regulators	510,	
	pulmonary disease (C				reflect the ordered flow rate, O2 care a	nd	
	. ,				assessment per facility protocol, and		
	Resident #80's quarte	erly Minimum Data Set			accurate O2 care plan and intervention	IS.	
	. ,	22 indicated the resident					
		, was dependent upon staff			After 6/8/22, no Contracted		
		ctivities of daily living (ADL)			Agency/Facility Nursing Staff will be		
		during the assessment			allowed to work until education on		
	period.				ensuring resident requiring O2 had	had	
	The resident's comm	ohonsivo caro plan was last			accurate orders and flow rates transcri to the EMAR per licensed provider order		
	-	ehensive care plan was last 2 and contained a focus for			concentrators/O2 cylinders regulators	515,	
	•	e breathing patter related to			reflect the ordered flow rate, O2 care a	nd	
		ndence, and respiratory			assessment per facility protocol, and		
	• •	included administer oxygen			accurate O2 care plan and intervention	IS	
	at 2 liters per minute						
	•				De singuia a 0/0/00 the Dise stern of Numeric	~	
					Beginning 6/9/22 the Director of Nursin	ıg,	

Facility ID: 923021

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	06/09/2022 APPROVEI 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	ETED
		345293	B. WING _		C 05/1	2/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
DICUMON				HIGHWAY 177 S BOX 1489		
RICHIVION	D PINES REALI IICARE	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 CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page	- 58	E G	05		
F 695	continuous for cyano and membranes) and breathing). The start 3/9/2022 and the ord electronic medical rea On 5/9/2022 Residen bed, alert, oriented, a device. She was obse oxygen via nasal can On 5/10/2022 at 1:50 observed resting in b oxygen concentrator minute and being adr An interview was con #2 on 5/10/2022 at 1: assigned to Resident resident's active ordet thought the resident of per minute of oxygen noticed the order was An interview was con 5/12/2022 at 11:42 A written order for oxyg Resident #80.	oxygen at 2 liters per minute sis (blueish color to nail beds d dyspnea (difficult or labored date for the order was er was entered in the cord by the SDC. at #80 was observed lying in and using an electronic erved to be on 4 liters of	F 6	 95 Staff Development Co assigned special proje will complete monitoric compliance of ensurin O2 had accurate ordet transcribed to the EM provider orders, conce cylinders regulators re flow rate, O2 care and facility protocol, and a plan and interventions Nursing, the Unit Mar assigned special proje will observe 6 random x 4 weeks, then 3x/we 2x/week x4 weeks to that ensuring resident accurate orders and f to the EMAR per licer concentrators/O2 cylii reflect the ordered flo assessment per faciliti accurate O2 care plan Beginning 6/15/22 the Assistant Director of N Staff Development Co and/or assigned spece department head will resident requiring O2 and flow rates transcr 	ect department head ing to ensure ng resident requiring ers and flow rates IAR per licensed eentrators/O2 eflect the ordered d assessment per accurate O2 care s The Director of nager(s), and /or the ect department head in residents 5x/week eek x4weeks, then ensure compliance t requiring O2 had flow rates transcribed insed provider orders, inders regulators w rate, O2 care and ty protocol, and in and interventions e Director of Nursing, Nursing (ADON), oordinator (SDC) cial project report the findings of had accurate orders	
	She stated she exped	irector of Nursing (DON). cted oxygen to be accurate ered per physician's order.		per licensed provider concentrators/O2 cyli reflect the ordered flo assessment per facilit accurate O2 care plan	nders regulators w rate, O2 care and ty protocol, and	
				to the members of the Intradisciplinary Team months to ensure con	e Cardinal n once weekly x3	

Event ID: J4MM11

Facility ID: 923021

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 05/12/2022	
AME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	03/12/2022	
			н	IIGHWAY 177 S BOX 1489		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	F	IAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC	
F 695	Continued From page	≥ 59	F 695	for further recommendations and/or f up as needed for continued compliar Beginning the month of July 2022 an continuing for 3 months, the DON or ADON will report the findings of the monitoring ensuring resident requirin had accurate orders and flow rates transcribed to the EMAR per licenset provider orders, concentrators/O2 cylinders regulators reflect the ordered flow rate, O2 care and assessment p facility protocol, and accurate O2 car plan and interventions monthly Quali Improvement (QI) Committee meetin The QI Committee will review for furt recommendations for follow up as ne or continued compliance to determin need and/or frequency of the continu monitoring to ensure compliance is maintained.	nce. d g O2 d ed ver re ty g. her seded e the	
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensured in the facility must ensured in the facility must ensured in the facility must ensure the facility of the fac	ure that residents who ve such services, consistent ndards of practice, the on-centered care plan, and nd preferences. is not met as evidenced	F 698	Date of completion 06/09/2022.	6/9/22	
	resident, staff, Medica Physician #1 interview	ns, record review and al Director (MD) and ws, the facility failed to obtain cian orders for the care and		On 5/11/22during a recertification ar complaint survey at Richmond Pines Healthcare and Rehabilitation Cente survey team observed Resident #17	r, the	

Event ID: J4MM11

Facility ID: 923021

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	OF DEFICIENCIES	MEDICAID SERVICES			STRUCTION		<u>NO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		STRUCTION	I Y Y	MPLETED
			A. DOILDING	·			С
		345293	B. WING				5/12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				HIGHW	VAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAML	.ET, NC 28345		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETIO DATE
F 698	Continued From page	e 60	F 69	8			
	monitoring of a reside	ent on hemodialysis		no	t have Licensed Provider orders a	nd/or	
	(Resident #17). This		fac	cility protocols in place for care and	ł		
	reviewed for dialysis.		m	onitoring of resident on hemodialys	sis.		
	Resident #17 was ad		Re	esident #17 continues to reside at t	he		
	readmitted on 2/19/2		fac	cility and continues to require			
	Stage Renal Disease	e (ESRD) requiring dialysis.		he	emodialysis.		
	His readmission Mini	mum Data Set dated 2/26/22		Or	n 5/10/22, Director of Nursing (DOI	N)	
	was coded for receivi	ing dialysis treatments.		ob	tained and implemented orders on	the	
					MAR/ETAR for care and monitoring		
	Resident #17 was ca			sident on hemodialysis to include o			
	ESRD with a risk for	complications due to entions included dialysis on			onitoring, and assessment of dialys unt/fistula.	SIS	
		s and Saturdays, no blood		511			
		ure (BP) in his dialysis		R	oot Cause: Nurses did not obtain o	r	
		ng the access site for			plement Licensed Provider orders		
	bleeding/infection and	d monitoring his vital signs			e EMAR/ETAR for care and monito	0	
	per facility protocol.				resident on hemodialysis to includ		
					re, monitoring, and assessment of		
		17's April and May 2022		dia	alysis shunt/fistula.		
		not include any orders his dialysis access site.			I dialysis residents have the potent	ial to	
					affected by this alleged deficient		
	Review of Resident #	17's April and May 2022			actice. The corrective actions set for	orth	
		ation records (MARs) and			Il be utilized for any residents foun		
		tion records (TARs) did not			in a similar situation as Resident		
		ntation related to dialysis or			include standing orders for care an	nd	
	his dialysis access si	le.			onitoring and assessment of unt/fistula site.		
		t17's dialysis communication					
	sheets from 4/12/22 t				n 5/10/22, the Director of Nursing		
		ented evidence that his right stude was assessed for a thrill			mpleted 100% audit of residents quiring orders for care and monitor	ing of	
		touching the fistula) and a			sident on hemodialysis to include of		
		sound when listening to the			onitoring, and assessment of dialys		
	fistula using a stethos				unt/fistula.		
	communication sheet	ts did not include any			n 5/10/22, the Assistant Director of		
	documented evidence	e that his fistula site was		Nu	ursing (ADON), Treatment Nurse, a	and	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09 FORM APPRO OMB NO. 0938-
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE
F 698	Continued From page	e 61	F 69	8	
	monitored for bleedin	g.		Quality Assurance & Improver obtained and implemented or	
	4/10/22 through 5/11/ documented evidence	17's nursing notes from /22 included 2 occasions of e that his dialysis fistula was		and monitoring of resident on hemodialysis to include care, and assessment of dialysis sh	
	bruit and on 5/6/22 at assessed for a thrill a	at 5:30 PM for a thrill and t 9:20 AM his fistula was and bruit and the appearance		The Staff Development Coord (SDC), Director of Nursing (Do	ON),
		. There was no documented Ila was monitored after his r signs of bleeding.		Assistant Director of Nursing (Regional Clinical Nurse Const begin education to facility dep	ultant will artment
	Resident #17 on 5/9/2	nterview was completed with 22 at 2:40 PM. He stated he		heads, therapy staff, and facil nursing staff on 6/1/22 on obta implementing orders for care a	aining and and
	-	ving his dialysis fistula ided surgical procedure to		monitoring of resident on hem include care, monitoring, and of dialysis shunt/fistula. This e also included no blood pressu	assessment education
	5/11/22 at 11:13 AM	ervation was completed on with Resident #17. He was ershirt under a short sleeve		needle sticks to access arm. T education will be completed o On 6/1/22, the SDC added thi	Γhis n 6/8/22.
	button down shirt. Ob of blood each approx	oserved were several spots imately the size of nickel on		to the new hire packet and agency/contract staff packet.	
		ver his fistula site. Resident ed the dressing earlier this a little bit". He also		On 6/9/22, the Staff Developm Coordinator will mail education Contracted Agency/Facility Nu	n to any
	spots of blood on it. F facility staff did not ro	ish cloth with multiple small Resident #17 stated the utinely check his vital signs ressing for bleeding after his		that had not completed educa obtaining and implementing of care and monitoring of resider hemodialysis to include care,	rders for nt on
	treatments, but some fistula for a thrill and	times they checked his bruit. He stated the facility		and assessment of dialysis sh	•
	right arm.	any lab work or BP's in his		After 6/8/22, no Contracted Agency/Facility Nursing Staff allowed to work until education	n on on
	AM with Nursing Assi	npleted on 5/10/22 at 10:50 istant (NA) #6. She stated no ssure (BP) checks were		obtaining and implementing of care and monitoring of resider hemodialysis to include care,	nt on
		's right arm because that		and assessment of dialysis sh	-

Facility ID: 923021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09 FORM APPRC OMB NO. 0938-
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DAT
F 698	Continued From page	e 62	F 69	98	
		is site was. NA #6 stated the			
		ed the aides to get vital signs		Beginning 6/9/22 22 the SI	DC, DON,
	-	en he returned from his		ADON, Treatment Nurse, (QA&I Nurse,
		irses were responsible for		and/or assigned special pro	
	checking his fistula to			department head will comp	-
		eeding and removing his		to ensure compliance on o	
		each treatment. She stated if		implementing orders for ca	
	would immediately in	ding from his fistula, she form his purse		monitoring of resident on h include care, monitoring, a	-
				of dialysis shunt/fistula. Th	
	An interview was con	npleted on 5/11/22 at 11:30		ADON, Treatment Nurse, (
		he confirmed she was		and/or assigned special pro	
	assigned to Resident	#17 on 5/9/10, 5/10/22 and		department head will obser	-
	today. She stated she	e obtained Resident #17's		residents 5x/week x 4 wee	ks, then
	-	h dialysis treatment, but she		3x/week x4weeks, then 2x/	
		is vital signs should be		weeks ensure compliance	
		atments. Nurse #1 stated		and implementing orders for	
		nat Resident #17's dialysis essed daily for a thrill and		monitoring of resident on h include care, monitoring, a	
		sing monitored for signs of		of dialysis shunt/fistula.	
		ne fistula dressing in place			
		treatments. She stated		Beginning 6/15/22, ADON,	DON,
	Resident #17 would r	remove his own dressing		Treatment Nurse and/or Q	
	after his dialysis treat	tments sometime the		report the findings of the m	nonitoring: on
	following day.			obtaining and implementing	-
				care and monitoring of resi	
		npleted on 5/11/22 at 4:10		hemodialysis to include car	_
		he stated she received dialysis on 5/5/22 and was		and assessment of dialysis the members of the Cardin	
		#17's vital signs should be		Intradisciplinary Team once	
		after each dialysis treatment		months to ensure compliar	-
		ten to document it. She		for further recommendation	
	-	checked his fistula dressing		up as needed for continued	
		and his fistula for a thrill and			
		d Resident #17 knew not to		Beginning the month of Jul	-
		essing until the following day.		continuing for 3 months, Al	
		npleted on 5/12/22 at 10:10		and/or QA&I nurse will rep	-
		he stated she was not aware		of the monitoring on obtain	
		Resident #17's vital signs		implementing orders for ca	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				PLETED
						С
		345293	B. WING		05/12/2022	
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	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETIC
F 698	F 698 Continued From page 63		F 698	8		
		ments. She stated she did		monitoring of resident on hemo	dialysis to	
		ssing for bleeding but		include care, monitoring, and as	•	
	frequently forgot to as	ssess for a thrill and bruit.		of dialysis shunt/fistula. monthly		
				Improvement (QI) Committee m		
		npleted on 5/11/22 at 8:55		The QI Committee will review for		
	AM with the Assistant (ADON). She stated t			recommendations for follow up or continued compliance to dete		
		for bleeding and obtained		need and/or frequency of the co		
	his vital signs after ea	0		monitoring to ensure compliance maintained.		
	An interview was con	npleted with the				
	Administrator and the	Director of Nursing (DON)		Date of completion 06/09/2022.		
		M. The DON stated she				
		obtain Physician orders,				
	-	ers and be knowledgeable				
	Resident #17. The D	a dialysis resident to include				
		oor nurses to ensure all				
		e obtained and any required				
		d into the electronic medical				
	record (EMAR) on ad	mission and readmission.				
	A telephone interview	/ was completed on 5/12/22				
	at 10:44 AM with Phy	sician #1. He stated he was				
		that the facility implemented				
		alysis residents and was not				
		did not have any orders. The				
		as his expectation that the r any missing orders and				
	implement those orde					
		npleted on 5/11/22 at 9:05				
		stated he was not Resident				
	-	was his expectation that				
		rs for dialysis. He stated rs for the assessment of a				
		gns, signs of bleeding and				
		ssing in place for 24 hours				
	before removing.	5 ···				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345293	B. WING	C ــــــــــــــــــــــــــــــــــــ			C 12/2022
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758 SS=D	CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as co in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medication diagnosed specific co in the clinical record; §483.45(e)(4) PRN or are limited to 14 days §483.45(e)(5), if the a prescribing practitione	ppic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that nts who have not used re not given these drugs is necessary to treat a diagnosed and documented nts who use psychotropic I dose reductions, and ns, unless clinically effort to discontinue these nts do not receive ursuant to a PRN order n is necessary to treat a undition that is documented and rders for psychotropic drugs . Except as provided in uttending physician or	F	758			6/9/22

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			PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
345293	B. WING		C 05/12/2022
	S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/12/2022
RE AND REHABILITATION CENTE			
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
e or she should document their ident's medical record and on for the PRN order. I orders for anti-psychotic o 14 days and cannot be e attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced eviews and interviews with cal Director, the facility failed to psychotropic medications were tion for 2 of 5 residents cessary medications (Residents ed: as originally admitted to the with a recent readmission r diagnoses included dementia, nxiety disorder. m Data Set (MDS) 3/15/22 indicated Resident y impaired cognition and was bg 3 days of an antianxiety the assessment period. ive physician orders revealed 4/22 for Alprazolam (Xanax-an tion) give 0.5 milligrams (mg) as needed (PRN) for anxiety. Alprazolam had no stop date	F 758	On 5/11/22 during a recertification complaint survey at Richmond Pir Healthcare and Rehabilitation Cer survey team observed Resident # Resident #59 did not obtain time I duration orders from Licensed Pro- for as needed psychotropic medic Resident #50 continues to reside facility. Resident #59 continues to reside facility. On 5/11/22, Resident #50 as need psychotropic medications were cla with the licensed provider with sto and were corrected on the EMAR On 5/11/22, Resident #50 as need psychotropic medications were cla with the licensed provider with sto and were corrected on the EMAR On 5/11/22, Resident #50 as need psychotropic medications were cla with the licensed provider with sto and were corrected on the EMAR Root Cause: Licensed Provider di give orders for stop dates on as n psychotropic medications, and the did not contact the license provider	nes nter, the t50, and limited bvider cations. at the at the ded arified op dates ded arified op dates id not leeded e nurse
	IDENTIFICATION NUMBER:	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING 345293 B. WING 345293 B. WING STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) ID PREFIX TAG age 65 F 758 e or she should document their ident's medical record and on for the PRN order. F 758 d orders for anti-psychotic 0 14 days and cannot be e attending physician or oner evaluates the resident for us of that medication. F 758 NT is not met as evidenced eviews and interviews with cal Director, the facility failed to psychotropic medications were titon for 2 of 5 residents Eessary medications (Residents led: as originally admitted to the with a recent readmission r diagnoses included dementia, nxiety disorder. m Data Set (MDS) 3/15/22 indicated Resident ly impaired cognition and was ng 3 days of an antianxiety the assessment period. iw physician orders revealed 4/22 for Alprazolam (Xanax-an tion) give 0.5 milligrams (mg) as needed (PRN) for anxiety. IAparazolam had no stop date to the Electronic Medical he Assistant Director of	& MEDICAID SERVICES (x1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A. BUILDING 345293 STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345 STATEMENT OF DEFICIENCIES NOY MUST BE PROCEDED BY FULL OR LSC IDENTIFYING INFORMATION) providers Splan OF CORREC (ECAN CORRECTIVE ACTION SHC (CROSS-REFERENCE) TO THE APP DEFICIENCY) age 65 F 758 e or she should document their ident's medical record and no for the PRN order. F 758 l orders for anti-psychotic o14 days and cannot be e attending physician or oner evaluates the resident for so fohat medication. NT is not met as evidenced On 5/11/22 during a recertificatio complaint survey at Richmond Pil Healthcare and Rehabilitation Ce survey team observed Resident for so for an needed psychotropic medications were tition for 2 of 5 residents pesschotropic medications (Residents On 5/11/22 during a recertificatio complaint survey at Richmond Pil Healthcare and Rehabilitation Ce survey team observed Resident for is a needed psychotropic medic facility. led: : as originally admitted to the : with a recent readmission r diagnoses included dementia, xiety disorder. On 5/11/22, Resident #50 as nee psychotropic medications were of with the licensed provider with st and were corrected on the EMAR Root Cause: Licensed Provider with st and were corrected on the EMAR Root Cause: Licensed Provider with st and were corrected on the EMAR Root Cause: Licensed Provider with st and were corrected on the EMAR Root Cause: Licensed Provider of with the license provider with st and were corrected on the EMAR

Facility ID: 923021

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
DIGUMON			1	HIGHWAY 177 S BOX 1489	
RICHMON	D PINES HEALI HUARE	AND REHABILITATION CENTE	1	HAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 758	Continued From page	e 66	F 758		
		nic medical records on			
	4/19/22.			All residents have the potential to be	e
				affected by this alleged deficient pra	
		ident #50's April 2022 and		The corrective actions set forth will	
	-	Administration Record		utilized for any residents found to be	
	(MAR) indicated she that had been discont	had orders for Alprazolam tinued as follows:		similar situation as Residents #50 &	. 59.
		1 tablet by mouth every 8		On 5/25/22, the Assistant Director o	f
	hours as needed for a	anxiety from 4/7/22 to		Nursing completed 100% audit of	
		0 received this medication		residents requiring stop dates on as	
	on 4/7/22.			needed psychotropic medications o	
		give one-half tablet by		Licensed providers were notified of	-
		s as needed for anxiety from esident #50 received this		concerns at that time for clarification orders and corrections were made or	
	medication on 5/4/22			resident EMAR of stop dates on as	
				needed psychotropic medications.	
		lay 2022 MARs revealed		On Old 100 the Oteff Development	
		eived as needed dosages of /as initiated on 3/24/22 with		On 6/1/22, the Staff Development Coordinator (SDC), Director of Nurs	ing
	-	es in April and six times in		(DON), Assistant Director of Nursing	
	May.			(ADON), and Regional Clinical Nurs	
	,			Consultant began education to facili	
	· ·	nacy medication reviews		department heads, and facility/agen	ю
	•	ompleted monthly with the		nursing staff on obtaining and	
	last review dated 4/14	4/22.		implementing stop dates on as need	
	An interview occurred	d with the Medical Director		psychotropic medications orders. The ducation will be completed on 6/8/2	
		<i>I</i> , who stated he was aware		On $6/1/22$, the SDC added this educed	
	of the regulation that	-		to the new hire packet and	
	•	ions to be time limited in		agency/contract staff packet.	
		d it was error if a stop date		On 6/9/22, the Staff Development	
		physician's order for the		Coordinator will mail education to an	
	PRN psychotropic me	edication.		Contracted Agency/Facility Nursing	
	The ADON was inter	viewed on 5/11/22 at 11:40		that had not completed education of obtaining and implementing stop da	
		sident #50's medical record		as needed psychotropic medication	
		022 and May 2022 MARs.		orders.	
		cility had recently merged			
	-	and felt the order had been		After 6/8/22, no Contracted	
	over to EMR records	and felt the order had been		After 6/8/22, no Contracted	

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		ND HUMAN SERVICES			FOF	D: 06/09/202 MAPPROVE <u>0. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		345293	B. WING		0	C 5/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 758	Continued From page	e 67	F 75	18		
	entered in error. She been on Alprazolam f orders in the past. Sh a stop date to provide	confirmed Resident #50 had for a while with time limited he was aware of the need for e reassessment of the he order dated 3/24/22 was		Agency/Facility Nursing Staff allowed to work until educatio obtaining and implementing st as needed psychotropic media orders.	n on top dates on	
	facility on 4/23/21 wit of 4/16/22. Her diagn disorder, dementia, b paranoid schizophrer	-		Beginning 6/9/22, the SDC, D Treatment Nurse, QA&I Nurse assigned special project depa will complete monitoring to en compliance on obtaining and implementing stop dates on a psychotropic medications orde SDC, DON, ADON, Treatmen QA&I Nurse, and/or assigned	e, and/or Irtment head Isure s needed ers. The t Nurse,	
	indicated they were of last review dated 3/1 unable to complete a 4/14/22 as Resident a	completed monthly with the 7/22. The pharmacist was medication review on #59 was in the hospital.		project department head will of random residents 5x/week x 4 then 3x/week x4weeks, then 2 weeks ensure compliance on and implementing stop dates	bbserve 6 I weeks, 2x/week x4 obtaining on as	
	an order dated 4/18/2 antianxiety medicatio a half of a tablet by m needed (PRN) for an Lorazepam had no st	e physician orders revealed 22 for Lorazepam (Ativan-an on) 0.5 milligrams (mg)- give nouth every 24 hours as xiety. This order for PRN top date and was entered edical Record (EMR) by the Nursing (ADON).		needed psychotropic medicati Beginning 6/15/22, ADON, DC Treatment Nurse and/or QA& report the findings of the moni obtaining and implementing si as needed psychotropic medic orders to the members of the Intradisciplinary Team once w	DN, I nurse will itoring: top dates on cations Cardinal	
	#59 had severely imp	22/22 indicated Resident paired cognition. The use of ons was not coded for during		months to ensure compliance for further recommendations a up as needed for continued co Beginning the month of July 2	and/or follow ompliance.	
	Review of the April 20 Medication Administr revealed Resident #5			continuing for 3 months, ADO and/or QA&I nurse will report of the monitoring on obtaining implementing stop dates on a psychotropic medications orde	N, DON, the findings and s needed	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/20 FORM APPROV OMB NO. 0938-03
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345293	B. WING		C 05/12/2022
				TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 177 S BOX 1489	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 758	Continued From page	e 68	F 758		
	none in May. An interview occurred	d with the Medical Director		Quality Improvement (QI) Committee meeting. The QI Committee will revie further recommendations for follow u	ew for
	of the regulation that psychotropic medicat duration. He indicated	ions to be time limited in d it was error if a stop date		needed or continued compliance to determine the need and/or frequency the continued QI monitoring to ensur compliance is maintained.	
	PRN psychotropic me	physician's order for the edication.		Date of completion 06/09/2022.	
	AM and reviewed Re to include the April 20 She confirmed Resid	viewed on 5/11/22 at 11:40 sident #59's medical record 022 and May 2022 MARs. ent #59 had an order for top date, was aware of the			
F 700	need for a stop date t the medication and fe have obtained a stop received.	to provide reassessment of elt it was an oversight to not date when the order was	E 700		2/2/22
F 760 SS=D	CFR(s): 483.45(f)(2)	f Significant Med Errors	F 760		6/9/22
	medication errors.	ure that its- nts are free of any significant ⁻ is not met as evidenced			
	Based on record rev Director interviews, th an antipsychotic med physician, for a reside behaviors (Resident	iew, staff and Medical ne facility failed to administer ication as ordered by a ent with aggressive #59). This was for 1 of 1 or behavioral and emotional		On 5/11/22 during a recertification a complaint survey at Richmond Pines Healthcare and Rehabilitation Cente survey team noted Resident #59 was administered an intramuscular, antipsychotic medication for aggress behaviors on 5/6/22 as ordered.	r, the s not
	The findings included	:		Resident #59 continues to reside at t	the
	Resident #59 was ad	mitted to the facility on		facility.	

Event ID: J4MM11

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		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COM	E SURVEY PLETED
		345293	B. WING			C / 12/2022
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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 69	F 760			
	•	readmission date of es included dementia, olar disorder, and paranoid		On 5/11/22, the licensed provide notified of the omitted intramusc antipsychotic medication for agg behaviors on 5/6/22 as ordered	ular ressive for	
	A quarterly Minimum assessment dated 4/2 #59 had severe cogn	22/22 indicated Resident		Resident #59. Licensed provider a follow up order to administer th intramuscular antipsychotic med aggressive behaviors on 5/11/22	ne ication for	
	during the assessme	n antipsychotic medication nt period. s note was reviewed for		updated order was transcribed to Resident #59 EMAR and medica given as ordered on 5/11/22.		
	5/5/22 and indicated noncompliance with o decision to begin Ris antipsychotic medica	Resident #59 had oral medication, with a perdal Consta (an		Root Cause: Assigned nurse clic the medication on the EMR as 'r available' on 5/6/22, and the ord re-populate on the EMAR.	not	
	aggression was defin identifiable triggers.	ed as impulsive with no		All residents have the potential to affected by this alleged deficient The corrective actions set forth v	practice. vill be	
	Resident #59 and inc for Risperdal Consta			utilized for any residents found to similar situation as Resident #59).	
		igrams (mg). Inject 12.5 mg ime a day every 14 days chizophrenia.		On 5/11/22 & 5/12/22, the Assist Director of Nursing, Assistant Di Nursing, Quality Assurance & Improvement Nurse, Treatment	rector of	
	Administration Record Consta 12.5 mg inject on 5/6/22. The entry of	#59's May 2022 Medication d (MAR) indicated Risperdal tion was added to the MAR dated 5/6/22 indicated the vailable in the facility. The		completed 100% audit of resider to ensure all medications are in t as per licensed provider orders. medications noted to not be in th were obtained at that time.	nts' orders the facility Any	
	next administration of injection was marked	f the Risperdal Consta as 5/20/22 on the May 2022 had not been administered		On 6/1/22, the Staff Developmer Coordinator (SDC), Director of N (DON), Assistant Director of Nur	lursing	
	on 5/11/22.	59's pharmacy records		(ADON), and Regional Clinical N Consultant began education to fa department heads, and facility/a	lurse acility	

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		ND HUMAN SERVICES			FOR	D: 06/09/20 MAPPROVE 0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		345293	B. WING		05	C 5/12/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 760	Continued From page	e 70	F 76	0		
	dispensed by the pha received at the facility Review of Resident # from 2/1/22 to 5/11/2 aggressive behaviors and other residents to liquids and food, layin kicking, biting, spitting An observation of Re 5/9/22 at 12:35 PM. the table for lunch sh (NA) arm and pinche glasses to the floor. glasses, but the NA p foot. She was redirect her lunch meal. On 5/10/22 at 1:30 P with Nurse #3. She et	 #59's nursing progress notes 2 revealed she had s towards staff, her family hat consisted of throwing ng on the floor, hitting, g, and pinching. esident #59 occurred on While staff were assisting to the grabbed the Nurse Aide's d her as well as hit her She attempted to step on the bushed them away with her cted to her seat and served M, an interview occurred explained the psychiatric 		nursing staff on education of r medications off on the EMAR and included notifying the pha the estimated delivery on any medication and notifying the D Nursing and/or the Administra additional guidance. This educ completed on 6/8/22. On 6/1/22, the SDC added this to the new hire packet and agency/contract staff packet. On 6/9/22, the Staff Developm Coordinator will mail education Contracted Agency/Facility Nu that had not completed educa clicking medications off on the not given and included notifyir pharmacy for the estimated de any needed medication and nu Director of Nursing and/or the Administrator for additional gu	as not given irmacy for needed Director of tor for cation will be s education hent n to any ursing Staff tion of not e EMAR as ng the elivery on otifying the	
	after a care plan mee order was provided for injections every 14 da was assigned to Res (7:00 AM to 3:00 PM the pharmacy so it we medication delivery. I cared for Resident #8 medication typically we the following day, after pharmacy.	ays. Nurse #3 stated she ident #59 on the day shift) and the order was sent to ould be sent with the evening Nurse #3 stated she had not 59 since then but stated the would have been provided er it was delivered from the		After 6/8/22, no Contracted Agency/Facility Nursing Staff allowed to work until education clicking medications off on the not given and notifying the pha the estimated delivery and not Director of Nursing and/or the Administrator for additional gu Beginning 6/9/22, the SDC, D Treatment Nurse, Quality Asse Improvement (QA&I) Nurse, a assigned special project depa will complete monitoring to en	n on not EMAR as armacy for tifying the idance. ON, ADON, urance & nd/or rtment head sure to	
	#59's impulsive and a	d he was aware of Resident aggressive behaviors. He c provider spoke with him		ensure all medications are in t per licensed provider orders. DON, ADON, Treatment Nurs	The SDC,	

Facility ID: 923021

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		E SURVEY PLETED
J FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			C
		345293	B. WING		05	5/12/2022
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	D PINES HEALTHCARE	AND REHABILITATION CENTE		HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	COMPLETIC
F 760	Continued From pag	e 71	F 760			
		on of the Risperdal Consta		Nurse, and/or assigned special p	project	
	injections in hopes of	f decreasing some of the		department head will observe 6		
		on 5/6/22, since Resident		residents 5x/week x 4 weeks, the		
		spit out her oral medications. was unaware the Risperdal		3x/week x4 weeks, then 2x/weel weeks to ensure all medications		
		d not been administered as		available in the facility as per lice		
		ave expected it to be started		provider orders.	Shood	
	-	er receival from the pharmacy				
		nt #59 had no negative		Beginning 6/15/22, ADON, DON		
	effects from not initia	ting the medication.		Treatment Nurse and/or QA&I nu		
	An interview occurred	d with the Assistant Director		report the findings of the monitor ensure all medications are availa	-	
		5/11/22 at 1:10 PM. After		facility as per licensed provider of		
		59's medical record and May		the members of the Cardinal		
		ON verified the Risperdal		Intradisciplinary Team once wee	kly x3	
	2	not been provided to		months to ensure compliance ar		
	-	et. She explained the facility		for further recommendations and		
	-	Electronic Medical Records Risperdal Consta was		up as needed for continued com	pliance.	
		ble on 5/6/22 it didn't		Beginning the month of July 202	2 and	
		to alert staff it had not been		continuing for 3 months, ADON,		
	provided. She stated	the next dose to be		and/or QA&I nurse will report the		
		20/22 at 8:00 AM and that is		of the monitoring on ensure all		
		again. The ADON stated		medications are available in the		
		ily behaviors of aggression nily and other residents and		per licensed provider orders mor Quality Improvement (QI) Comm	-	
		the medication to be		meeting. The QI Committee will		
		t was received from the		further recommendations for follo		
	pharmacy.			needed or continued compliance		
				determine the need and/or frequ	•	
				the continued QI monitoring to e compliance is maintained.	nsure	
				Date of completion 06/09/2022.		
F 761 SS=D	Label/Store Drugs ar CFR(s): 483.45(g)(h)	-	F 761			6/9/22
	§483.45(g) Labeling					

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/2022 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 05/12/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		IIGHWAY 177 S BOX 1489 IAMLET, NC 28345	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The faci locked, permanently a storage of controlled the Comprehensive D Control Act of 1976 a abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio facility failed to discar and failed to date one for 1 of 2 medication of medication storage (4) The findings included A review of the facility Storage" dated 6/202 vials and pens should	a used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit ition systems in which the imal and a missing dose can f is not met as evidenced ans and staff interviews, the rd three expired insulin vials e insulin vial when opened carts reviewed for 400 hall- SPARKS). cities of the dated upon opening and arded within the timeframe	F 761	On 5/12/22, during a recertification and complaint survey at Richmond Pines Healthcare and Rehabilitation Center, survey team observed three vials of expired insulin on the 400 hall-SPARH medication cart. Resident #50, #42 currently live in the facility and could have potentially bee affected by this deficient practice. On 5/12/22, the Assistant Director of Nursing removed the three vials of	, the <s< td=""></s<>

Facility ID: 923021

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2022 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING _			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE			IGHWAY 177 S BOX 1489			
-	-			H	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	Continued From page	e 73	F	761				
	On 5/12/22 at 10:56 AM, an observation of the medication cart for the 400 hall SPARK unit was				expired insulin and disposed of them a per facility protocol.			
	included:	e #8. Items discovered r Resident #50 was opened			Root Cause: Assigned nurse did remo three vials of expired insulin from the SPARKS medication cart and dispose	of		
	and undated. - 70/30 Insulin vial for Resident #50 was dated as opened on 3/25/22. A label was present that				these expired vials of insulin per facilit protocol.	Ŋ		
	read to discard 28 da				All residents have the potential to be affected by this alleged deficient pract	ice.		
	-	2. A label was present that			Cart audits by floor nurses per facility			
	read to discard 28 da				protocol will be verified by a Clinical			
		l for Resident #42 was dated 2. A label was present that ys after opening.			Administrative Registered Nurse to protect residents in similar situations.			
		2/22 at 11:05 AM, Nurse #8			On 5/12/22 and 5/13/22, the Assistant Director of Nursing, Assistant Director			
		iced the medications were			Nursing, Quality Assurance &	01		
		and wasn't assigned to that			Improvement Nurse, Treatment Nurse	•		
		/as unable to state who on carts routinely for expired			completed 100% audit of facility medications and removed any expired	ł		
		ions and had not checked			medications from the medication carts and disposed of them per facility proto	;		
		M, an interview occurred			On 6/1/22, the Staff Development			
		ursing. She stated it was			Coordinator (SDC), Director of Nursin	g		
		ials to be dated when d at the recommended time			(DON), Assistant Director of Nursing (ADON), and Regional Clinical Nurse			
	-	nurses should be reviewing			Consultant began education to facility			
		sure they had not expired.			department heads, and facility/agency	/		
					nursing staff on checking medications			
					including multi vial medication expirati dates and exposing of them per facilit			
					protocol. This education will be compl			
					on 6/8/22.	1 :		
					On 6/1/22, the SDC added this educa to the new hire packet and	lion		
					agency/contract staff packet.			
L	l							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2022 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345293	B. WING			05/12/2022	
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
RICHMON	ID 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 761	Continued From page	2 74	F	761	On 6/9/22, the Staff Development Coordinator will mail education to any Contracted Agency/Facility Nursing St that had not completed education of checking medications including multi w medication expiration dates and expose of them per facility protocol After 6/8/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education on checking medications including multi w medication expiration dates and expose of them per facility protocol Beginning 6/9/22, the SDC, DON, ADO Treatment Nurse, Quality Assurance & Improvement (QA&I) Nurse, and/or assigned special project department h will complete monitoring to ensure exp medications are removed from medicat carts and exposing them per facility protocol The SDC, DON, ADON, Treatment Nurse, QA&I Nurse, and/or assigned special project department h will observe 6 random residents 5x/we x 4 weeks, then 3x/week x4weeks, the 2x/week x4 weeks to ensure expired medications are removed from medicat carts and exposing them per facility protocol. Beginning 6/15/22 ADON, DON, Treatment Nurse and/or QA&I nurse w report the findings of the monitoring to ensure all expired medications are removed from medications are	vial sing vial sing DN, ead bired ation eek en ation vill he ary	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/0 FORM APPF OMB NO. 0938	ROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345293	B. WING		C 05/12/202	22
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 AMLET, NC 28345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMP	X5) PLETION ATE
-	 (i) A facility may not resident-identifiable to (ii) The facility may reresident-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 	dentifiable Information 483.70(i)(1)-(5) nt-identifiable information. elease information that is to the public. elease information that is to an agent only in ntract under which the agent disclose the information he facility itself is permitted	F 761	compliance and review for further recommendations and/or follow up as needed for continued compliance. Beginning the month of July 2022 and continuing for 3 months, ADON, DON and/or QA&I nurse will report the find of the monitoring on ensure all expire medications are removed from medic carts and exposing them per facility protocol monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as ne or continued compliance to determine need and/or frequency of the continu- monitoring to ensure compliance is maintained. Date of completion 06/09/2022.	d I, ings ed eation at eded e the	2

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	MENT OF HEALTH AN						FORM	D: 06/09/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345293	B. WING					C 12/2022
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 AMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 842	 (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faciall information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permittive with 45 CFR 164.506 (iv) For public health an eglect, or domestic watch a serious threat to heat by and in compliance §483.70(i)(3) The facial record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The medical series and the series is no requireme (iii) For a minor, 3 year legal age under State 	ented; e; and janized lity must keep confidential ned in the resident's records, or storage method of the release is- r their resident permitted by applicable law; ment, or health care red by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings, oses, organ donation urposes, or to coroners, ineral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity 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 urs after a resident reaches	F	842				

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CENTERS FOR MEDICARE & TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 05/12/2022		
	345293	B. WING _		0			
NAME OF PROVIDER OR SUPPLIER	AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CC HIGHWAY 177 S BOX 1489 HAMLET, NC 28345				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE		
 (iii) The comprehense provided; (iv) The results of an and resident review of determinations cond (v) Physician's, nurse professional's progree (vi) Laboratory, radio services reports as reports as reports as reports as the resident grade on staff intermination facility failed to main medical records in the treatments, (Resident #17) and s (Resident #40). This reviewed for accurate records. The findings 1. Resident #30 was pressure ulcer to his His admission Minim 3/10/22 indicated he pressure ulcers. Review of Resident as for a conductional and a new order for a conduction of the described as his sace and a new order for a condu	sident's assessments; ive plan of care and services y preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and ology and other diagnostic equired under §483.50. T is not met as evidenced views and record review, the tain complete and accurate he areas pressure ulcer ht #30, Resident #38 and urgical wound treatments is was for 4 of 20 residents e and complete medical is included:	F8	 On 5/11/22 during a recertif complaint survey at Richmo Healthcare and Rehabilitatio survey team noted Resident Resident #38, Resident #17 #40 had incomplete (omissio records. Resident #30 no longer facility. Resident #38 continues the facility and was noted with on pressure ulcer treatment Resident #17 continues the facility and was noted with on pressure ulcer treatment Resident #40 continues the facility and was noted with on pressure ulcer treatment Resident #40 continues the facility and was noted with on surgical wound treatmen Resident #38 has had affect from the omitted docu 3. Resident #17 has had r affect from the omitted docu 4. Resident #40 has had r 	nd Pines on Center, the #30, , and Resident ons) medical resides at the to reside at thomissions orders. to reside at ith omissions orders. to reside at ith omissions orders. to reside at ith omissions torders. no adverse mentation no adverse			

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						0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING	۔	с	
		345293	B. WING			2/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				HIGHWAY 177 S BOX 1489		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HAMLET, NC 28345		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE A		(X5) COMPLETIO
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	DATE
F 842	Continued From page	e 78	F 84	12		
	Administration Record	d (TAR) revealed no				
		e his wound care was		Root Cause: Treatment I		
	-	/5/22, 5/6/22, 5/8/22 and		having trouble with the d		
	5/11/22.			Electronic Treatment Sys	stem	
	Review of Resident #	30's nursing notes from		All residents have the po	tential to be	
		not include any documented		affected by this alleged o		
	evidence of wound ca	are refusals.		On E/12/22 the Assistant	t Dinastan of	
	An interview with the	Treatment Nurse (TN) was		On 5/13/22, the Assistan Nursing, implemented ac		
		2 at 4:50 PM. He reviewed		one training on the ETAF		
		FAR and acknowledged				
		entation of his wound care on		On 6/1/22 the Staff Deve		
	-	le stated the wound care		Coordinator (SDC), Direc		
	-	dered for Resident #30 but e his documentation by		(DON), Assistant Directo (ADON), and Regional C	-	
		ent #30's electronic medical		Consultant began educa		
		ated he had not gotten used		department heads, and f		
	to documenting in the			nursing staff on checking		
				and correcting any omiss		
	An interview was com	-		Electronic Medication &		
		Director of Nursing (DON)		System before leaving for	-	
		M. The DON explained the		education will be comple		
		ansitioned from paper to /19/22 but expected the		On 6/1/22 the SDC adde to the new hire packet ar		
		well as any other nursing		agency/contract staff pac		
		wound care was completed		On 6/9/22 the Staff Deve		
	-	fused by the resident.		Coordinator will mail edu	-	
				Contracted Agency/Facil	ity Nursing Staff	
				that had not completed e		
		admitted on 11/28/17and		checking for omissions a		
		n 11/4/21 with pressure		omissions in the Electror		
	ulcers to his right and	i ieil neeis.		for your shift	n before leaving	
	His quarterly Minimur	m Data Assessment dated		After 6/8/22, no Contract	ed	
		was coded for one stage 3		Agency/Facility Nursing		
	pressure ulcer and 3			allowed to work until edu		
				checking for omissions a		
	Review of Resident #	38's April 2022 Physician		omissions in the Electror	nic Medication &	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345293	B. WING		C 05/12/2022		
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		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	Continued From pag	e 79	F 842				
		were new wound care		treatment Record System befor for your shift	-		
	Review of Resident #38's April 2022 Treatment Administration Record (TAR) revealed no documented evidence his wound care was			Beginning 6/9/22 22 the SDC, ADON, Treatment Nurse, Qua Assurance & Improvement (Qua and/or assigned special project	llity A&I) Nurse,		
	4/30/22.	4/24/22, 4/26/22 and		department head will complete of electronic medical records a complete daily The SDC, DON	are N, ADON,		
	revealed no docume	#38's May 2022 TAR nted evidence his wound om 5/6/22 through 5/10/22.		Treatment Nurse, QA&I Nurse assigned special project depair will observe 6 random residen x 4 weeks, then 3x/week x4we	rtment head ts 5x/week		
	4/19/22 to 5/11/22 di	#38's nursing notes from d not include any æ of wound care refusals.		2x/week x4 weeks to ensure e medical records are complete	electronic		
	completed on 5/11/2 Resident #38's May	Treatment Nurse (TN) was 2 at 4:50 PM. He reviewed TAR and acknowledged		Beginning 6/15/22 ADON, DO Treatment Nurse and/or QA&I report the findings of the moni ensure all electronic medical r	nurse will toring to ecords are		
	the days identified. H completed as ordere needed to improve h	entation of his wound care on le stated the wound care was d for Resident #38 but he is documentation by initialing		complete daily to the members Cardinal Intradisciplinary Tean months to ensure compliance for further recommendations a	n daily x3 and review and/or follow		
		electronic medical record e had not gotten used to EMR.		up as needed for continued co Beginning the month of July 2 continuing for 3 months, ADO	022 and		
	on 5/12/22 at 1:15 P	e Director of Nursing (DON) M. The DON explained the		and/or QA&I nurse will report to of the monitoring on ensure al medical records are complete	l electronic monthly		
	electronic TAR's on 4 Treatment Nurse as	ransitioned from paper to 4/19/22 but expected the well as any other nursing wound care was completed		Quality Improvement (QI) Con meeting. The QI Committee w further recommendations for for needed or continued complian	ill review for ollow up as		
		efused by the resident.		determine the need and/or free the continued QI monitoring to compliance is maintained.	quency of		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 06/09/202 /I APPROVE). 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05/12/2022		
		345293	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CO	•	-	
RICHMON	D PINES HEALTHCARE	AND REHABILITATION CENTE		IGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From page	e 80	F 842				
	-	2 after an amputation of all		Date of completion 06/09/20	022.		
	His readmission Mini was coded for a surg	mum Data Set dated 2/26/22 ical wound.					
		17's April 2022 Physician were new wound care					
	Administration Recor	e his wound care was					
		17's May 2022 TAR nted evidence his wound n 5/3/22, 5/5/22, 5/6/22,					
	completed on 5/11/22 Resident #17's May T there was no docume the days identified. H completed as ordered needed to improve hi off in Resident #17's	Treatment Nurse (TN) was 2 at 4:50 PM. He reviewed FAR and acknowledged entation of his wound care on e stated the wound care was d for Resident #17 but he s documentation by initialing electronic medical record had not gotten used to MR.					
	on 5/12/22 at 1:15 PM facility had recently tr electronic TAR's on 4 Treatment Nurse as v	npleted with the Director of Nursing (DON) M. The DON explained the ansitioned from paper to /19/22 but expected the well as any other nursing wound care was completed					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345293	B. WING				C 1 2/2022
NAME OF P	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE		HI	GHWAY 177 S BOX 1489		
				H	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	or indicate if it was re 4. Resident #40 was facility on 1/3/22 with 1/18/22. His diagnos fasciitis (a severe soft caused by bacteria), a and type 2 diabetes. A quarterly Minimum assessment dated 3/- #40 was cognitively in wounds present. A review of the active Resident #40, reveale 4/1/22: - Clean the perineal with gel-like covering to he environment that pror secure every day. - Clean the right butts saline using gauzes, a apply Calcium Alginate every day. The April 2022 and M Administration Record demonstrated the sur Resident #40's perine not initialed as comple- resident at 9:00 AM of 5/5/22 and 5/6/22. Review of the nursing	fused by the resident. originally admitted to the a readmission date of es included necrotizing t tissue infection that is abscess of the perineum, Data Set (MDS) 17/22 indicated Resident ntact and had surgical the physician orders for ed the following orders dated wound with normal saline with clean gauze, apply Silver (a highly absorbent elp maintain a moist motes wound healing) and ock wound with normal pat dry with clean gauze, te with Silver and secure lay 2022 Treatment d (TAR) was reviewed and gical wound care to eum and right buttock was eted or refused by the on 4/21/22, 4/26/22, 5/3/22,	F 8	342			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/09/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345293	B. WING			-		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
RICHMON	ID PINES HEALTHCARE	AND REHABILITATION CENTE			IIGHWAY 177 S BOX 1489 IAMLET, NC 28345			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>		PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORREC CROSS-REFEREN	ETIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		COMPLETION DATE
F 842	The Treatment Nurse at 4:50 PM and expla care dressing change the day shift (7:00 AM reviewing the missing #40, on the April 2022 stated he would have dates. The Treatment completed the wound ordered and "needed treatments in the new system. It's just a but computer and I've jus yet". On 5/12/22 at 1:15 PI with the Director of N explained the facility I from paper to electron expected the Treatment other nursing staff to	was interviewed on 5/11/22 ined he completed wound as Monday through Friday on A to 3:00 PM). After documentation for Resident 2 and May 2022 TARs, he been on duty on those to Nurse stated he had care to Resident #40 as to get better with signing off or Electronic Medical Record inch of clickity clacks on the t not gotten the hang of it M, an interview was held	F	842				

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