STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	07/12/2013

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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record	F 431	Richmond Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Nursing and Rehab ilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brenda A. Conklin | Administrator | 8/2/2013

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.

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F 431	Continued From page 1 review, the facility failed to return discontinued medications for active residents in 2 of 4 medication carts, and the facility failed to label 2 inhalers with the resident's name and directions for use in 1 of 4 medication carts reviewed for medication storage. Findings included: 1. On 7/9/13 at 5:20 PM, the medication cart for 100 hall-lower end was inspected for medication storage. A tube of Neo/Poly/Dex, an antibiotic ophthalmic ointment was observed with resident #17's name on it with the fill date of 9/22/11. Nurse # 1 stated that resident #17 was no longer receiving the medication. She indicated that it should have been returned to the pharmacy once it was discontinued. A review of the July 2013 medication administration record (MAR) for resident #17, indicated she was no longer prescribed Neo/Poly/Dex ophthalmic ointment. In an interview on 7/11/13 at 10:47 AM, the administrator indicated her expectation that discontinued medications be returned to the pharmacy and not left on the medication cart. 2. On 7/9/13 at 6:00 PM, the medication cart for the 400/100 hall-upper end cart was inspected for medication storage. There was 1 bottle of Durezol 0.5 % eye drops for resident #5 in the cart. Durezol eye drops are steroidal drops used to treat pain after eye surgery. The bottle label read, " Durezol 0.5% to the right eye for 1 week then discontinue. " It was dated as filled on 7/12/12. In an interview nurse #2, indicated that the bottle of Durezol had been discontinued for resident #5 and should have been returned to the pharmacy. A review of the July 2013 MAR for resident #5 indicated she was not receiving	F 431	F-431 Resident #17 is not identified on the resident roster from the state agency. On 7-9-13, the discharged medication for resident #5 and resident #45 was removed from the medication cart by the QI nurse and returned to the pharmacy. On 7-9-13 a 100% audit of all medication carts was completed by the DON, ADON, QI nurse, MDS nurses, and Medication Aides to ensure that all discharged and/or unused resident medications were removed from the medication carts and returned to pharmacy per facility procedure. On 7-9-13 a 100% audit of all medication room refrigerators and the medication room was completed by the DON, ADON, QI nurse, and MDS nurses to ensure that all discharged and/or unused resident medications were removed and returned to pharmacy per facility procedure.	8-26-13

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F 431	Continued From page 2 Neo/PolyDex eye drops to her right eye. Also observed on 7/9/13 at 6:00 PM, the medication cart for the 400/100 hall-upper end contained a bottle of Neo/Poly/HC 1% ear drops for resident #45. This medication was used to treat bacterial infections of the ear. It was dated as filled 11/30/12. The label indicated it was to be administered 3 times a day for 5 days then discontinued. Nurse #2 indicated that when this medication was discontinued, it should have been returned to the pharmacy. A review of the July 2013 MAR for resident #45 indicated she was not receiving Neo/Poly/HC ear drops. In an interview on 7/11/13 at 10:47 AM, the administrator indicated her expectation that discontinued medications be returned to the pharmacy and not left on the medication cart. 3. On 7/9/13 at 5:20 PM, the medication cart for 100 hall-lower end contained a Spiriva Handi-Inhaler and a Symbicort Inhaler, both used to treat chronic obstructive pulmonary disease and/or asthma, were found with no resident name or instructions for use. Nurse #1 indicated she was unsure which resident was using the inhalers. She stated they should have been labeled with the resident's name or they should have been kept inside the package they came in from the pharmacy. In an interview on 7/11/13 at 10:47 AM, the administrator indicated her expectation that all medications be labeled with the resident's name and how the medication was to be administered to a resident to include inhalers.	F 431	On 7-9-13 the facility nurse consultant initiated an in-service with all nursing staff, to include, RN's and LPN's, on Facility Procedure for Disposal of Unused Medications from the medication carts, medication room refrigerators, and medication room to ensure that all discharged and/or unused resident medications are removed and returned to pharmacy per facility procedure. On 7-9-13 the administrator initiated the Quality Improvement Audit Tool to monitor disposal of discharged and/or unused resident medication and correct labeling of residents' medications. The Quality Improvement Audit Tool will be completed weekly for four weeks, then one time every other week for three months. The Quality Improvement Audit Tool will be completed by the DON, ADON, QI Nurse, and/or MDS nurse to ensure all discharged and/or unused resident medication is disposed of per facility procedure. On 7-29-13, the facility nurse consultant initiated an in-service with RNs, LPNs and medication aides on medication labels. Medication labels must contain the medication name (generic and/or brand), strength, expiration date when applicable, resident's name, route of administration, appropriate instructions and precautions.	

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F 505 F 505 SS=D	Continued From page 3 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the attending physician of the positive wound culture results dated 5/31/2013 for 1 of 2 sampled residents (Resident # 126.) Findings included: Resident #126 was admitted to the facility on 1/30/13. A review of an incident report dated 3/20/13 revealed resident sustained a bruised blister to right lower leg. During an interview on 7/11/2013 the Treatment Nurse indicated the area continued to increase in size with increased drainage and she renamed the wound a vascular wound on 4/18/2013. The attending physician gave a telephone order dated 5/28/2013 to obtain a culture and sensitivity of the wounds of the legs. On 7/12/2013 at 2:47 pm the Director of Nursing (DON) stated, " I cannot find where the doctor was notified of these results. " She further indicated, " My expectation is that lab results are received and abnormal labs are reported to the physician immediately. " The DON obtained a copy of the wound culture results from the hospital printed 7/12/2013 at 12:54 pm. Review of the wound culture results dated 5/31/2013 indicated positive growth of the bacteria Citrobacter Koseri.	F 505 F 505	The Quality Improvement Executive Committee (consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director) will review the Quality Improvement Medication Audit Tool monthly make recommendations and take actions as appropriate to maintain compliance in this area. F-505 Resident #126 no longer resides in the facility and was sent to hospital on 7-8-13. On 7-19-13 the QI nurse initiated a 100 % audit to ensure all wound culture results were completed from 6-1-13 to 7-19-13 to include culture obtained, results obtained, MD/RP notification, and MD orders received were followed through on as applicable. On 7-30-13 a facility nurse consultant completed a 100% lab audit of all residents' charts to ensure all labs were completed from 6-1-13 to 7-29-13. Any identified concerns were addressed with the medical doctor and followed up on by the QI nurse.	8-26-13

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			On 7-12-13, the facility nurse consultant initiated an in-service for the administrator on the Quality Improvement Wound Care Audit Tool. The Quality Improvement Wound Care Audit Tool includes wound status, intervention, assessment, MD and RP notification, associated wound culture results, and treatment administration record completion. On 7-12-13, the facility nurse consultant initiated an in-service for the DON, ADON, QI nurse, and MDS nurses. The in-service covered the need for review of all labs five times a week, to ensure completion of labs, follow-up on labs, MD/RP notification, and review of any new orders. On 8-1-13, the facility nurse consultant initiated an in-service for the DON, ADON, QI nurse, and MDS nurses the in-service covered the need for review of the wound culture results once per week to ensure completion of wound cultures, follow-up on wound cultures, MD/RP notification, and review of any new orders. On 7-12-13, the facility nurse consultant initiated an in-service on for all RN's, LPN's, ward clerks, medication aides, and the medical records director regarding the placement of a lab results tray, labeled "Lab Results", at the nurses' station. All received lab results will be placed in the Lab Results tray. See attachment (1) for remainder of E505 Plan of Correction.	

F 505

The QI nurse will complete a lab audit five times a week for four weeks and then twice a week for three months to ensure completion of labs, follow-up on lab results, MD/RP notification, and review of any new orders utilizing the Lab QI Audit Tool.

The QI nurse will complete a wound culture audit weekly for four months to ensure completion of wound cultures, follow-up on wound culture results, MD/RP notification, and review of any new orders utilizing the Wound Culture QI Audit Tool.

The Administrator will review the Quality Improvement Wound Care Audit Tool and the Quality Improvement Lab QI audit tools once weekly for four months to ensure all areas are reviewed with appropriate interventions and notification to MD and RP.

The Quality Improvement Executive Committee (consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director) will review the quality improvement audit tools, to include the Lab Audit Toll, Wound Care Audit Tool, and the Quality Improvement Action Team for Wound Care and Skin Assessment. The Quality Improvement Executive Committee monthly reviews will be for the purpose of making recommendations and taking actions as appropriate to maintain compliance in these areas.

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	345293	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/07/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. Building 0102 and 0202 are Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Richmond Pines Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following building construction type was non-compliant, specific findings include ceiling penetrations in the ceiling of the riser room does not meet the required fire resistance rating.	K 012	K012 The ceiling in the riser room was repaired with a fire sealant by the Maintenance Director on 8-7-2013. An audit of the facility ceilings was completed on 8-7-2013 by the Maintenance Director and Assistant Maintenance with no other areas identified.	K012 9-21-13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029	The Administrator inserviced on 8-23-2013 the Maintenance staff on assuring that anytime an outside contractor completed work in the facility to always check the area to assure no penetrations have been made that affects the fire resistant rating of facility ceilings and smoke barriers. The Maintenance staff will check any areas of the facility where outside contractors have worked monthly for 3 months to assure that ceilings still meet the appropriate fire resistance rating and do not have penetrations utilizing a Fire Pentration QI Audit Tool. The Administrator will review the Fire Penetration QI Audit Tool monthly to assure continued compliance in this area.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda A. Conklin — TITLE: Administrator — (X6) DATE: 8/23/13

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.

DRW

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K 029	Continued From page 1 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following hazardous area was non-compliant, specific findings include the door to the clean linen side of laundry did not close, latch and seal tightly in it's frame.	K 029	K012 cont... The Executive Quality Improvement Committee will review monthly the Fire Penetration QI Audit tool for additional recommendations and monitoring of continued compliance in this area. K029 The Maintenance Director repaired the door to the clean linen side of the laundry to assure proper close, latch, and seal on 8-9-2013. An audit of facility doors was conducted by the Maintenance Director and Assistant Maintenance on 8-9-2013 to assure doors close, latch, and seal properly. Any doors identified were adjusted as appropriate. The Administrator inserviced on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that doors properly close, latch, and seal. The Maintenance Staff will check all facility doors to assure that doors close, latch, and seal properly monthly for three months then quarterly thereafter utilizing a Door Closure QI Audit Tool. The Administrator will review the Door Closure QI Audit Tool monthly for three months then quarterly thereafter to assure continued compliance in this area. The Executive Quality Improvement Committee will review monthly for three months then quarterly thereafter, the Door Closure QI Audit Tool for additional recommendations and monitoring of continued compliance in this area.	K029 9-21-13
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following emergency lighting was non-compliant, specific findings include the existing emergency light located near the generator did not function properly upon testing.	K 046		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	K046 The emergency light located near the generator was replaced by the Maintenance Director on 8-8-2013. All other emergency lighting at the facility was checked by the Maintenance Director on 8-23-2013. Any areas identified were corrected as appropriate.	K046 9-21-13

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K 062	Continued From page 2 42 CFR 483.70(a) By observation at approximately noon the following automatic sprinkler system was non-compliant, specific findings include documentation dated 6/5/13 indicating sprinkler certification had deficiencies that had not been corrected. Items included sprinkler heads in the cooler needed to be changed and the dip stick for the air compressor was broken and needed to be changed.	K 062	K046 Cont... The Administrator inserviced on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that all emergency lighting is checked routinely to assure it is working properly. The Maintenance Staff will check all facility emergency lighting monthly for three months then quarterly thereafter utilizing an Emergency Lighting QI Audit Tool. The Administrator will review the Emergency Lighting QI Audit Tool monthly for three months then quarterly thereafter to assure continued compliance in this area.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	The Executive Quality Improvement Committee will review monthly for three months then quarterly thereafter, the Emergency Lighting QI Audit Tool for additional recommendations and monitoring of continued compliance in this area. K062 A sprinkler outside contractor was contacted by the Maintenance Director on 8-23-13 who will change sprinkler heads in the cooler and replace dip stick for the air compressor. The Administrator inserviced on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that all deficient areas listed on sprinkler inspections are repaired timely when report is received and a copy of the report be given immediately to the Administrator for review upon completion of inspections. The Maintenance Director will report any inspections of sprinkler systems monthly on a Maintenance QI Audit tool to assure that all inspections have been reviewed and Administrator is aware of any needed repairs and status. The Administrator will review this audit tool monthly. The Executive Quality Improvement Committee will review monthly for three months the Maintenance QI Audit Tool for additional recommendations and monitoring of continued compliance in this area	K062 9-21-13
	(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4			

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K 066	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following smoking regulations were non-compliant, specific findings include both the staff smoking area and the Alzheimer's smoking area; A. Ashtrays of noncombustible material and safe design per paragraph 3 above were not provided. B. A metal container with a self-closing cover into which ashtrays can be emptied in the smoking area per paragraph 4 above was not provided.	K 066	K066 Ashtray of non-combustible material and safe design and a metal container with a self closing cover into which ashtrays can be emptied in the smoking area of the staff and Alzheimer's smoking area were implemented on 8-9-2013 by the Maintenance Director. There are no other smoking areas at the facility to audit. The Administrator inserviced on 8-23-2013 the Maintenance Director and Assistant Maintenance on assuring that both smoking areas always had the appropriate ashtrays of non-combustible material and self closing metal container for ashtrays to be emptied into accessible. The Maintenance Staff will check the staff and Aalzheimer's smoking areas monthly for three months then quarterly thereafter utilizing an Smoking Area Safety QI Audit Tool. The Administrator will review the Smoking Area Safety QI Audit Tool monthly for three months then quarterly thereafter to assure continued compliance in this area. The Executive Quality Improvement Committee will review monthly for three months then quarterly thereafter, the Smoking Area Safety QI Audit Tool for additional recommendations and monitoring of continued compliance in this area.	K066 9-21-13
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following emergency generator was non-compliant, specific findings include documentation for total run time was not recorded. The staff could not substantiate that the emergency generator was exercised under load for a minimum of 30 minutes per month, not including cool down time.	K 144	(K144 POC located on Building 02 page 1 of 1)	

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000	**K144** **The generator test sheet was revised by the Maintenance Director on 8-7-2013 to clearly show written documentation of emergency generator exercise under load for a minimum of 30 minutes per month, not including cool down time.** **The Maintenance Director will continue to exercise the generator monthly for a minimum of 30 minutes under load, not including cool down time and will document the full load on the generator test sheet.** **The Administrator will review the Generator Test Sheet monthly for three months to assure continued compliance in this area.** **The Executive Quality Improvement Committee will review monthly for three months the Generator Test Sheet for additional recommendations and monitoring of continued compliance in this area.**	K144 9-21-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brenda A. Conklin | Administrator | 8/23/13

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.

DRW