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 _____	C 06/09/2017

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 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 06/04/17 through 06/09/17. Immediate Jeopardy was identified at: CFR 483.10 at tag F157 at a scope and severity (J) CFR 483.10 at tag Fxxx at a scope and severity (J) CFR 483.12 at tag Fxxx at a scope and severity (J) CFR 483.21 at tag Fxxx at a scope and severity (J) CFR 483.25 at tag Fxxx at a scope and severity (J) CFR 483.70 at tag Fxxx at a scope and severity (J) CFR 483.75at tag Fxxx at a scope and severity (J) The tags F157, F221, F224, and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/4/17 and it is ongoing. An extended survey was conducted. This is the initial statement of deficiencies that included only the tags that were cited at the J level. The complete statement of deficiencies, including all tags, will be posted in EPOC at a later date.	F 000		
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.	F 156		7/25/17

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

Electronically Signed | 07/06/2017

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F 156	Continued From page 1 §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and	F 156		

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F 156	Continued From page 2 (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud	F 156		

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F 156	Continued From page 3 Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning	F 156		

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F 156	Continued From page 4 to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	F 156		

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F 156	Continued From page 5 (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or	F 156		

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F 156	Continued From page 6 discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) form a minimum of 2 days in advance of the end date of Medicare services for 2 of 3 residents (Residents #2 and #144) reviewed for liability notices. The findings included: 1. Resident #2 was admitted to the facility on 1/9/17 and he was discharged from skilled nursing services on 3/10/17. There was no documentation that indicated Resident #2 ' s Responsible Party (RP) was provided with a NOMNC form prior to his discharge from skilled services on 3/10/17. An interview was conducted with the Assistant Business Office Manager (ABOM) on 6/6/17 at 12:03 PM. She stated that she was responsible for providing the NOMNC form to the RP a minimum of 2 days prior to the skilled service end date. The NOMNC form for Resident #2 ' s discharge from skilled services on 3/10/17 was requested for review. The ABOM stated she was unable to provide evidence a NOMNC form was	F 156	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 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 proceeding. F156	

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F 156	Continued From page 7 provided to Resident #2 ' s discharge from skilled services on 3/10/17. She indicated she was on vacation during that timeframe and the Business Office Manager (BOM) had been responsible for her duties while she was away. An interview was conducted with the BOM on 6/6/17 at 12:07 PM. She confirmed she was responsible for the ABOM ' s duties when she was on vacation. She stated she was unable to recall if she had provided a NOMNC form for Resident #2 ' s discharge from skilled services on 3/10/17. An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She stated her expectation was for the NOMNC to be provided within the required time frame. 2. Resident #144 was admitted to the facility on 11/17/16 and he was discharged from skilled nursing services on 12/5/16. A review of the NOMNC form for Resident #144 revealed the effective coverage end date was 12/6/16. The NOMNC form was signed by the RP on 12/5/16. An interview was conducted with the Assistant Business Office Manager (ABOM) on 6/6/17 at 12:03 PM. She stated that she was responsible for providing the NOMNC form to the RP a minimum of 2 days prior to the skilled service end date. The NOMNC form for Resident #144 that was signed 1 day prior to the skilled service end date was reviewed with the ABOM. She revealed this form was not signed within the required timeframe. She indicated she was unable to recall why this had happened.	F 156	On 6/24/17, the business office manager notified Resident #2's resident representative (RR) of the notice of Medicare non coverage (NOMNC). On 6/24/17, the business office manager notified via telephone Resident #144, who had discharged home, of the NOMNC. On 6/23/17 through 6/24/17, under the direction of the regional vice president (RVP), the business office manager audited the NOMNC for residents that have been discharged from Medicare covered services from 12/1/16 through 6/23/17 to ensure the resident or RR was notified of the discharge within the allowable time frame. The audit revealed 42 residents that were not notified or not notified in an allowable time frame from 12/1/16 through 6/23/17. The business office manager on 6/24/17 began notifying the identified residents and/or their resident representative via telephone. If the resident or RR was unreachable by telephone, a copy was sent via the United States (US) postal service of the NOMNC. The notification of all identified residents and/or resident representatives was either by telephone or US postal service and was completed on 7/4/17 by the business office manager. On 6/23/17, the RVP in-serviced the business office manager and assistant office manager on the review and execution of the NOMNC. The residents that are being discharged from Medicare services are being reviewed by the administrator during the weekly Medicare meeting to ensure	

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F 156	Continued From page 8 An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She stated her expectation was for the NOMNC to be provided within the required time frame.	F 156	residents are provided their 48 hour notice of Medicare non coverage- right to appeal and prior to exhausting their 100 days. The administrator will continue to review and initial the NOMNC notification copies weekly during the Medicare meeting for 4 weeks then monthly for 2 months. Any identified areas of concern will be corrected through notification of the resident/resident's representative. The business office manager or administrator will present the NOMNC audit findings to the monthly Quality Improvement (QI) Committee for three months to determine if the corrective actions are effective and being sustained or if additional root cause analysis is required with subsequent interventions necessary. The business office manager or administrator will present the NOMNC audit findings and QI committee recommendations to the quarterly executive quality assessment and assurance (QAA) committee for one quarter for review and recommendations to sustain regulatory compliance.	
F 157 SS=J	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 157		7/25/17

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F 157	Continued From page 9	F 157		

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and

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F 157	Continued From page 10	F 157		

phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:
Based on record review and staff, Nurse Practitioner and Physician interview, the facility failed to notify the physician when a cognitively impaired resident was entrapped between the mattress and the foot board causing a bruise to the back of the resident's neck. This was evident for 1 of 3 sampled residents reviewed for accidents (Resident #80).

Immediate jeopardy began on 5/1/17 when Resident #80 was found entrapped between the mattress and the foot board and the facility did not notify the physician.

The immediate Jeopardy is present and ongoing.

Findings included:

1. Resident #80 was admitted to the facility on 1/23/17 with multiple diagnoses including Alzheimer's disease. The quarterly MDS assessment dated 4/25/17 indicated that Resident #80 had memory and decision making problems and needed extensive assistance with bed mobility. Resident #80 resided in the secured unit.

Resident #80's incident report dated 5/1/17 at 4:42 AM was reviewed. The report revealed" resident observed by writer facing the base board of their bed with their head wedged between the base board and the mattress. Writer, nurse, medication aide and Nursing aide (NA) helped remove resident's head from being wedged between base board and mattress by lifting resident's body and pulling mattress out from

F157 Notification

On 5/1/17, at approximately 4:40 am, Nurse #1 entered Resident #80's room and observed Resident #80 facing the footboard of the bed with Resident #80's head wedged between the footboard and the mattress. Resident #80 was trying to get up. Nurse #1, a medication aide, and a nursing assistant helped to remove Resident #80's head that was wedged between the footboard and mattress by lifting Resident #80's body and pulling the mattress away from the resident to make room to slide Resident #80's head from under the footboard. Resident #80 was assessed by Nurse #1. Nurse #1 assessed Resident #80 as having a bruise to the back of the neck, denying pain or discomfort, blood pressure 126/68, pulse 72, respirations 18, and temperature of 98.2F. Nurse #1 noted no changes in Resident #80's level of consciousness, pupils were equal, round and reactive to light and accommodation, able to move all extremities within baseline.

On 5/1/17, the hall nurse notified the physician by phone message at 4:50 am of the incident. On 5/1/17 at 4:50, am the hall nurse spoke with the resident representative (RR) by phone of the incident.

On 5/16/17, 5/24/17, 5/30/17, and

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F 157	Continued From page 11 under resident to make room to slide resident's head out from under base board of their bed. Bruise noted to back of neck. (Name of physician) was notified. Responsible party (RP) notified." Resident #80's nurse's notes were reviewed. The notes dated 5/1/17 at 4:40 AM revealed "resident observed by writer facing the base of their bed with their head wedged between the base board and the mattress. Write asked resident "what are you doing?" Resident stated "trying to get up." Writer, nurse, medication aide and NA helped remove resident's head from being wedged between base board and the mattress by lifting resident's body and pulling the mattress out from under the resident to make room to slide resident's head out from under the base board. Bruise noted to back of neck. Physician notified and responsible party (RP) notified. No change in resident's base line, level of consciousness (LOC), pupils equal, round, reactive to light and accommodation (PERRLA). Able to move all extremities within resident's normal base line. Skin warm and dry to touch. Respiration even and unlabored. Lung sounds clear. No shortness of breath noted. Denies any pain or discomfort. No adverse reaction noted. Vital signs (VS) 126/66, 72, 18, 98.2." On 6/8/17 at 7:55 AM, Nurse #2 was interviewed. Nurse #2 was assigned to Resident #80 on 4/30/17 (night shift). Nurse #2 stated that she was checking the rooms and she found Resident#80's head stuck under the base board of the bed. She clarified that she meant the base board as foot board. The resident was facing the floor and his neck was under the base of the foot board and his head was hanging out. The	F 157	6/12/17, the treatment nurse completed a full body audit on Resident #80 with no negative finding of injury related to entrapment. On 6/9/17, the director of nursing (DON) notified the physician concerning the incident of Resident #80's head being wedged between the mattress and the footboard. On 6/12/17, the DON re-assessed Resident #80. The DON assessed there were no bruises or other injuries noted to Resident #80□s neck. On 6/9/17, Resident #80 received a new bed with a properly fitting mattress from hospice. On 6/27/17, the regional vice president replaced the hospice bed and removed the hospice bed from the facility. On 6/27/17, the resident was provided a new facility owned bed to eliminate any further risk of entrapment between the footboard and the mattress. On 6/16/17, the corporate consultants completed a 100% audit of all residents' nursing progress notes and risk management reports from 3/1/17 through 6/16/17 to ensure all residents with bruises and/or entrapment were assessed, provided appropriate interventions, and the physician and RR were notified via phone, with voice to voice conversation (no message left for MD), and appropriate documentation is in the medical records. The identified areas of concern; was multiple notification to the	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 157	Continued From page 12 resident's body was in bed on downward facing position. He was not talking but he was alert. Four staff members helped to get the resident's head out from the foot board by lifting his body up and pulling the mattress out under him. Nurse #2 stated that she called the attending physician of Resident #80 and not the on-call and left a message on his voice mail. She further stated that she was told to always call the resident's attending physician and not the after-hours access line. Nurse #2 further stated she was not aware that the attending physician of Resident #80 was on vacation at that time. Interview with the DON was conducted on 6/8/17 at 9:27 AM. She stated that she expected the nurses to follow their after-hours procedure in calling the physician. The DON also indicated she expected the nurses to call her if unable to reach the physician and to send the resident to the emergency room (ER). The DON indicated that the incident with Resident #80, the nurse should have sent the resident to ER if unable to reach the physician. Review of the doctor's progress notes from 5/1/17 through 5/7/17 was conducted. There were no notes which addressed the resident's entrapment. Interview with the Physician was conducted on 6/8/17 at 9:58 AM. He stated that he was not informed of the incident with Resident #80 which happened on 5/1/17. He stated that he was on vacation the last week of April and was back to work the morning of 5/1/17. He stated that he expected the nurse to call the Nurse Practitioner or the on call physician. At 4:40 PM, the Physician indicated that his work phone was showing that the facility had called on 5/1/17 at	F 157	RR and/or physician were not completed, two elopements were not investigated, there were no interventions to decrease or eliminate bruises, allegations of abuse, misappropriation or injuries of unknown injury were not being reported, and accidents and incidents were not entered into the system with proper interventions. These notifications, reporting, investigations or interventions were completed by the nurse consultants on 7/16/17. Any further areas of improper notification will be addressed by the director of nursing (DON) or corporate consultant by 7/16/17, with RR and attending physician notification and documentation in the electronic medical record. On 6/13/17, the corporate consultant posted a laminated bright colored sign at each nurse station as a visual guideline. The guideline reminds nurses it is the nurse's responsibility for voice-to-voice notification to the physician for incidents, to include entrapment and changes in resident condition. In-servicing of 100% of all registered nurses and licensed practical nurses was initiated on 6/12/17 by the DON and completed by 6/16/17 regarding: 1) notification of Physician for Changes in Residents Condition, 2) notify Physician (speak with the physician) by telephone: Acute Change in Resident Condition occur, Changes in Cognitive Status occur, Changes in Behavior occur, Changes in Oral Intake to include fluids occur,	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 157	Continued From page 13 4:15 AM and left a message on his voice mail. He stated that he was unable to retrieve the message on his voice mail. Interview with the Nurse Practitioner (NP) was conducted on 6/8/17 at 10:50 AM. The NP stated that she was scheduled to come to the facility every Tuesday and Thursday and at times on Friday and the Physician came every Monday between 8 AM to 5 PM. She stated that she was not informed of the incident with Resident #80. The NP added that she expected the nurses to call her or the physician during office hours Monday through Friday between 8 AM to 5 PM and to call the on call number during after- hours and on the weekends. A follow up interview with the DON was conducted on 6/8/17 at 1:10 PM. The DON stated that she expected the nurses to notify the physician of any incidents/accidents with or without injury. She indicated that she also expected the nurses to call her if unable to reach the physician and she would try to call the physician. She added that if they were unable to reach the physician, the resident should be sent to the ER. The administrator and the DON were notified of immediate jeopardy on 6/8/17 at 12:06 PM.	F 157	Changes in Immune System occur, Changes in Normal Body Functioning occur, PANIC laboratory values occur, Residents Condition Warrants based upon nurses assessments, 3) incidents to include, bruises of unknown origin, entrapment, elopement, and initiation of restraints, 4) if the nurse is unable to reach the attending physician, the nurse may call the on-call physician. If the nurse is unable to reach the attending physician or on-call physician, the nurse may call the facility's medical director, 5) notification of the physician of these types of changes in a resident'□s condition by fax or leaving a message is not acceptable! 6) documentation of the notification of the physician will be documented in the resident's chart, 6) if the nurse is unable to reach, voice-to-voice the attending physician, the on-call physician, or the medical director, the nurse MUST call the director of nursing and the resident must be sent to the emergency department. No nurse will be allowed to work until receiving the in-service on "Notification of Physician for Changes in Residents Condition and Documentation". Questionnaires were initiated on 6/12/17 and were completed by 6/16/17 with 100% of all nurses by the Administrator in Training (AIT), corporate consultants, RN Nurse, and DON for validation of understating regarding physician and RR Notification to include 1) How is the physician to be notified with a change with the resident? 2) What can be considered	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 14	F 157	a change in the resident that the physician would be called? 3) If you are unable to speak with the physician what do you do? 4) If unable to speak with the attending physician or the on-call physician, who would you call? 5) Where is the notification of the physician documented? The licensed nurse is responsible to assess, document, provide appropriate interventions and notify the attending physician and RR of any acute changes in condition, to include bruises of unknown origin, entrapment, and/or any other significant clinical information noted. If the licensed nurse is unable to reach the attending physician, the on-call physician must be called. If unable to contact the attending physician or the on-call physician, the nurse must call the medical director. If unable to reach, voice-to-voice, the attending physician, the on-call physician or the medical director, the DON MUST be notified. The licensed nurse will implement appropriate interventions based on the needs of the resident and notify the attending physician and RR. On 6/16/17, the DON, quality improvement (QI) nurse, staff facilitator, hall nurse, and corporate consultants will audit the nurse progress notes and risk management reports in the electronic medical record to ensure the physician and resident RRs were notified of bruises, elopement, or entrapment, and the notifications are documented in the electronic medical record utilizing a nurse	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 157	Continued From page 15	F 157	progress audit tool. The audit will be completed 5 days a week (Saturday and Sunday progress notes will be reviewed on the weekend or on Monday) for 4 weeks, then 3 times a week for 4 weeks, at least 1 time a week for 4 weeks. The DON or QI nurse will present the findings of the progress note audits at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly x 6 months, identify trends, use "5 Whys" root cause analysis, and make recommendations for follow-up as needed. The DON or QI nurse will present the findings of the progress note audits regarding physician notification at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility's follow-up to the recommendations. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight. The administrator is accountable for ensuring QAA Committee recommendations are implemented and newly implemented process are sustained to maintain regulatory compliance in the area of physician notification.	
F 166 SS=E	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		7/25/17

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 _____	C 06/09/2017

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F 166	Continued From page 16	F 166		

(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations

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F 166	Continued From page 17	F 166		

by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency

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F 166	Continued From page 18 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to investigate and resolve grievances for 2 of 3 residents reviewed for grievances (Residents #76 and #37). The findings included: The facility's grievance policy dated 3/10/17 was reviewed. The policy read in part " ...the right to file grievances orally, in writing, or anonymously ...when a resident, family member, or resident representative reports a concern to a staff member, the staff member will forward the concern to their supervisor, department head, or Administrator ...the Administrator is responsible for overseeing, directing, and investigating grievances in a prompt manner ...the Administrator will assure the resident or resident representative are notified timely of the results of the investigation, of any corrective measures taken, and issue written grievance decisions as appropriate." 1. Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included muscle weakness, difficulty in walking, and history of cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated 5/4/17 indicated Resident #76's cognition was intact. Resident #76 was	F 166	F 166 Resolve Grievances On 6/30/17, the licensed practical nurse (LPN) admissions coordinator interviewed Resident #76 and discussed the concern related to not receiving assistance with showers as scheduled. Resident #76 currently states satisfaction with receiving two showers per week. Resident #76 received a shower on 6/20/17, 6/23/17, and 6/27/17. On 6/30/17, the LPN admissions coordinator again interviewed Resident #76 and Resident #76 agreed assistance with two showers weekly is now being provided. On 6/30/17, the LPN admissions coordinator interviewed Resident #37's resident representative (RR) and discussed the concern related to: 1) staff not assisting Resident #37 with meals, 2) staff not changing Resident #37's incontinence brief timely, and 3) staff not bathing Resident #37. Resident #37's RR currently states satisfaction with assistance with meals, incontinence care, and bathing. On 6/29/17 and 6/30/17, the social worker (SW) and LPN admissions coordinator	

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F 166	Continued From page 19 assessed as dependent on 1 staff member for bathing. He had impairment on 1 side of his upper and lower extremities and was assessed as not steady on his feet. The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care (initiated on 8/12/16 and most recently reviewed on 5/5/17) that indicated the focus area: "Requires assistance/potential to restore or maintain maximum function of self-sufficiency for bathing related to: impaired mobility, physical limitations, [and] weakness." Resident #76 was assessed as dependent on one staff for assistance with bathing. A review of the shower documentation from 3/3/17 through 5/31/17 revealed Resident #76 received 15 showers in 90 days. An interview was conducted with Resident #76 on 6/5/17 at 12:25 PM. Resident #76 indicated he preferred showers to bed baths and he required the assistance of staff with showers. He stated his preference was to have a minimum of 2 showers per week. Resident #76 revealed he had not received his showers as scheduled. He stated he had spoken with the Director of Nursing (DON) about his showers not being provided as scheduled in the past, but it had still been a problem. A review of the facility grievance logs from 12/1/16 through 6/6/17 revealed no grievances were filed by or on behalf of Resident #76 related to showers not being provided as scheduled. An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She	F 166	reviewed all resident concerns for the past thirty days to ensure residents and/or the RRs are satisfied with the resolution and follow-up to their grievance. Any areas of concern were addressed immediately by the social worker or LPN admissions coordinator. On 6/30/17, the administrator initiated an in-service for the administrative staff (director of nursing, SW, admissions coordinator, AR bookkeeping, accounts payable, maintenance, activities, quality improvement nurse, minimum data set nurses, environmental services director, therapy manager) on "Follow Up to Resident Concerns" which included: 1) When addressing resident concerns, you must include detailed information for resolution of concern to include a date and 2) any needed audits or observations to support monitoring should be documented. All newly hired administrative staff will receive the "Follow Up to Resident Concerns" in-service during new employee orientation. Beginning 6/30/17, the administrator and/or DON will review resident concerns weekly for three months to ensure concerns have been addressed and the resolution reviewed with the resident/RR in a timely manner to include a written response on the concern form with details of the follow up that occurred and the date. Beginning 7/1/17, the social worker or admissions coordinator will present the	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 166	Continued From page 20 indicated it was her expectation for showers to be provided as scheduled and as requested by the resident. The DON revealed the facility had an ongoing problem with the provision of showers as scheduled. She indicated she was familiar with Resident #76. She revealed she was aware of a problem with Resident #76 receiving his showers as scheduled as he had reported this to her verbally (she was unable to recall a date). She revealed she had not completed a grievance form for Resident #76's reported concerns. She indicated a grievance form should have been completed for Resident #76's verbal report of his showers not being provided as scheduled. An interview was conducted with the Administrator on 6/8/17 at 3:02 PM. She stated she expected the grievance policy to be followed and for verbal concerns voiced to staff to be written up by that staff member and addressed as per the grievance policy. 2. Resident #37 was admitted on 1/20/11 with cumulative diagnoses of dysphasia, anxiety and aphasia. A social worker (SW) note dated 3/23/17 read a care plan meeting was scheduled for 3/31/17 with Resident #37 ' s family at 10:00 AM. A review of the SW note dated 3/31/17 at 7:14 PM read the care plan meeting was held with the Resident #37 ' s family, MDS nurse, Director of Nursing (DON), Dietary Manager (DM), activities director (AD) and the SW. The note read the resident care guide was used to review each department ' s participation in Resident #37 ' s care. (A resident care guide is a brief synopsis of what needs and precautions were to be	F 166	grievance findings at the monthly quality improvement (QI) committee meeting for three months. The QI committee will review the grievance findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assessment and assurance (QAA) committee for one quarter for further recommendations and oversight.	

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 _____	C 06/09/2017

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

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F 166	Continued From page 21	F 166		

addressed daily with Resident #37. This information was kept in her room and in the computer for the nursing assistant (NAs) to following while providing care.) The SW documented "All concerns addressed and given to appropriate staff".

A review of the facility grievance logs from 12/1/16 to present only included one intake by or on behalf of Resident #37. The grievance was dated 5/22/17 regarding a missing blanket. The outcome read the blanket was found in Resident #37 ' s closet on 5/23/17 and the family was notified.

Resident #37 ' s quarterly Minimum Data Set (MDS) dated 5/22/17 indicated severe cognitive impairment, physical behaviors toward others, and extensive assistance of two staff for her activities of daily living (ADLs) except extensive assistance of one staff for eating. She was coded as incontinent of bowel and bladder.

Resident #37 was last care planned on 5/23/17 for all of her ADL care to be provided by facility staff.

In an interview on 6/4/17 at 5:00 PM, a family member of Resident #37 stated their concerns were that the staff were not feeding, changing her brief or bathing her. The family member also stated Resident #37 ' s room was too cold and her wheelchair brakes were broken on the right side. (The wheelchair brakes were assessed as broken by the surveyor). Resident #37 was in bed and appeared well groomed and absent of odors at this time. The family member recalled that a care plan meeting on 3/31/17 but their concerns were not addressed according to this family

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 166	Continued From page 22 member. In a telephone interview on 6/5/17 at 10:04 AM, the responsible party (RP) for Resident #37 stated he was very upset with facility because their concerns were not addressed. He recalled a care plan meeting but he asked his local family members to attend since he worked out of town. The RP stated none of the issues that were discussed had been addressed by management to his knowledge. In an interview on 6/7/17 at 8:32 AM, the SW recalled the care plan meeting held with Resident #37 ' s family. She stated she did not complete grievance forms because the departments were in the care plan meeting and they could have done their own grievance forms. She stated it was only her responsibility to schedule the care plan meanings. In an interview on 6/7/17 at 1:05 PM, the Administrator stated it was her expectation that the SW would have completed grievance forms during the care plan meeting on 3/31/17 for Resident #37 with a copy given to the responsible department and the original form to her for any necessary follow up.	F 166		
F 221 SS=J	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not	F 221		7/25/17

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 _____	C 06/09/2017

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F 221	Continued From page 23 required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility utilized a device (foot board) in bed without considering it to be a restraint and without a medical symptom. Resident #80's head was caught between the bed's mattress and the foot board causing a bruise to the back of the resident's neck. This was evident for 1 of 3 sampled residents whose beds had a gap of 4 inches or more between the mattress and the foot board in the facility's secured unit (Resident #80). Immediate jeopardy began on 5/1/17 when Resident #80 was found with his head entrapped	F 221	F 221 Restraints On 1/23/17, Resident #80 was admitted to the facility secured unit. On 4/15/17, the licensed practical nurse (LPN) completed a work order for Resident #80□s bed with a broken footboard. On 6/12/17 the maintenance assistants were in-serviced by the regional vice president (RVP) on the Dimensional Limits for Identified Entrapment Zones per the Food and Drug Administration (FDA) Guidelines. The footboard was missing two screws on the	

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F 221	Continued From page 24 between the mattress and the foot board causing a bruise to the back of the resident's neck. The immediate jeopardy is present and ongoing. Findings included: 1. Resident #80 was admitted to the facility on 1/23/17 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 4/25/17 indicated that Resident #80 had memory and decision making problems and needed extensive assistance with bed mobility. The assessment further indicated that the resident was not using any physical restraint in bed and in the chair. Resident #80 resided in the facility's secured unit. Resident #80's care plan dated 4/25/17 was reviewed. The care plan problem was "resident was at risk for falls" and the goal was the "resident will be free of falls through the next review." The approaches included to assist during transfer and mobility, ensure environment free of clutter, administer medications as ordered and have commonly used articles within easy reach. Resident #80's incident report dated 5/1/17 at 4:42 AM was reviewed. The report revealed, "Resident observed by writer facing the base board of their bed with their head wedged between the base board and the mattress. Writer, nurse, medication aide and nursing side (NA) helped remove resident's head from being wedged between base board and mattress by lifting resident's body and pulling mattress out from under resident to make room to slide resident's head out from under base board of	F 221	right side of the board, thus causing a gap between the mattress and footboard which was identified as an entrapment zone. The identified gap between the footboard and mattress for Residents #80□s bed impeded his ability to rise from the bed. The footboard for Resident #80 was repaired by the maintenance assistant by placing two screws on the right side of the board and securing the footboard to the frame and eliminating the footboard as a restraint on 6/8/17. On 6/9/17, hospice provided Resident #80 with a newer style bed and mattress for comfort not because the bed was broken. On 5/1/17, at approximately 4:40 am, Nurse # 1 entered Resident #80□s room and observed Resident #80 facing the footboard of the bed with Resident #80□s head wedged between the footboard and the mattress. Nurse #1, a med aide, and a nursing assistant helped remove Resident #80□s head from being wedged between the footboard and mattress by lifting Resident #80□s body and pulling the mattress out from under the resident to make room to slide Resident #80□s head out from underneath the footboard. Resident # 80 was assessed by the hall nurse with observation of a bruise to the back of the neck, Resident #80 denied pain or discomfort. On 5/1/17, the hall nurse obtained Resident #80□s vital signs: blood pressure was 126/68, pulse 72, respirations 18, and temperature 98.2F. No changes were noted during the assessment by the hall nurse in Resident #80□s level of consciousness, pupils	

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F 221	Continued From page 25 their bed. Bruise noted to back of neck." Resident #80's nurse's notes were reviewed. The notes dated 5/1/17 at 4:40 AM revealed "resident observed by writer facing the base of their bed with their head wedged between the base board and the mattress. Writer asked resident, "What are you doing?" Resident stated "trying to get up." Writer, nurse, medication aide and NA helped remove resident's head from being wedged between base board and the mattress by lifting resident's body and pulling the mattress out from under the resident to make room to slide resident's head out from under the base board. Bruise noted to back of neck." This note was written by Nurse #2. Resident #3 was observed up in wheelchair in his room on 6/5/17 at 4:20 PM. His bed had a ¼ side rail, a foot board and a head board. His bed had no gap between the mattress, foot board and head board. Interview with Nurse Aide (NA) #3 (assigned to Resident #80) was conducted on 6/7/17 at 5:40 PM. NA #3 stated that that the resident was independent with bed mobility, transfer and ambulation but he needed constant reminder due to his confusion. On 6/8/17 at 7:55 AM, Nurse #2 was interviewed. Nurse #2 was assigned to Resident #80 on 4/30/17 (night shift). Nurse #2 stated that she was checking the rooms and she found Resident #80's head stuck under the base board of the bed. She clarified that she meant the base board as foot board. The resident was facing the floor and his neck was under the base of the foot board and his head was hanging out. The	F 221	equal round and reactive to Light and Accommodation, able to move all extremities within baseline. On 5/1/17 at 4:50am, the hall nurse notified the MD by leaving a telephone message. On 5/1/17 at 4:50am, the hall nurse notified the resident representative (RR) by leaving a telephone message. A full body audit was completed on Resident #80 on 5/16/17, 5/24/17, 5/30/17, and 6/12/17 by the treatment nurse with no negative findings of injuries related to restraints or entrapment/gap. On 6/9/17, the Director of Nursing (DON) notified the MD concerning the incident of Resident #80□s head being wedged between the mattress and the footboard. On 6/9/17, hospice provided a new bed with a properly fitting mattress for Resident #80. Resident #80 was re-assessed by the DON on 6/12/17 with no bruises or other injuries noted to neck. On 6/15/17, the quality improvement (QI) nurse and the corporate consultant evaluated Resident #80□s new bed and footboard, to determine the footboard does not meet the definition of a restraint per the resident assessment instrument (RAI) manual. A 100% of all residents□ beds, to include Resident #80, were audited by the maintenance assistants on 6/13/17 to ensure there were no identified risks for entrapment zones/gaps or potential risk for restraining the resident (to include entrapment/gap between mattress, footboard, head board entrapment within the rail, entrapment under the rail, between the rail supports or next to a	

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F 221	Continued From page 26 resident's body was in bed in the downward facing position. He was not talking but he was alert. Four staff members helped to get the resident's head out from the foot board by lifting his body up and pulling the mattress out from under him. Interview with the Maintenance Director was conducted on 6/8/17 at 8:15 AM. He stated that he didn't know that he had to check the gaps between the mattress, foot board, head board and side rails and he was not told to check them. An interview with the Director of Nurses (DON) was conducted on 6/8/17 at 9:27 AM. The DON stated that nobody was checking the gaps between the mattress and the foot board even after the incident with Resident #80 on 5/1/17. She further stated nothing had been done after the resident's entrapment. The resident was moved to another room per family request and not related to the resident's entrapment. Interview with the Administrator was conducted on 6/8/17 at 9:37 AM. She indicated that she expected the maintenance director to check the gaps between the mattress and the foot board at least monthly but she didn't know if the maintenance director was doing it or not. Interview with the Quality Assurance (QA) Nurse was conducted on 6/9/17 at 3:35 PM. The QA Nurse stated that she didn't consider the foot board as a restraint. Interview with MDS Nurse #2 was conducted on 6/9/17 at 3:36 PM. She stated that she didn't consider the foot board as a restraint.	F 221	single support, entrapment between the rail and the mattress, entrapment under the rail, at the end of the rail, entrapment between the bed rails, and entrapment/gap between the end of the rail and the side edge of the head or footboard). The audit identified 3 beds that were not the correct size for the resident due to weight and multiple head and footboards that were loose. The maintenance assistants completed the repairs of all beds on 6/13/2017. The 3 residents that were in a regular bed were provided bariatric beds on 6/13/2017 by the central supply coordinator and maintenance assistant. On 6/13/17, the maintenance assistants adjusted the mattress flaps on the two mattresses to eliminate risk for gaps between the head and footboards. On 6/15/17, the quality improvement (QI) nurse and the corporate consultant evaluated Resident #80□s bed and footboard, determining the footboard does not meet the definition of a restraint per the resident assessment instrument (RAI) manual and Federal Regulations. On 6/13/17, the RN facility consultants completed a 100% audit of residents while in bed to ensure the resident is free from physical restraints by assessing the bed footboard, headboard, side rails and mattresses. The audit resulted in 3 resident beds being removed from service to eliminate the unintended restraining devices. The corporate consultant also ensured the resident was provided enough space while moving around in the bed for repositioning and the bed was not	

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F 221	Continued From page 27 The Regional Vice President and the Administrator were notified of the immediate jeopardy on 6/9/17 at 3:30 PM.	F 221	a restraining device. On 3/1/17 to 6/16/17, 100% of all residents, to include Resident #80, nurse progress notes and risk management reports from 3/1/17 to 06/16/2017 were reviewed for bruises, entrapment/restraint and behaviors by the corporate consultants and will be completed by 6/16/17, to ensure all identified residents with bruises, entrapment/restraints and behaviors were assessed and provide appropriate interventions and that the MD and RR were notified via phone, with voice to voice conversation. All identified areas of concern will be addressed by the facility consultant or director of nursing (DON) by 6/16/17 with resident s representative and attending physician notification and documentation in the electronic medical record. On 6/15/17, the corporate consultant in-serviced 100% of the registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants on restraints. This in-service included the resident assessment instrument (RAI) and Regulatory definition of a restraint (Medical symptom is defined as an indication or characteristic of a physical or psychological condition) and examples of restraints to include: medical symptom is defined as an indication or characteristic of a physical or psychological condition. Before a resident is restrained, the care plan team will determine the presence of a specific medical symptom that required	

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F 221	Continued From page 28	F 221		

the use of restraints. In determining the need for restraint use, an assessment of a resident'□s medical condition, circumstances, and environment should occur. The assessment and evaluation should also include: How a restraint will treat the medical symptom, protect the resident'□s safety and assist the resident in attaining or maintaining his or her highest level of physical and psychological well-being. Medical symptoms that require restraint use will be documented in the medical record. This documentation should occur on the restraint assessment and care plan. Physician orders are necessary for restraint devices. Physician orders should reflect the presence of the medical symptoms that warrants the device use. The facility is accountable for the appropriateness of the device use. broken equipment that restricts freedom of movement, side rails that keep resident from voluntarily getting out of bed, tucking in or using Velcro to hold a sheet, fabric or clothing tightly so that a resident□s movement is restricted, using trays, tables, bars or belts that the resident cannot remove easily, that prevent the residents from rising. Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of the bed.

On 6/14/17, the Regional Vice President reviewed the policy for restraints per the Nursing Policy Manual with the Administrator, Director of Nursing, and Quality Improvement (QI) nurse to include it is the policy of the facility that in order to

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F 221	Continued From page 29	F 221	prevent possible injury or entrapment, the facility will provide an organized and systemic method for body positioning and bed measurements to include gaps per FDA guidelines for hospital beds for the residents. By 6/16/17, the Regional Vice President reviewed the Quality Improvement System for restraints per the Quality Improvement Manual with the Administrator, Director of Nursing and QI nurse to include the purpose in monitoring residents with restraints and high potential for entrapment to ensure that physical restraints are used only as prescribed by the physician. The Administrator, Director of Nursing and Quality Improvement Nurse are to ensure systems are initiated, functional, and maintained. The DON, Administrator and QI nurse will review the incident report form and ensure a proper investigation and follow up to include appropriate interventions. An in-service was initiated by the Facility Consultant on 6/12/17, to be completed by 6/16/17 for 100% of all staff on Entrapment/Gaps □Bed entrapment-an occurrence involving a resident who is caught, trapped, or entangled in the bed system, which includes the spaces in or around the bed rail, bed mattress, or bed frame, to include the footboard. Entrapped body parts associated with risk for severe injury include the head, neck, and chest. Who is at risk for entrapment? Residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and	

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F 221	Continued From page 30	F 221	acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of: timely toileting, position change, and frequent individualized care are factors that may also contribute to the risk of entrapment. The risk may also increase due to technical issues to include, improperly sized mattresses or broken equipment. These technical issues must be reported to the nurse and maintenance director immediately and work order must be completed per policy. Interventions/What to do□ensure that mattress fits the bed if unsure notify the Maintenance Director and nurse immediately to assess the mattress. If a resident is noted to have a body part, to include the head/neck, entrapped in any part of the bed system, to include the footboard, immediately call for assistance and ease the entangled body part out of area. Assess the resident for injuries, CALL and speak with the attending physician, or the on-call physician, to notify of what occurred and your assessment. Initiate any orders if given. Call the Resident Representative (RR) and notify them of what occurred and that the attending physician was notified and any orders or recommendation that was given. Document ALL in the resident'□s chart. Make sure that an incident report is completed along with witness statements from all staff involved. Administrator/DON need to be notified. Prevention-If a resident'□s body position is unsafe in the bed at any time due to space between the mattress and bed or any other reason, the	

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F 221	Continued From page 31	F 221		

nurse must be notified immediately. The nurse must find out the root cause (the cause of the change) of why the resident is in that position and provide appropriate interventions to ensure the resident□s safety, such as: therapy referral, taking the resident to the bathroom, maintenance work order, positioning device, new bed and/or new mattress, or transfer out of the bed per resident'□s choice.

Questionnaires were initiated on 6/12/17 and were completed by 6/16/17 with 100% of all staff to include licensed nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, bookkeeping, payroll, maintenance staff, receptionist, and supply clerk by the Administrator in Training (AIT), corporate consultants, RN Nurse, and Director of Nursing for validation of understating regarding entrapment to include: 1. What do you do if you find broken or faulty equipment? 2. What is entrapment? 3. Can a bed cause entrapment? 4. What do you do if you suspect or observe entrapment? 5. Who is at risk for entrapment? 6. What are some things that can contribute to entrapment? 7. If entrapment occurs, what can you do to ensure the resident□'s safety? 8. Who needs to be notified immediately if a resident is unsafe in bed due to space between that mattress and bed?

On 6/18/17, the corporate consultants began using questionnaires to evaluate

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F 221	Continued From page 32	F 221	facility nurses knowledge of restraints, what a restraint is and examples of restraints. Any nurse that is unable to pass the questionnaire was retrained and retested. If upon the second attempt the nurse was unable to successfully pass the Restraint Questionnaire, the nurse will be removed from the assignment schedule until the nurse is able to pass the questionnaire. A 100% of the nursing assistants were in-serviced by the RN facility consultant by 6/16/17 on restraints and examples of restraints. The nursing assistants will be tested on their knowledge of the subject matter of observing and reporting changes in resident's condition. Any nursing assistant that is unable to pass the test will be retrained and retested. If upon the second attempt the nursing assistant staff is unable to successfully pass the restraint test will be removed from the schedule until the nurse is able to pass the questionnaire. On 6/13/17, the maintenance assistants began auditing 100% of all residents beds to ensure there are no restraints created by gaps or entrapment zones. On 6/13/17, the corporate facility consultants began auditing 100% of all nurse progress notes and risk management reports to ensure there are no unaddressed entrapment or restraint issues. On 6/16/17, the DON, QI nurse, staff facilitator, hall nurse, and/or corporate consultant began auditing nurses	

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F 221	Continued From page 33	F 221	progress notes and risk management reports in the electronic medical record. The audit was to ensure the physician and resident'□s representative (RR) was notified of restraint use. Notifications are documented in the electronic medical record to include a corresponding physician'□s order with a medical symptom for any restraint prescribed. The audit will be documented on the Progress Note Audit Tool. Beginning 6/26/17, the audit will be completed 5 days a week for 4 weeks to include weekends (Saturday and Sunday progress notes will be reviewed on the weekend or on Monday), then 3 days a week for 4 weeks, then weekly for 4 weeks. The DON or QI nurse will present the findings of the Progress Note Audit Tool at the monthly Quality Improvement Committee meeting. The Quality Improvement Committee will review the results of the audits monthly for 3 months, identify trends, use 5 Whys root cause analysis, and make recommendations for follow-up as needed. The DON or QI nurse will present the findings of the Progress Note Audit Tool at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility'□s follow-up to the recommendations. The QAA Committee will perform additional root cause analysis as needed, make additional	

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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

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F 221	Continued From page 34	F 221	recommendations, and provide oversight. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of residents right to be free from physical restraints.	
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility neglected to supervise a cognitively impaired resident who was identified as a wanderer which resulted in an unsupervised	F 224	F224 Neglect On 3/4/17, Nurse #1 assessed Resident #3 was for signs of injury, with no noted	7/25/17

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F 224	Continued From page 35 exit from the facility for 1 of 3 sampled residents reviewed for accidents (Resident #3). Resident #3 was found a few feet to the road heading towards a busy highway. Resident #3 had to go through a parking lot to get to the road. Immediate jeopardy began on 3/4/17 when Resident #3 exited the building unsupervised. Immediate jeopardy is present and ongoing. Findings included: The facility's wandering risk potential protocol dated 1/16/16 was reviewed. The protocol read in part "the purpose of this protocol is to implement guidelines to identify a resident's risk for inappropriate wandering within or outside the facility and to ensure a resident's safety in regards to the identified behavior. To identify this behavior and to ensure a resident's safety, utilization of the wandering risk potential protocol should occur as indicated. These guidelines apply to all residents within the facility including this residents who may reside on secured dementia units." The purpose of the protocol were "to prevent the resident's unsupervised exit and to plan for the resident's safety and well-being within the facility." The procedure included "implement preventative interventions up to or including the application of an alarm bracelet, monitoring the care plan, etcetera (etc.)." 1. Resident # 3 was admitted to the facility on 7/7/16 with multiple diagnoses including pelvic fracture. The quarterly Minimum Data Set (MDS) assessment dated 3/26/17 indicated that Resident #3 had moderate cognitive impairment	F 224	injuries due to an unsupervised exit. On 3/4/17, after assisting Resident #3 back into the facility and assessing for signs and symptoms of injury, Nurse #1 immediately placed Resident #3 on 1:1 constant supervision (to prevent any further attempts to exit the facility) The constant supervision was provided by a nursing assistant until Resident #3 was placed in bed at approximately 8:30 pm. Nurse #1 determined Resident #3, while in bed, was no longer at risk of exiting the facility unsupervised during the shift because of Resident #3's inability to ambulate or rise from the bed without extensive assistance. The resident representative (RR) was notified at 7:35 pm on 03/04/2017 of the occurrence and the licensed nurse documented per the time stamp at 7:45pm. On 3/4/17, Nurse #1 notified Resident #3's physician of the resident exiting the facility by leaving a message due to no injury to the resident. Nurse #1 was drug tested and suspended per facility policy on 6/10/17 related to a neglect allegation. On 6/10/17, a 24 hour report was completed by the administrator and faxed to the Health Care Personnel related to the neglect allegation. On 6/10/17, an investigation was initiated by the Regional Vice President (RVP), corporate consultants, administrator, and director of nursing (DON) related to the allegation of neglect of Resident #3, exiting the facility unsupervised. On 4/9/17, an unidentified staff person of which the DON does not remember, reported to the DON that Resident #3 had an unsupervised exit through the front	

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F 224	Continued From page 36	F 224		

and was independent with locomotion on and off unit. The assessment also indicated that the resident needed extensive assistance with transfer and was using a wheelchair for mobility. The assessment further indicated that the resident had not exhibited a wandering behavior during the assessment period.

Resident #3's wandering risk evaluations were reviewed. The risk evaluation form indicated that a resident with a score of greater than 5 was at risk for wandering.

The wandering risk evaluation form dated 10/7/16 revealed that Resident #3 was at risk for wandering with a score of 16. The form indicated that the resident has had one or more attempts to leave home/facility and or wander in the past 3 months. The form also indicated that the resident had made verbal statement of desire or intent to leave the facility.

The wandering risk evaluation form dated 3/23/17 and 5/18/17 revealed that Resident #3 was at risk for wandering with a score of 19. The form indicated that the resident has had one or more attempts to leave home/facility and or wander in the past 3 months. The form also indicated that the resident had made verbal statement of desire or intent to leave the facility.

Resident #3's care plan for wandering was reviewed. The wandering care plan was initiated on 8/9/16 and was reviewed on 3/28/17. One of the care plan problems was wandering and or at risk for unsupervised exits from facility related to: attempts to leave unit/building. The goal was the resident will have no episode of unsupervised exits from facility through next review. The

door. The previous employee (DON is unable to remember the employee) witnessed Resident #3 heading towards the facility□'s front door. The local Emergency Services was entering the facility and, while coming through the front door, the resident exited out the front door with the assistance of the emergency medical technician (EMT) holding the door open. The unidentified staff member immediately redirected Resident #3 back into the facility. The wander guard door alarm did enunciate, but the door was already open by the EMT□s thus allowing the resident to propel in the wheel chair out the door. The resident was immediately redirected by a staff member back into the facility while the front door wander guard alarm was still sounding.
On 4/10/17, the DON spoke in person with Resident #3□'s RR and requested the RR to attend a 4/11/17, 11:00am care plan meeting. The resident representative declined to attend the care plan meeting.
On 5/14/17, at approximately 4:00pm, the assigned hall Nurse #1 was at the nurse□ station and observed Resident #3 at the front door. Nurse #1 overheard Resident #3 stating to a visitor "let me out". Nurse #1 yelled at the visitor not to let Resident #3 out the front door but the visitor held the front door open for Resident #3 and the resident wheeled out of the facility in the wheel chair. The alarm was sounding when Resident #3 exited the facility. Nurse #1 immediately went outside to assist Resident #3 back inside and observed Resident #3 on the front porch. Nurse #1, a certified nursing assistant

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F 224	Continued From page 37 approaches included to "allow resident to wander on units, to check daily to ensure resident has an alarm bracelet on and it is functioning properly, documents episodes of wandering per facility protocol, ensure identification (ID) bracelet is in place, ensure resident's picture and name are on the wandering resident board, ensure that alarm exits are functional, provide 1:1 staff monitoring as necessary, provide supervision during recreational programs, and provide resident with opportunities to attend group activities of choice". All of these care plan approaches were initiated/started on 8/9/16. There were no new interventions added after 8/9/2016. The nurse's notes dated 3/4/17 at 7:45 PM revealed "alarm sounding at front door. Upon investigating, visitor said that he had let resident (Resident #3) out of door because resident asked him to. Upon going outside, this nurse noted (name of Resident#3) in his chair within a few feet of roadway. This nurse could not get resident return to building. He was yelling "I'm not going back in the building, I'm going home." This nurse continued to hold chair to prevent resident from entering roadway and turned on her cell phone and phoned facility. Advised staff of situation and 3 staff members came and assisted writer to get resident back into building." The notes indicated that the resident had no injuries from the incident. The nurse's notes dated 4/11/17 at 4:47 PM revealed "late entry for 4/10/17 at 5:30 PM, Director of Nursing (DON) and Social Worker (SW) spoke with wife to inform her that the resident had an unsupervised exit and that the team needed to meet with her and the family to discuss the move to sparks (secured unit) unit.	F 224	(CNA) #1, and CNA #2 heard the front door alarm and came outside to assist Nurse #1 with assisting Resident #3 back into the facility. Resident #3 was combative with the staff when attempting to assist the resident back inside the facility. Resident #3 was assisted back into the facility by Nurse #1, Nurse #2, CNA #1, and CNA, #2 approximately 10 minutes after the unsupervised exit. On 5/14/17, upon assisting Resident #3 to the resident's room, Nurse #1 assessed Resident #3 with no injuries observed. On 5/14/17, Nurse #1 notified the physician and RR of Resident #3 exiting the facility unsupervised. On 5/15/17, the social worker (SW) requested Resident #3□'s RR/family for a care plan meeting to be held 5/17/17 to discuss Resident #3's unsupervised exits. The RR/family agreed, but did not attend the 5/17/17 care plan meeting. On 5/18/17, the Minimum Data Set (MDS) Nurse updated the care guide for Resident #3, adding that Resident #3 is at risk for wandering, written in all capital letters for immediate recognition. On 5/18/17, Resident #3'□s RR/family stated to the DON that the RR/family would seek alternate placement due to the RR/family's decision to avoid the facility placing Resident #3 into the secured dementia unit which is recommended by facility and Resident #3's attending physician. On 6/7/17, the SW followed-up with Resident #3'□s RR/family about placement of Resident #3 to another facility. On 6/7/17, the family made no decision regarding alternate facility placement for Resident #3 but	

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F 224	Continued From page 38 She stated that we could go ahead and plan a meeting and she would make sure the family was present." The nurse's notes dated 4/14/17 at 1:59 PM revealed resident "at front door yelling trying to get out. Redirected to lunch with good results. Returned to door, loudly yelling for his wife and son." The nurse's notes dated 4/14/17 at 3:02 PM revealed that at 2:05 PM, Resident #3 was still wanting to leave the facility. The nurse's notes dated 5/15/17 at 4:26 PM revealed that "DON was notified that resident was allowed to leave the building by a family member visiting another resident. The nurse asked the visitor not to let the resident out but they did it anyway. The resident made it out the door but not off the porch and supervised by the nurse the entire time." The nurse's notes dated 5/16/17 at 4:40 PM revealed "resident propelling self-up and down halls in wheelchair yelling and screaming for someone to pay him and that he needs a ride home. Resident repeatedly asking visitors to let him out so he can find a ride home." The nurse's notes dated 5/23/17 at 3:37 PM revealed "wife notified that the resident has been trying to exit building all day. The wife stated that she knows that he will not come back if he is allowed to exit facility." The nurse's notes dated 5/24/17 at 1:53 PM revealed that the resident "attempts to leave facility to vacate the premises. Is cognitively	F 224	continued to refuse for the resident to be moved to the secured dementia unit to prevent future unsupervised exits. On 6/7/17, at approximately 2:00pm, the administrator directed the DON to place Resident #3 on 1:1 constant observation while the resident is out of bed. The resident's RR agreed to move the resident to the designated secured dementia care unit on 06/14/2017 to prevent further unsupervised exits from the front door. The resident will remain on 1:1 supervision until adjusting to the room change and to provide for the resident's psychosocial wellbeing. On 6/15/17, the administrator and DON concluded a thorough investigation which determined Resident #3 had an unsupervised exit on 3/4/17, 4/9/17, and 5/14/17. On 6/15/17, the administrator completed the 5 day investigations for the three occurrences of an unsupervised exit and the 5 day reports were sent to the Health Care Personnel office via fax. The 5 day investigation revealed the facility neglected to supervise a cognitively impaired resident (Resident #3) who was identified as a wanderer which resulted in an unsupervised exit on 3/4/17, 4/9/2017 and 5/14/17. On 5/14/17, the administrator changed the front door sign color from white to yellow for higher visibility to visitors. The sign requested visitors not to assist residents out the front door unattended. On 6/9/17,	

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F 224	Continued From page 39 impaired and cannot make good decision to protect himself from danger." The nurse's notes dated 6/4/17 at 10:20 PM revealed "resident sitting in wheelchair propelling self about facility. Third shift reports that resident didn't sleep last night, he has been up all night wandering about facility in his wheelchair." Resident #3 was observed up in wheelchair in his room on 6/5/17 at 4:20 PM. A wander guard was observed attached to his wheelchair. Interview with NA #1 (assigned to Resident #3 on first shift) was conducted on 6/6/17 at 12:05 PM. NA #1 stated that Resident #3 was independent with locomotion using a wheelchair. She stated that the resident was always out of bed around 10 in the morning and he propelled his wheelchair around facility talking to other residents. NA #1 revealed that the resident was a wanderer and she heard that he had wandered outside during the second shift but she didn't know the date of the incident. NA #1 stated that she was the only NA on the hall. An interview with Nurse #1 was conducted on 6/6/17 at 2:10 PM. Nurse #1 stated that she worked second shift. She indicated that she heard and responded to a front door alarm twice (didn't remember the dates). She indicated that a family member had let Resident #3 out the door. Nurse #1 didn't remember the exact time but it was late in the evening. She found the resident on the road towards the highway (highway 177) in his wheelchair. The resident refused to come back. She had to use her cell phone to call the facility to get help because the resident would not return back to facility. The nurse claimed that	F 224	the maintenance director changed the front door code, verified the wander guard alarm sounded upon a wander guard nearing the front door, and the front door's closure arm tightened securely when the door closed. The RVP, administrator, and DON also verified the wander guard system and closure arm on the front door was operating correctly. On 6/11/17, 11x7 inch signs were ordered by the corporate consultant for the front door from the print shop. The 11x7 inch signs state "please assist us with resident safety by NOT HOLDING the door open for any resident not accompanied by a staff member. Please notify the nurse if someone goes out or if an alarm is heard for better visibility to visitors". On 6/13/17, the RVP placed the signs inside and outside of the front door and around the facility for visibility to visitors. On 6/11/17, the corporate consultant ordered post cards that states "please assist us with resident safety by NOT HOLDING the door open for any resident not accompanied by a staff member. Please notify the nurse if someone goes out or if an alarm is heard for better visibility to visitors." The front door monitor began passing the post cards out on 6/13/17 to all visitors who entered the facility. The SW sent 100% of all RRs and the family members notification via the United States (US) postal service on 06/09/2017 regarding "Do not assist any resident out of the facility, if you are unsure if the person is a resident please ask a staff member."	

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F 224	Continued From page 40 she didn't know how long the resident was outside and how long the alarm was sounding before she answered it. She indicated that she completed the incident report and informed the physician, responsible party, DON and Administrator of the incident. Nurse #1 further revealed that she had responded also to another front door alarm and found the resident on the porch. She stated that a family member had let the resident out. Nurse #1 claimed that she didn't know how long the resident was outside on the porch. She also indicated that she didn't remember the dates and times of the incidents. Nurse #1 also claimed that she didn't remember if she was assigned to the resident on the days Resident #3 was found outside. The location where Resident #3 was found on 3/4/17 was measured by the maintenance director and it was 236 feet (78 yards) away from the facility's front door. The weather underground report revealed that the temperature in the area where Resident #3 was found was on the low 40's degree Fahrenheit (F) on 3/4/17 between 7:30 PM and 7:45 PM. An interview with the DON was conducted on 6/6/17 at 2:50 PM. She indicated that she had asked the resident's family member to move Resident #3 to the secured unit but the family member had refused. She stated that she posted a sign on the door reminding visitors not to let any resident out, but this didn't work. She also stated that the resident had a wander guard. Interview with NA #2 was conducted on 6/6/17 at 3:40 PM. NA #2 was assigned to Resident #3 on 3/4/17 and 4/10/17 on the second shift. NA #2	F 224	The Monthly newsletter for June/July was revised by the Activity Director on 6/11/17 with an increase in font size (26 font) to stress the importance of "before assisting a resident out of the building, check with a staff member." Also, "please be sure that doors close completely behind you upon your exit so a resident is not able to follow you outside." The order of the newsletter was revised to address this important message first. The newsletter was mailed to all the alert and oriented residents and 100% of RRs by the Activities Director by 6/13/17. On 6/11/17, the Minimum Data Set (MDS) Nurse #1, MDS Nurse #2, Admission□s Coordinator, and treatment nurse completed 100% audit of all resident□ progress notes and behavior sheets, including Resident #3, for the past six months to identify residents with exit-seeking behaviors (to include wandering in and out of resident rooms, wandering around the facility, and making comments about exiting the facility) to ensure appropriate interventions were put into place for the prevention of actual unsupervised exit. Interventions were put into place to include 1:1 constant supervision as necessary immediately during the audit by the Maintenance Director and/or the MDS Nurse #1, MDS Nurse #2, Admission□s Coordinator, and treatment nurse for any identified areas of concern. By 6/16/17, the corporate consultants completed 100% audit of all residents' nursing progress notes and	

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F 224	Continued From page 41 stated that she had known Resident #3 as a wanderer. NA #2 revealed that she was the only NA on the hall that day. Interview with the Administrator was conducted on 6/6/17 at 4:46 PM. The Administrator stated that this was the time of the day that Resident #3's behavior was worst, trying to leave the facility. She stated that she had met with the family who gave her permission to move the resident to the secured unit if it was necessary but she felt that the resident was safe if only the staff were monitoring him and responding to the door alarm immediately. The Administrator further stated that there was a staff member (receptionist) in the lobby until 9 PM every day who could monitor the front door. The Administrator further indicated that incident reports were reviewed during the morning meeting and interventions were discussed and the MDS Nurse was responsible to update the care plan. She acknowledged that completion of incident report was an issue as evidenced by Resident #3's wandering incidents on 3/4/17 and 4/10/17 had no incident report completed. The administrator and the DON were notified of immediate jeopardy on 6/7/17 at 1:23 PM.	F 224	incident reports from 3/1/17 to present for residents with actual supervised and unsupervised exits to ensure any resident that had exited the facility unsupervised was not neglected (the exit could not have been prevented by staff, the exit was appropriately handled and appropriate interventions were put into place) and that an investigation was completed to determine the root cause of the supervised or unsupervised exit. The protocol and policy for neglect will be immediately initiated during the audit by the administrator and followed-up on for any resident identified with a supervised or unsupervised exit that could have been prevented by staff. 100% of all residents' Wandering Assessments were reviewed by the MDS nurses by 6/9/17 for accuracy. All inaccurate wandering risk assessments were revised on 6/9/17 by the MDS nurses. A second audit of the wandering assessments was completed on 6/11/17 and compared to the resident progress notes and behavior sheet for accuracy and revised on second time 6/11/17 by the MDS nurses. There was one wandering assessment that was updated by the MDS nurse on 6/11/17. By 6/12/17, the MDS nurses updated the residents'□ care plans, and care guides as appropriate for all residents identified as at risk for wandering and to ensure appropriate interventions were addressed on the resident care plan and resident care guide with oversight by the MDS Consultant. A total of twenty-six (26) residents were	

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F 224	Continued From page 42	F 224	identified as at risk for wandering. As of 06/15/2017, the MDS Nurse and the corporate consultant notified the direct care staff (nurses, nursing assistants, activity staff, social worker, dietary administrator and DON)of any changes in the list of residents included in the wandering program. Beginning on 6/12/17 at approximately 12 noon, the administrator directed that a staff member was placed at the front door to monitor the front door 24 hours a day, 7 days a week, to prevent resident unsupervised exits through the front door. On 6/12/17, the corporate consultants initiated an in-service with 100% all staff (to include license nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, book keeping, pay roll, maintenance staff, receptionist, and supply clerk)regarding the front door will have a person to monitor it 24 hours a day, 7 days a week. The monitor will ensure no resident with a wander-guard device is allowed to exit the facility unsupervised for ninety days. After ninety days the monitor will be replaced by the relocated reception desk adjacent to the front door for continued monitoring. All residents upon admission will be assessed for wandering type of behavior. The wandering assessment triggers at a score of greater than five (5) for being at risk for elopement. The resident care plans will be updated to include a list of	

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F 224	Continued From page 43	F 224	preventive interventions and measures implemented for the prevention of elopement. Any resident that is identified in the wandering risk assessment as a wanderer and at risk for an unsupervised exit will have their picture placed on the wandering board and in the wandering binder. For residents that have the diagnosis of Alzheimer's or residents with dementia that are cognitively declining that do not have a wander guard, the facility will implement the following: 1) upon increased agitation leading to verbalization or behavior to exit the facility the nurse will immediately remove from the egress location, 2) the nurse will assess the resident for wandering utilizing the wandering risk assessment, 3) the resident's representative, the DON and administrator will be notified immediately, 4) the attending physician will be notified of the wandering risk assessment results, 5) The resident will be placed within the secured dementia unit, if appropriate at that time. At no time can the front door monitor turn their back away from the front door. The front door must be in eyes' view at all times. The monitor cannot leave the monitoring station until there is relief. If the monitor is found in violation of appropriately monitoring the front door at any time, retraining and disciplinary action will be taken. There will be a notebook kept at the monitoring station to identify residents that are not to exit the facility without supervision. Visitors and residents enter and exit through the front door. All other exits are locked and require codes to enter or exit. All exit door alarms are	

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 44	F 224	audited daily by the Central Supply clerk during the week and by the manager on duty (MOD) on weekends. During the absence of the Central Supply clerk, the Medical Records, or the Activities Director will check monitors to ensure proper functioning of the wander guard door alarm system. No resident with a wander guard device will be allowed to exit the front door unsupervised. 100% of alert and oriented residents were interviewed by the social worker with questions regarding 1. Do you know what it means to be neglected? If no, please explain definition of neglect to resident. 2. Do you feel that the facility has been neglectful in ensuring your safety to prevent accidents? There are 31 alert and oriented residents that were interviewed. There were no negative findings from the interviews. An in-service was initiated by the corporate consultant on 6/12/17 and was completed by 6/16/17 with 100% of all staff to include nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, bookkeeping, payroll, maintenance staff, receptionist, and supply clerk by the Administrator in Training (AIT), corporate consultants, RN Nurse, and DON regarding the definition of elopement ELOPMENT IS: Unsupervised wandering which results in a resident leaving the nursing home facility. Supervision is a critical component to a safe nursing home facility. It is every	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 224	Continued From page 45	F 224	staff member's responsibility to ensure the nursing home residents do not enter into situations which may put themselves or others at risk of bodily harm. REASON FOR ELOPMENT: Any member of a nursing home population may elope at some point in time. There are no defining traits that accompany elopement among nursing home residents. However, a resident's mental and physical attributes may come into play when it comes to elopement. From a mental standpoint, residents who suffer from dementia, Alzheimer's disease or other forms of mental impairment may be more likely to elope. When eloping, a resident may mistakenly feel that they need to get home to feed a pet, or get back to the office. Individuals with existing psychiatric diseases or mental impairments should usually be placed on an increased watch for elopement by nursing home staff. Residents who have full mobility but impaired mental function may be prime candidates for elopement, and thus need to be carefully monitored by nursing home staff. ELOPMENT PREVENTION: The single greatest factor which can prevent elopement is proper training and vigilance on the part of nursing home staff. It is important for nursing home staff to be well-versed on the habits of residents. Additionally, it is necessary for staff to be familiar with the specific mental and physical issues that residents may have. Residents who suffer from mental issues that increase their likelihood of elopement need to be more closely watched. Also a resident may wander more a certain time	

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F 224	Continued From page 46	F 224	of the day and need to be watched more closely at that particular time of the day. When elopement does take place, it is often a result of too little supervision. Exits which are not intended to be operated by nursing home residents should be either locked securely or equipped with alarms. In addition to keeping a close eye on residents, it is important for nursing home staff to make sure that the alarms on exits work correctly. It is also the responsibility of nursing home staff to respond promptly in the event that a door alarm goes off. NURSING ELOPMENT AND NEGLECT: Failure to enforce the necessary security measures to avoid patients from wandering could be a case of neglect on the part of the nursing home. Another example of negligence is if the staff does not act quickly when an alarm goes off signaling a possible wandering patient. Wandering can also trigger a series of injuries such as falls, bruises, and broken bones. Elopement could even be fatal in some cases, thus the importance of prevention. Facility staff needs to ensure that all cases of elopement or potential elopement are reported immediately to the nurse. CODE ORANGE/PREVENTION OF ELOPMENT: Provide diversional activities for residents with behaviors to include residents who attempt to exit the facility to prevent actual unsupervised exits. If a resident is constantly exit seeking and/or commenting on leaving the facility, diversional activities are to be provided such as snacks, activities of resident'□s interest, family involvement, past life	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 224	Continued From page 47	F 224		

experience activities and/or socially appropriate interactions in a group setting. The exit seeking behavior must be reported to the nurse immediately. It is the nurse'□s responsibility to assess the resident to find out the cause of the exit seeking behavior and ensure appropriate interventions are provided and document in the medical records. It is also the responsibility of ALL nursing home staff to respond promptly in the event that a door alarm goes off. If you observe a resident exiting the facility but cannot respond in a timely manner then a code orange must be called. A code orange is an emergency situation that indicates missing resident/resident elopement and summons medical aides as indicated by using a room number or location. Again, a code orange is used to alert staff and/or summons help. The unsupervised exit must be reported to the nurse immediately.

An in-service was initiated with 100% of license nurses on 6/12/17 and will be completed by 6/16/17 by the Facility Consultants, RN Nurse, and Director of Nursing regarding NURSES RESPONSIBILITIES FOR SUPERVISED OR UNSUPERVISED EXITS. It is the NURSE□S responsibility to:

" Assess the resident from head to toe for any injuries

" Provide appropriate interventions to include initiate wandering protocol if resident was not previously at risk for wandering (update wander risk assessment, place wander guard on

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 48	F 224		

resident'□s ankle or chair if not able to place on ankle, picture on wandering board, add resident'□s name to the transmittal log book), Q 15 minute checks, 1:1 CONTSTANT SUPERVISION as necessary to prevent reoccurrence.
" If an intervention is already in place related to wandering risk, an additional intervention must be put into place after an actual elopement to prevent reoccurrence.
" The resident care guide and care plan must be updated for any new/additional interventions
" Notify the Medical Doctor (MD) and resident representative
" Notify the DON/Administrator of occurrence and intervention initiated
" Complete an incident report
" Document in the medical records

Questionnaires were initiated on 6/12/17 and will be completed by 6/16/17 with 100% of all staff to include will be completed with all staff to include license nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, book keeping, pay roll, maintenance staff, receptionist, and supply clerk by the Administrator in Training (AIT), Facility Consultants, RN Nurse, and Director of Nursing for validation of understating regarding elopement to include 1. What is Elopement? 2. If a resident feet crosses over the threshold what is that called? 3. If a resident is trying to exit the facility or constantly commenting on leaving the facility, what are some things that you can

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 224	Continued From page 49	F 224		

do? 4. What code is utilize to alert staff and summons help for a missing resident/elopement. 5. How often should there be a monitor at the front door? 6. When should you report to the nurse that a resident has exit seeking behavior, commenting on leaving the facility, or actually exited the facility?

A 100% of the licensed nurses, nursing assistants and non-licensed staff will have their questionnaires reviewed by the RN-nurse consultant. The subject matter that is reviewed on the questionnaire will be reviewed by the RN-nurse consultant. Any identified licensed nurses, nursing assistants and non-licensed staff member that is unable to pass the test will be retrained and retested. If upon the second attempt the licensed nurses, nursing assistants and non-licensed staff member is unable to successfully pass the significant change test will be removed from the schedule until remediation is provided.

A 100% of the Nursing Assistants and non-nursing staff will be in serviced by the RN Facility Consultant by 06/16/2017 on Observing and Reporting Change□s in Resident's Condition. The nursing assistants and non-nursing staff will be tested on their knowledge of the subject matter of observing and reporting changes in resident□'s condition. Any nursing assistant or non-licensed staff that is unable to pass the test will be retrained and retested. If upon the second attempt the nursing assistant or non-licensed staff

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F 224	Continued From page 50	F 224		

is unable to successfully pass the significant change test will be removed from the schedule until remediation is provide.

On 6/7/17, the RVP completed a 100% re-training for all department managers (administrator, DON, QI nurse, MDS nurses, treatment nurse, SW, maintenance director, medical records, accounts payable, accounts receivable, admissions director, activity director, dietary manager, environmental services director, and therapy manager) regarding the Action Check list for Unsupervised Exits.

Beginning on 6/7/17, for all unsupervised exits, the facility will complete the Action Checklist for Unsupervised Exit for Nursing Staff to ensure appropriate supervision of the resident at risk of exiting the building and also what to do when the alarm sounds to make sure a thorough search is done, to make sure the staff find the resident if they exited the door. The checklist will include but is not limited to:
1. Missing Resident Search conducted
a. In-House Search
b. Out of Facility Search
2. Notification of CEO or other corporate staff as appropriate
3. Notification of attending MD
4. Notification of resident'□s representative
5. Notification of appropriate authorities as directed by RVP such as law enforcement
6. Assessment of resident with

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 51	F 224	documentation of condition in the medical record 7. Implementation of corrective measures to protect resident (i.e., alarm bracelet, 1:1 monitoring, etc.) 8. Review resident'□s wandering risk assessment and complete new form as necessary; verify resident□'s placement on wandering residents□ board 9. Review resident'□s care plan and revise as indicated 10. If present, check resident'□s alarm bracelet for proper functioning 11. Completion of Resident QI Reporting document, electronic QI incident record, or as necessary. 12. Review all residents that have been identified at risk for wandering to include Wandering Assessments a. Wandering Board Pictures, as applicable b. Review of Care Plan 13. Implementation of corrective measures to protect all other residents that have the potential to be affected by the same or similar issue as necessary 14. Verification of residents□ alarm bracelets checked for proper functioning. 15. Verification of door alarms checked for proper functioning; if door alarms are not functioning, system for monitoring doors until functioning properly 16. Review trends and patterns of unsupervised exits in the facility. 17. Conduct cross referencing of nurse notes to QI reporting forms as indicated 18. Conduct re-education programs for employees with documentation on identified issues as necessary.	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 224	Continued From page 52	F 224	19. Initiation of QI monitoring and consistent audits related to issues as indicated (i.e., preventative interventions appropriate/ in place, alarm bracelets in place, functioning door alarms; resident care guides; at risk wandering evaluations, etc.) 20. Checklist completed and forwarded to appropriate leadership (Regional Vice president, Vice president of Clinical Operations, President of Operations) On 6/13/17, the corporate consultant initiated an in-service with all nurses regarding the Action Checklist for Unsupervised Exit for Nursing Staff to ensure licensed nurses are aware of responsibilities during an unsupervised exit. The in-service was completed by 6/17/17. On 6/13/17, the unsupervised exit checklist for licensed nurses was posted at the nurse station by the corporate consultant as a guide and quick reference for nurses when a resident exits the facility. On 6/16/17, the DON, quality improvement (QI) nurse, staff facilitator, hall nurse, and/or corporate consultant began auditing nurse□ progress notes and risk management reports in the electronic medical record. The audit is to ensure all interventions are in place to prevent cognitively impaired, wandering residents from unsupervised exit. Any concerns were immediately addressed by the auditor to include reporting to the administrator.	

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F 224	Continued From page 53	F 224	On 6/23/17, the supply clerk, maintenance assistant, accounts payable, administrator, DON, QI nurse, MDS nurses, and/or corporate consultants began monitoring the front door, signage, front door monitor, wandering board and books, wander guard locking system on all doors, resident care plans and care guides, staff response times to door alarms, and staff knowledge of code orange to ensure cognitively impaired, wandering residents are supervised, not neglected, and prevented from unsupervised exits from the facility. The unsupervised exit audit tool revealed the staff required further in-servicing on code orange, and the door arm to the front door required replacement. Further in-servicing was provided by the corporate consultant by 7/25/17 and the door alarm was repaired by maintenance assistant on 7/6/17. The monitoring will be documented on the Unsupervised Exit Audit Tool. Beginning 6/26/17, the audit will be completed 5 times a week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months. The DON or QI nurse will present the findings of the Unsupervised Exit Audit Tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly x 6 months, identify trends, use 5 Whys root cause analysis, and make recommendation for follow-up as needed.	

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F 224	Continued From page 54	F 224	The DON or QI nurse will present the findings of the Unsupervised Exit Audit Tool at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility□'s follow-up to the recommendations. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of residents□ right to be free from abuse, neglect, misappropriation of resident property, and exploitation.	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to provide showers as scheduled resulting in a resident feeling unimportant for 1 (Resident #76) of 3 residents reviewed for dignity. The findings included:	F 241	F 241 Dignity and Respect On 6/9/17, the assigned certified nursing assistant (CNA) assisted Resident #76 with a shower, ADL care, and assisted with redressing according to Resident	7/25/17

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 55 Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included muscle weakness, difficulty in walking and history of cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated 5/4/17 indicated Resident #76 ' s cognition was intact. He was assessed with no rejection of care and no behaviors. Resident #76 required extensive assistance of 1 staff member with bed mobility, transfers, and toileting. He was assessed as dependent on 1 staff member for bathing, personal hygiene, and dressing. Resident #76 had impairment on 1 side of his upper and lower extremities and was assessed as not steady on his feet. The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care (initiated on 8/12/16 and most recently reviewed on 5/5/17) that indicated the focus area: "Requires assistance/potential to restore or maintain maximum function of self-sufficiency for bathing related to: impaired mobility, physical limitations, [and] weakness." Resident #76 was assessed as dependent on one staff for assistance with bathing. The shower schedule for Resident #76 indicated he was scheduled for showers on Tuesdays and Fridays. A review of the shower documentation from 3/3/17 through 5/31/17 revealed Resident #76 received 15 showers in 90 days. Resident #76 received 4 showers from 3/3/17 through 3/31/17 (3/6, 3/13, 3/20, and 3/30), 5 showers from 4/1/17 through 4/30/17 (4/4, 4/7, 4/12, 4/25, and 4/28), and 6 showers from 5/1/17 through 5/31/17 (5/2, 5/9, 5/12, 5/16, 5/23, and 5/30).	F 241	#76□s preferences. On 6/29/17, the director of nursing (DON) verified Resident # 76 had showers on 6/20/17, 6/23/17, 6/27/17. On 6/29/17, the director of nursing (DON) completed a 100% audit of the previous 14 days of shower/bathing records for all residents□ to ensure residents were provided a shower/bath according to their preference. The audit revealed 75% of residents had not been assisted with two showers per week for the previous 14 days. Any resident that did not receive a shower or bath was provided one upon review. On 6/29/17, the DON ensured each resident not receiving two showers weekly in the previous 14 days was offered a shower/bath. The audit was documented on the electronic health record look-back report for bathing and shower schedule was updated to reflect the changes by the DON. On 6/29/17, the DON, quality improvement nurse (QI) nurse, and corporate consultant initiated a 100% licensed nurse and CNA in-service titled Showers per Schedule. The in-service instructs nurses to monitor that showers are being given and CNAs to provide residents assistance with showers according to the shower schedule. On 6/29/17, the DON, QI nurse and corporate consultant initiated a Grievance Process and Resident Rights in-service which covers My Rights including the right to be respected, make choices, and to receive good care. The two in-services will be	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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 241	Continued From page 56 An interview was conducted with Resident #76 on 6/5/17 at 12:25 PM. Resident #76 indicated he required the assistance of staff with showers. He reported his scheduled shower days were Tuesdays and Fridays. Resident #76 revealed he had not received his showers as scheduled. He stated he had been informed on several occasions by staff (unable to recall staff names) that they were unable to complete his shower because there was not enough staff on duty. He reported it had, "made me feel like I wasn ' t important enough to be showered because the staff didn ' t have the time". Resident #76 indicated he had spoken with the Director of Nursing (DON) about his showers not being provided as scheduled in the past, but it had still been a problem. An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She indicated it was her expectation for showers to be provided as scheduled and as requested by the resident. She stated she expected showers to be scheduled a minimum of twice per week. The DON revealed the facility had an ongoing problem with the provision of showers as scheduled. She indicated at times there had been difficulty filling in shifts if an NA called off of work. She reported that the facility had previously implemented a shower team, four NA ' s assigned specifically to showers, to address the problem of showers not being provided as scheduled. The DON revealed the implementation of the shower team had not solved the problem. She explained that if an NA called off of work and they were unable to fill in the call off, an NA who was assigned to the shower team was reassigned to the floor. She stated the facility was constantly hiring new NAs,	F 241	completed by 7/7/17. After 7/7/17, no nursing staff will be allowed to complete a shift until they have completed and signed the Showers per Schedule in-service. All newly hired licensed nurses and certified nursing assistants will receive the in-service during new employee orientation. On 6/30/17, the DON, QI nurse, staff facilitator, minimum data set (MDS) nurses, charge nurses, activities staff, payroll bookkeeper, ward clerk, and/or social worker began resident care observations and interviewing alert and oriented residents and Resident representatives (RR) for cognitively impaired residents to ensure they have been bathed/showered, provided privacy, and treated with dignity and respect according to the resident□'s preference and/or needs through resident or RR interviews, observation for cleanliness and record review of refusals utilizing a Dignity/Staffing Audit tool. These audits will be completed with 20% of the residents weekly for 4 weeks, then once weekly for 8 weeks, then once monthly x 3 months. On 7/1/17, the administrator began reviewing the Dignity/Staffing Audit tool 3 times weekly for 4 weeks, then once weekly for 4 weeks, then monthly for 1 month and initialing to acknowledge completion and follow-up. On 7/3/17, the MDS nurses completed care plan/care guide updates which	

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F 241	Continued From page 57 but they were unable to sustain a full roster of NAs. The interview with the DON continued on 6/6/17 at 12:44 PM. She indicated she was familiar with Resident #76. She revealed she was aware of a problem with Resident #76 receiving his showers as scheduled as he had reported this to her verbally (she was unable to recall a date). An interview was conducted with NA #12 on 6/7/17 at 10:39 AM. She stated she had worked at the facility for about 2 years. She revealed there had been times when she was not able to complete the showers that were assigned to her due to time limitations. She reported that sometimes her resident assignment had a lot of high needs residents which made it difficult to complete showers as scheduled. NA #12 revealed this was an ongoing problem, but she had done the best she could to complete her assigned tasks. The interview with NA #12 continued on 6/7/17 at 10:43 AM. She indicated she was familiar with Resident #76 and she had worked with him on multiple occasions when he was scheduled for showers. She reported there had been times when she was unable to complete Resident 76 ' s shower as scheduled due to time limitations. She stated when she was unable to complete Resident #76 ' s shower as scheduled, she spoke with him and explained that she was not able to get to his shower due to time limitations and she offered him a bed bath instead. A follow up interview was conducted with the DON on 6/7/17 at 11:34 AM. She stated she expected all residents to be treated with dignity	F 241	included all bath/shower preferences. On 7/12/17, the corporate consultant completed the review and shower schedule updates according to the resident/RR preferences for resident showers. The MDS nurses or DON will review with the monthly QI Committee the results of the Dignity/Staffing Audit Tool for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The MDS nurse or DON will present the Dignity/Staffing Audit Tool findings and QI Committee recommendation to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.	

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F 241	Continued From page 58 and respect. The interview with Resident #76 in which he indicated he felt unimportant when staff were unable to provide his shower as scheduled was reviewed with the DON. She revealed she was unaware that Resident #76 had felt that way, but she was not surprised by his feelings as he had the right to receive his shower as scheduled.	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews, observations and record review, the facility failed to honor a family request for a cooler in the room as stated by the dietary department (Resident #37) and failed to provide showers as scheduled (Resident #76) for 2 of 3 residents reviewed for choices. Findings included 1. Resident #37 was admitted on 1/20/11 with cumulative diagnoses of dysphasia, anxiety and aphasia.	F 242	F 242 Right to Make Choices On 6/7/17, the assistant dietary manager placed a cooler in Resident #37□s room, as requested by the resident representative (RR), to provide extra fluids for hydration. On 6/9/17, the nursing assistant (NA) assisted Resident #76 with a shower per the resident□'s preference.	7/25/17

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F 242	Continued From page 59 Resident #37 ' s quarterly Minimum Data Set (MDS) dated 5/22/17 indicated severe cognitive impairment, physical behaviors toward others, extensive assistance of two staff for her activities of daily living (ADLs) except extensive assistance of one staff for eating. Resident #37 was last care planned on 5/23/17 for all of her ADL care to be provided by facility staff. Staff were to encourage her to drink fluids with meals and encourage extra fluids related to a history of urinary tract infections. A review of Resident #37 diet orders from March 2017 to present indicated she was on double portions, pureed foods with thin liquids. A dietary note dated 3/24/17 at 11:09 AM read the responsible party (RP) called and requested a small cooler be left in the room with some juices due to Resident #37 ' s dry mouth and for hydration. The note read Resident #37 was on thin liquids and his preference would be arranged. In an interview on 6/4/17 at 5:00 PM, a family member of Resident #37 stated the RP party spoke to the dietary manager in March about the facility keeping a small cooler in the room with juices in order for the staff and family to provide the extra fluids needed to keep her hydrated. The family member stated for a while the cooler was in the room with a cold pack inside but after a few weeks, the cooler disappeared. She stated it was mentioned in the care plan meeting in March but she was unsure what happened to the cooler. There was no observed cooler in the room and Resident #37 ' s water pitcher was empty.	F 242	On 6/28/17, the social worker completed interviews with all alert and oriented residents, to include Resident #76, regarding preferences for bathing. Resident #76 prefers to receive a shower two times per week. The director of nursing (DON) and corporate consultant revised the shower schedule on 7/10/17 through 7/11/17 to include the residents□ preferences. On 7/10/17 through 7/11/17, the results of the interviews were compiled and the shower schedule was updated by the director of nursing (DON) and corporate consultant based on the residents□ preferences. On 6/28/17, the DON initiated a 100% in-service of licensed nurses and nursing assistants regarding the resident right to choose activities, schedules, and health care consistent with his or her interests and to make choices about aspects of his or her life in the facility that are significant to the resident. The in-service included the resident'□s/resident representative'□s choice to have a cooler at bedside for extra fluids and to have a minimum of 2 showers per week. The in-service also included the need to document baths/showers provided, the resident'□s right to decline a shower, reporting to the nurse when a resident declines a bath/shower, and documenting resident'□s choice in the electronic health record. The Resident Self-Determination-Right to Make Choices in-service will be added to new staff orientation.	

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F 242	Continued From page 60 In an interview on 6/5/17 at 12:45 PM, Nursing Assistant (NA) #5 stated Resident #37drank all the juices and drinks provided on her tray. NA #5 stated she began working at the facility on 3/30/17 and she remembered a cooler in Resident #37 ' s room with extra juices inside of it. She recalled the family wanted the staff to encourage extra fluids. NA #5 stated she offered Resident #37 water during her shift. There was no observed cooler in Resident #37 ' s room on 6/5/17, 6/6/17 or 6/7/17. In an interview on 6/7/17 at 3:30 PM, the assistant dietary manager (DM) recalled speaking to the RP on 3/24/17 and she agreed to put a cooler in Resident #37 ' s in room. She stated she simply forgot about it. She stated normally the coolers were reserved for residents on thickened liquids which Resident #37 was on at one time and that was likely why the cooler was removed in the first place. She stated she was putting the cooler in her room on weekdays and the cooks were putting it in her room on the weekends. The assistant DM stated the cooler was in the kitchen at present and she would go put it back into Resident #37 ' s room. In an interview on 6/7/17 at 5:46 PM, the DM stated it was her expectation that the assistant DM would have discussed the RP ' s request with her before promising to put the cooler in the room since the coolers were reserved for residents on thickened liquids. In an interview on 6/8/17 at 2:22 PM, the Administrator stated it was her expectation that	F 242	On 6/29/17, the social worker completed interviews with all resident representatives (RR) for non-alert/non-oriented residents to determine the bathing preference. On 7/10/17 through 7/11/17, the results of the interviews were compiled and the shower schedule was updated by the director of nursing (DON) and corporate consultant based on the residents□ preferences (according to the RRs). By 7/3/17, social worker, the quality improvement (QI) nurse, treatment nurse, MDS nurse, director of nursing (DON) and/or corporate consultant will complete 100% audit for all residents, to include resident #76, to ensure each resident is receiving the bathing type of their choice at the frequency of their choice. The 100% audit will be documented on a Bathing/Shower/Choices QI tool. All identified issues are addressed immediately by the auditor to ensure each resident is given the type of bathing and frequency of bathing according to their preference and the shower schedule updated as required by the DON. Beginning 7/3/17, social worker, the quality improvement (QI) nurse, treatment nurse, MDS nurse, administrator, and or corporate consultant will complete a Bath/Shower/Choices audit tool, to include Resident #34□s choice to have a cooler in the room and Resident #76□s choice to be assisted with 2 showers per week. The audit tool will be completed with 20% of resident care observations and	

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F 242	Continued From page 61 any reasonable request for Resident #37 be honored and the assistant DM would have included the DM in the decision of placing a cooler in her room since they were for resident on thickened liquids. 2. Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included muscle weakness, difficulty in walking and history of cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated 5/4/17 indicated Resident #76 ' s cognition was intact. He was assessed with no rejection of care and no behaviors. Resident #76 required extensive assistance of 1 staff member with bed mobility, transfers, and toileting. He was assessed as dependent on 1 staff member for bathing, personal hygiene, and dressing. Resident #76 had impairment on 1 side of his upper and lower extremities and was assessed as not steady on his feet. The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care (initiated on 8/12/16 and most recently reviewed on 5/5/17) that indicated the focus area: "Requires assistance/potential to restore or maintain maximum function of self-sufficiency for bathing related to: impaired mobility, physical limitations, [and] weakness." Resident #76 was assessed as dependent on one staff for assistance with bathing. The shower schedule for Resident #76 indicated he was scheduled for showers on Tuesdays and Fridays. A review of the shower documentation from 3/3/17 through 5/31/17 revealed Resident #76 received 15 showers in 90 days. Resident	F 242	interviews or RR on non-alert and oriented residents to include Resident #37 and Resident #76, 3 times per week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. Any concerns will be addressed immediately by the auditor and a resident concern form initiated by the auditor. As of 7/11/17, the minimum data set (MDS) nurses had updated the resident care plans, to include resident #76, to reflect the residents□ bathing preferences. Beginning 7/25/17, the DON and or administrator will review and initial the Bathing/Shower/ Choices Audit Tool weekly for 8 weeks then monthly for 1 month to signify the audit has been reviewed, completed, and all identified areas of concern were addressed. Beginning 7/25/17, the QI nurse or DON will present the findings of the Bathing/Shower/Choices Audit tool to the monthly QI committee for 3 months for review of results, trends, root cause analysis of deficiencies, and make recommendations. The DON will present the findings, trends, and QI committee recommendations and follow-up to the QI committee recommendations to the quarterly executive quality assessment and assurance (QAA) committee for additional review and recommendations.	

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F 242	Continued From page 62	F 242		

#76 received 4 showers from 3/3/17 through 3/31/17 (3/6, 3/13, 3/20, and 3/30), 5 showers from 4/1/17 through 4/30/17 (4/4, 4/7, 4/12, 4/25, and 4/28), and 6 showers from 5/1/17 through 5/31/17 (5/2, 5/9, 5/12, 5/16, 5/23, and 5/30).

An interview was conducted with Resident #76 on 6/5/17 at 12:25 PM. Resident #76 indicated he preferred showers to bed baths and he required the assistance of staff with showers. He stated his preference was to have a minimum of 2 showers per week. He reported his scheduled shower days were Tuesdays and Fridays. Resident #76 revealed he had not received his showers as scheduled. He stated he had been informed on several occasions by staff (unable to recall staff names) that they were unable to complete his shower because there was not enough staff on duty. Resident #76 indicated he had spoken with the Director of Nursing (DON) about his showers not being provided as scheduled in the past, but it had still been a problem.

An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She indicated it was her expectation for showers to be provided as scheduled and as requested by the resident. She stated she expected showers to be scheduled a minimum of twice per week. The DON revealed the facility had an ongoing problem with the provision of showers as scheduled. She indicated at times there had difficulty filling in shifts if an NA called off of work. She reported that the facility had previously implemented a shower team, four NA ' s assigned specifically to showers, to address the problem of showers not being provided as scheduled. The DON revealed the implementation of the shower team had not

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F 242	Continued From page 63	F 242		

solved the problem. She explained that if an NA called off of work and they were unable to fill in the call off, an NA who was assigned to the shower team was reassigned to the floor. She stated the facility was constantly hiring new NAs, but they were unable to sustain a full roster of NA ' s.

The interview with the DON continued on 6/6/17 at 12:44 PM. She indicated she was familiar with Resident #76. She revealed she was aware of a problem with Resident #76 receiving his showers as scheduled as he had reported this to her verbally (she was unable to recall a date).

An interview was conducted with NA #12 on 6/7/17 at 10:39 AM. She stated she had worked at the facility for about 2 years. She revealed there had been times when she was not able to complete the showers that were assigned to her due to time limitations. She reported that sometimes her resident assignment had a lot of high needs residents which made it difficult to complete showers as scheduled. NA #12 revealed this was an ongoing problem, but she had done the best she could to complete her assigned tasks.

The interview with NA #12 continued on 6/7/17 at 10:43 AM. She indicated she was familiar with Resident #76 and she had worked with him on multiple occasions when he was scheduled for showers. She reported there had been times when she was unable to complete Resident 76 ' s shower as scheduled due to time limitations. She stated when she was unable to complete Resident #76 ' s shower as scheduled, she spoke with him and explained that she was not able to get to his shower due to time limitations and she

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F 242	Continued From page 64 offered him a bed bath instead. An interview was conducted with NA #6 on 6/7/17 at 12:00 PM. She stated she had worked at the facility for about 3 weeks. She revealed there had been times when she was not able to complete the showers that were assigned to her if the facility was running short on staff. She indicated if she was unable to complete a shower as scheduled she offered the resident a bed bath instead.	F 242		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on review of the resident council minutes and interview with the staff and the president of the resident council (Resident #12), the facility failed to respond to and to resolve grievances that were voiced in the resident council meetings for 4 consecutive months (January 2017 through April 2017).	F 244	F 244 Group Grievances On 6/9/17, the social worker interviewed Resident #76 and discussed the concern related to not receiving assistance with showers as scheduled. Resident #76 currently states satisfaction with receiving	7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 244	Continued From page 65 Findings included: The minutes of the resident council meetings over four consecutive months (January, February, March, and April 2017) were reviewed. The minutes dated 1/26/17 revealed that the residents had voiced concerns regarding food being cold and no variety. The minutes dated 2/23/17 revealed that the residents had voiced concerns with ice machine not working. The minutes dated 3/23/17 revealed that residents had voiced concerns regarding room temperatures, short staff, cold food, call lights not being answered timely and missing items. The resident council minutes dated 4/27/17 revealed that the residents had voiced concerns regarding not getting their baths/showers, cold food and call lights not being answered timely. There was no resident council meeting in May 2017. Interview with Resident #12 (president of the resident council) was conducted on 6/7/17 at 9:10 AM. Resident #12 stated that the facility was still short of staff especially on the second shift with only one nursing aide (NA) on the hall. She also stated residents had to wait a long time for the call lights to be answered. Resident #12 stated that the issue with short staff, food and call bell response had been brought up in the resident council meetings and were still an issue. Interview with the Director of Nursing (DON) was conducted on 6/7/17 at 9:15 AM. The DON stated that she didn't know that the resident council was meeting every month. She also indicated that she had never seen the minutes of the resident council including their concerns.	F 244	two showers per week. Resident #76 received a shower on 6/20/17, 6/23/17, 6/27/17. On 6/30/17, the social worker again interviewed Resident #76 and Resident #76 agreed assistance with two showers weekly is now being provided. On 6/9/17, the social worker interviewed Resident #37s resident representative (RR) and discussed the concern related to: 1) staff not feeding, changing the brief, or bathing; 2) Resident #37. Resident #37□s RR currently states satisfaction with receiving meal assistance, incontinence care, and bathing. On 6/29/17, the social worker (SW) reviewed all resident council meeting minutes for the past 6 months, to include January 2017 through April 2017. The admissions coordinator reviewed the resident council meeting minutes for March, April, and June of 2017 (no May 2017 meeting was held). The review identified the resident council to include short staff, food, ice machine not working, room temps, call lights, and missing items. The purpose of the review was to ensure concerns from a resident or family group meetings were responded to and the residents/RRs are satisfied with the resolution and follow-up to the grievances. The review of the resident council grievances revealed the concerns were on-going related to assistance with incontinent care, assistance with bathing/showers, and comfortable room temperatures.	

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F 244	Continued From page 66 Interview with the Social Worker (SW) was conducted on 6/7/17 at 3:12 PM. The SW stated that she was responsible in setting up and in writing notes during the resident council meeting. She stated that after the meeting, she had to write the concerns and had to give it to the department heads, for example, she would give the DON any nursing concerns. The department head would address the concerns, document the corrective action and then return the form to her. The SW was unable to provide information that the concerns voiced during the resident council meetings had been addressed by the department heads. Interview with the Administrator was conducted on 6/8/17 at 3:05 PM. The Administrator stated that the SW was responsible in making sure the concerns from the resident council meetings had been addressed by the department heads. She stated that after the resident council meeting, the SW had to make a copy of the minutes and had to give a copy to the department heads including the Administrator. The department head was responsible for addressing the concerns in his/her department and document the corrective action. The Administrator indicated that she had not received copies of the minutes of the resident council meeting and so she was not aware of the concerns the residents had voiced during the meetings.	F 244	On 6/29/17, the administrator initiated an in-service for the DON, SW, quality improvement nurse, activity assistant, admission coordinator, and business office staff on Listen/Act on Group Grievances which included: 1) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility, 2) When there resident council minutes or interviews with residents indicate there are concerns or grievances, the facility must respond to and resolve grievances in a timely manner, 3) While the grievances are being addressed, the social worker, director of nursing, and/or administrator shall keep the resident or family group updated on the progress with resolving the grievance/recommendation. Any needed audits or observations to support monitoring should be documented. This in-service was completed 6/30/17 by the Quality improvement (QI) nurse. All new hires will receive the grievance the grievance in-service during their orientation by the QI nurse. On 7/7/17 and 7/13/17, the admissions coordinator/social worker facilitated additional resident council meetings for the resident council in an effort to allow for the resident council to get updates on previous group grievances and express new concerns. The activity director/assistant, social worker, or admissions coordinator will	

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 _____	C 06/09/2017

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F 244	Continued From page 67	F 244	document grievances from the resident council meeting. The admission coordinator/social worker will ensure the grievances are logged and routed to the respective department heads for investigation and resolution. The grievance will be investigated under the direction of the social worker/administrator within 3 days of the date of the grievance. The administrator will ensure all grievances, including group grievances, are addressed and resolved. The administrator and/or DON will review resident concerns and resident council concerns weekly for six months to ensure concerns have been addressed and the resolution reviewed with the residents/RRs/resident council in a timely manner. The response will be in writing, dated, and include details of the follow up that occurred. The social worker or admissions coordinator will present all findings at the monthly QI committee meeting for six months. The QI committee will review the minutes and grievances of the resident council meeting monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The social worker or admissions coordinator will present the findings and recommendations of the monthly QI committee to the quarterly executive QA	

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F 244	Continued From page 68	F 244	committee for six months for further recommendations and oversight.	
F 249 SS=C	483.24(c)(2)(i)(ii) QUALIFICATIONS OF ACTIVITY PROFESSIONAL (c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to have a qualified activities professional to direct the provision of activities to the residents. The findings included: An interview was conducted with the Director of Nursing on 6/6/17 at 12:34 PM. She revealed the	F 249	F 249 Qualified Activity Professional On 6/10/17, the administrator demoted the uncertified activity director to activity assistant. The activity assistant is scheduled to take the activity director certification class on 9/11/17 at the local	7/25/17

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F 249	Continued From page 69 facility's Activities Director was not a qualified activities professional. An interview was conducted with the Activities Director on 6/6/17 at 3:12 PM. She indicated she had been the facility's Activities Director for 3 or 4 years. She stated she had no training or certifications that qualified her as an activities professional. She indicated she had gone through the facility's orientation for activities, but she had no other qualifications as an activities professional. She reported she had been scheduled to attend a training program in January 2017, but it had been cancelled. She additionally reported she had been scheduled for a training program in 2015, but it had been cancelled. The Activities Director indicated the next training was scheduled for August 2017 and she planned on attending as long as it was not cancelled. She explained that the training courses were cancelled if there were not enough students registered. An interview was conducted with the Administrator on 6/6/17 at 5:45 PM. She revealed the facility's Activities Director was not a qualified activities professional. She explained that she had tried to get the Activities Director enrolled in a training program, but the most recent training program scheduled for January of 2017 was cancelled due to a low number of student enrollment. An interview was conducted with the Assistant Director of Activities on 6/7/17 at 8:32 AM. She indicated she had worked at the facility as the Assistant Activities Director since February of 2017. She stated this was her first job related to activities and she had no training or certifications	F 249	community college. The activity assistant will remain under the direction of a certified activity director until the completion of their training. The certified activity director, employed by a sister facility, will review the monthly activity calendars, weekly 1:1 documentation and activity programming weekly for further recommendations and follow up as indicated. On 6/30/17, the administrator placed a help wanted advertisement with an online recruitment agency and posted the activity director position in the facility. On, 6/29/17, the regional vice president (RVP) in-serviced the administrator and director of nursing on employing a qualified activities professional to direct the provision of activities to the residents. Beginning 7/10/17, the certified activity director will assist in the development of the monthly activity calendar and specialized dementia calendar until a qualified activity professional is employed by the facility. The activity assistant will remain under the direction of a certified activity director until the completion of their training or until a certified activity director is hired. The certified activity director will review the monthly activity calendars, weekly 1:1 documentation and activity programming weekly for further recommendations and follow up as indicated. Beginning 7/10/17, the certified activities	

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F 249	Continued From page 70 that qualified her as an activities professional.	F 249	director, social worker, administrator, and/or corporate consultant will review the monthly calendars with the resident council president during the resident council monthly meeting to ensure the federal requirements are met and the resident choices for activities are met. The review will be completed for 3 months and documented in the resident council meeting minutes. The administrator will review the qualifications of the new activity director with the monthly quality improvement (QI) meeting for further recommendation or changes as indicated.	
F 257 SS=D	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record review, the facility failed to maintain comfortable resident rooms temperature with acceptable ranges of 72 to 81 degrees for 3 (Room # 118, Room #104 and Room #112) of 5 room reviewed for comfortable room temperatures. Findings included: In an interview on 6/4/17 at 5:00 PM, a family member for Resident #37 in Room #118 stated her room was drafty and cold. She stated it was difficult keeping Resident #37 covered with	F 257	F 257 Comfortable Temperatures Rooms 118, 104 and 112 were inspected by the Maintenance Director on 6/30/17 and the thermostats were adjusted to the units operating the identified rooms. Interviews with Resident # 37□s resident representative (RR), Resident #15, and Resident #131 on 6/30/17 by Admissions Director revealed changes needing to be made to room temperatures. On 6/30/17, the Maintenance director adjusted thermostat to make residents	7/25/17

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F 257	Continued From page 71 blankets due to her constant jerking movements. She stated the family had made multiple request for curtains for her room or temperature adjustment. She stated the facility staff stated there was no way to adjust the room temperatures since there was no thermostats in the rooms. In an interview on 6/5/17 at 11:13 AM, Resident #15 stated her Room #104 was cold most of the time and there was no place to regulate it. She stated she had asked staff to turn the thermostat up but they don't do anything about it. A man came in one time and looked at the vent at the end of my bed and said it was broken and he couldn't fix it. Resident #15 stated she asked staff to put her to bed early because she got cold. In an interview on 6/5/17 at 5:10 PM, Resident #131 stated he was uncomfortable because it was so hot in his Room #112. He stated the facility put a fan in his room but it only blew hot air around and did not improve the temperature. He stated he had not asked the maintenance director to look into the excessive heat in his room since they put the fan in his room. In an observation with the maintenance director on 6/6/17 at 4:30 PM, the temperature in the upper 100 hallway was testing using an infrared temperature gun. The temperature was 70.4 degrees while the wall thermostat read 73 degrees. The maintenance director stated there were no individual thermostats in the resident rooms and the temperature was controlled from the hallway thermostat. The following rooms were checked with the infrared gun: Room #118 read 70.1 degrees, Room 104 read 68.3 degrees and Room 112 read 81.5 degrees. He stated he was	F 257	comfortable. On 6/29/17, the maintenance director completed an audit of each resident room to ensure temperatures are within comfortable limits. Any areas outside those limits were addressed immediately by the Maintenance Director by adjusting the thermostat operating those resident rooms. The Maintenance Director was in-serviced by the regional vice president (RVP) on 6/30/17 on ensuring comfortable resident room temperatures. The Administrator and DON were in-serviced by the RVP on 6/27/17 regarding ensuring comfortable resident room temperatures. Administrator will review the Resident room temp Audit Tool weekly to ensure comfortable resident room temperatures. Any identified areas of concern will be corrected by the maintenance director or heating and air conditioner contractor upon identification. The maintenance director, social worker, dietary manager, DON and/or corporate consultants will check 5 resident rooms per hall (to include room 118, 104 and 112) 5 days weekly, including weekends, for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks utilizing the Resident Room Temp Audit Tool. The Administrator will review and initial the resident room temperature audit tool	

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F 257	Continued From page 72 not aware of any problems with the air conditioner unit and had not received any complaints about rooms being cold or hot since January 2017. He was unable to provide evidence of resident room temperature checks during his weekly rounds. The maintenance director stated the room temperatures should be between the 72 degrees and 81 degrees. He said he would get Heating, Ventilation and Air Conditioning (HVAC) team out to the facility tomorrow. In an observation on 6/7/17 at 8:30 AM, the maintenance director and HVAC team were on the 100 hall checking room temperatures. Temperatures were reassessed using the infrared gun on 6/7/17 at 9:20 AM. Room #118 temperature was 72.0 degrees, Room #104 read 72.3 degrees and Room #112 read 72 degrees. In an interview on 6/8/17 at 2:22 PM, the Administrator stated it as her expectation that resident rooms were maintained from 72 degrees to no more than 81 degrees for comfort. She stated was further her expectation a weekly round be made to ensure the building remained within acceptable range.	F 257	weekly for 12 weeks for completion and to ensure all areas of concern were addressed. The maintenance director or administrator will review with the monthly quality improvement (QI) Committee the Resident Room Temp Audit Tool results monthly x 3 months for any recommendations, take action as appropriate and to monitor for continued compliance. The maintenance director or administrator will review with the quarterly assessment and assurance (QAA) Committee the Resident Room Temp Audit Tool results for 1 quarter for any recommendations, take action as appropriate and to monitor for continued compliance in the area of comfortable temperatures.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 272		7/25/17

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F 272	Continued From page 73 (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 272	F 272 Comprehensive Assessments	

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F 272	Continued From page 74 facility failed to comprehensively assess residents on the Minimum Data Set (MDS) assessment in the areas of cognition and mood for 3 of 22 sampled residents (Resident #140, #59 and #60). The findings included: 1. Resident #140 was admitted to the facility on 5/23/17. The admission Minimum Data Set (MDS) assessment dated 5/30/17 indicated Resident #140 had clear speech, was usually able to make himself understood, and was usually able to understand others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #140. Question C0100 was coded to indicate Resident #140 was rarely/never understood and the resident Brief Interview for Mental Status (questions C0200 through C0500) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #140. Question D0100 was coded to indicate Resident #140 was rarely/never understood and the resident mood interview (questions D0200 through D0300) was not conducted. An interview was conducted with the Social Worker (SW) on 6/8/17 at 9:25 AM. The SW indicated she was responsible for the completion of Section C and D on the MDS assessment. Section C and D of the admission MDS dated 5/30/17 for Resident #140 was reviewed with the SW. She reported she attempted the resident interviews for Sections C and D with Resident #140, but he was unable to answer the questions appropriately. She indicated this was the reason she had coded Resident #140 as rarely/never understood. She revealed that Resident #140 was not rarely/never understood even though he was not able to answer the questions	F 272	On 6/27/17, The Minimum Data Set (MDS) assessment for Resident # 140, #59, and #60 were reviewed by the MDS Coordinator and corporate consultant to include the areas of cognition and mood. The admission MDS with ARD 5/30/17 for Resident #140, Annual MDS with ARD 4/9/17 for Resident #59, and the Quarterly MDS with ARD 5/7/17 for Resident #60 will be modified to reflect the correct information by 7/25/17. Resident #140 was discharged from the facility on 6/6/17 and has not returned. On 6/30/17, Resident #140, #59, and #60 were reviewed by the MDS coordinator with oversight of the corporate consultant, to ensure the current cognitive status and symptoms of mood are appropriately addressed in the resident's plan of care. A 100 % audit of the most recent MDS assessments by the MDS nurses, with oversight of the corporate consultant, was completed on 6/29/17 to review coding for sections C and D of the MDS, and that resident mood symptoms and cognition were appropriately and accurately addressed in the MDS assessments for each resident. All comprehensive, quarterly, or significant change MDS will be coded accurately through the next quarterly review to be completed by 10/17/2017. On 6/26/17, an in-service was initiated for the Care Plan Team to include MDS	

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F 272	Continued From page 75 appropriately during the resident interviews for the 5/30/17 MDS. The SW stated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual for the completion of Sections C and D. An interview was conducted with the Director of Nursing (DON) on 6/8/17 at 2:35 PM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS. 2. Resident #59 was admitted to the facility on 3/10/15. The annual MDS assessment dated 4/9/17 indicated Resident #59 had clear speech, was able to make herself understood, and was able to understand others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #59. Question C0100 was coded to indicate Resident #59 was rarely/never understood and the resident Brief Interview for Mental Status (questions C0200 through C0500) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #59. Question D0100 was coded to indicate Resident #59 was rarely/never understood and the resident mood interview (questions D0200 through D0300) was not conducted. An interview was conducted with the SW on 6/8/17 at 9:25 AM. The SW indicated she was responsible for the completion of Section C and D on the MDS assessment. Section C and D of the annual MDS dated 4/9/17 for Resident #59 was reviewed with the SW. She reported she attempted the resident interviews for Sections C and D with Resident #59, but she was unable to answer the questions appropriately. She	F 272	Nurses, Activities, Social Services, Dietary, and the Director of Nursing by the corporate consultant regarding completing comprehensive assessments per the Resident Assessment Instrument (RAI) Manual to include conducting and coding correctly, the resident interviews for cognition and mood, and was completed on 6/27/17. When coding the MDS assessment, the MDS Nurse and the Care Plan Team to include Activities, Social Services and Dietary will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident'□s current condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks then 10% monthly x 2 months by the Director of Nursing to ensure compliance and accuracy of the MDS to include coding for cognition and mood utilizing a MDS Audit Tool. All Identified areas of concern will be addressed immediately by the Director of Nursing through retraining and by modification or significant correction of the MDS Assessment by the MDS Nurse to accurately reflect the resident'□s current condition. The results of the MDS Audit tool will be reviewed by the Administrator weekly. The MDS nurse or DON will take the results of the MDS Audit tool to the monthly Quality Improvement (QI) Committee that will	

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F 272	Continued From page 76 indicated this was the reason she had coded Resident #59 as rarely/never understood. She revealed that Resident #59 was not rarely/never understood even though she was not able to answer the questions appropriately during the resident interviews for the 4/9/17 MDS. The SW stated she was unaware of the coding instructions specified in the RAI manual for the completion of Sections C and D. An interview was conducted with the DON on 6/8/17 at 2:35 PM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS. 3. Resident #60 was admitted to the facility on 7/7/16. The quarterly MDS assessment dated 5/7/17 indicated Resident #60 had clear speech, was able to make himself understood, and was able to understand others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #60. Question C0100 was coded to indicate Resident #60 was rarely/never understood and the resident Brief Interview for Mental Status (questions C0200 through C0500) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #60. Question D0100 was coded to indicate Resident #60 was rarely/never understood and the resident mood interview (questions D0200 through D0300) was not conducted. An interview was conducted with the SW on 6/8/17 at 9:25 AM. The SW indicated she was responsible for the completion of Section C and D on the MDS assessment. Section C and D of the quarterly MDS dated 5/7/17 for Resident #60 was reviewed with the SW. She reported she	F 272	review all audit results monthly x 3 months for further recommendations, take action as appropriate, and to monitor continued compliance. The MDS nurse or DON will take the results of the MDS Audit tool to the quarterly quality assurance and assessment (QAA) Committee for further review, recommendations and follow up as needed for sustaining regulatory compliance in the area of comprehensive assessments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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F 272	Continued From page 77 attempted the resident interviews for Sections C and D with Resident #60, but he was unable to answer the questions appropriately. She indicated this was the reason she had coded Resident #60 as rarely/never understood. She revealed that Resident #60 was not rarely/never understood even though he was not able to answer the questions appropriately during the resident interviews for the 5/7/17 MDS. The SW stated she was unaware of the coding instructions specified in the RAI manual for the completion of Sections C and D. An interview was conducted with the DON on 6/8/17 at 2:35 PM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification	F 278		7/25/17

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 _____	C 06/09/2017

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F 278	Continued From page 78 (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview and resident interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of dental and diagnoses for 2 (Resident #71 and Resident #100) of 22 MDS assessments reviewed for accuracy. Findings included: 1. Resident #71 was admitted 9/4/14 with cumulative diagnoses of cerebral vascular accident (CVA), hemiplegia and contractures. His significant change MDS assessment dated 5/17/17 indicated moderate cognitive impairment and no behaviors. He required extensive assistance with his hygiene and section L (Oral/Dental Status section) was not coded for any missing or broken teeth. In an observation and interview on 6/5/17 at 1:13 PM, Resident #71 stated he was experiencing no discomfort with his teeth or gums. On	F 278	F 278 Assessment/Accuracy/Coordination/Certified On 6/27/17, The Minimum Data Set (MDS) assessment for Resident # 71 was reviewed and a Significant Correction to prior Comprehensive Assessment was made to include coding of dental status with Assessment Reference Date (ARD) of 6/28/17 and was submitted by the MDS Nurse and accepted into the National repository on 7/5/17. On 6/27/17, The MDS nurse reviewed the MDS assessment for Resident #100 and the appropriate modifications were made to include coding of diagnoses on 6/27/17, and accepted into the National repository on 6/28/17. A 100 % audit of the last completed MDS	

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F 278	Continued From page 79 observation, his teeth were noted discolored with multiple missing teeth. In an interview on 6/8/17 at 2:22 PM, the Administrator stated it was her expectation the MDS assessment be accurate and reflect Resident #71 ' s current status and needs. In an interview on 6/8/17 at 2:37 PM. MDS nurse #2 stated section L of the significant change MDS dated 5/17/17 was coded with no missing or broken teeth, therefore a Care Area Assessment (CAA) was not triggered. She stated the MDS assessment should be based on observation, staff and resident interviews and record review. In another interview on 6/8/17 at 2:50 PM, MDS Nurse #2 stated she went and assessed Resident #71 ' s teeth and noted multiple missing teeth and evidence of tarter and discoloration. She stated his dental concerns should have been noted on the MDS assessment dated 5/17/17, a CAA completed and a dental care plan completed. 2. Resident #100 was admitted to the facility on 4/8/16 with multiple diagnoses including cerebrovascular accident (CVA) and depression. The quarterly Minimum Data Set (MDS) assessment dated 3/24/17 indicated that Resident #100 had received an antidepressant medication and anticoagulant medications during the 7 days of the assessment period. Review of the assessment also revealed that depression and CVA were not coded under the diagnoses. Review of the doctor's order revealed that Resident #100 was on Lexapro (antidepressant drug) 15 milligrams (mgs) by mouth daily since 9/20/16 and Xarelto (anticoagulant drug) 15 mgs	F 278	assessment for all residents to include Residents #71 and Resident #100 was initiated on 6/26/17 by the corporate consultants, director of nursing (DON), and staff facilitator to ensure the most recent MDS assessment accurately reflects the residents current condition to include coding of dental status and diagnoses, to be completed by 6/30/17. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) was completed by the MDS nurses as indicated by the Resident Assessment Instrument (RAI) manual by 7/6/17. All comprehensive, quarterly, or significant change MDS will be coded accurately through the next quarterly review to be completed by 10/17/17. On 6/26/17, an in- service was initiated for the Care Plan Team to include MDS Nurses, Activities, Social Services, Dietary, and the Director of Nursing by the corporate consultant regarding proper coding of the MDS assessments per the Resident Assessment Instrument (RAI) Manual, and was completed on 6/27/17 . When coding the MDS assessment, the MDS Nurse and the Care Plan Team to include Activities, Social Services and Dietary will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident's current condition. An audit of 25% of completed Minimum	

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F 278	Continued From page 80 by mouth daily since 4/9/16. Interview with the MDS Nurse #2 was conducted on 6/7/17 at 12:25 PM. MDS Nurse #2 acknowledged that Resident #100 was on Lexapro for depression and Xarelto for CVA and the MDS assessment should have been coded for Depression and CVA under the diagnoses but it was not. Interview with the Director of Nursing (DON) was conducted on 6/8/17 at 11:15 AM. The DON stated that she expected the MDS assessments to be accurate.	F 278	Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks then 10% monthly x 2 months by the Director of Nursing o to ensure compliance and accuracy of the MDS to include coding for dental status and diagnoses utilizing a MDS Audit Tool. All Identified areas of concern will be addressed immediately by the Director of Nursing o through retraining and by modification or significant correction of the MDS Assessment by the MDS Nurse to accurately reflect the resident'□s current condition. The results of the MDS Audit tool will be reviewed by the Administrator weekly. The DON will take audit results to the Quality Improvement Executive Committee will review all audit results monthly x 4 months for further recommendations, take action as appropriate, and to monitor continued compliance.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279		7/25/17

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F 279	Continued From page 81	F 279		

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to

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F 279	Continued From page 82 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to have a comprehensive and individualized care plan for three of nineteen sampled residents in the areas of inappropriate behaviors (Resident #91), activities of daily living (ADL) PASRR (Pre-Admission Screening and Resident Review) and psychotropic medication (Resident #76) and use of anticoagulant medication (Resident #100). Findings included: 1a.. Resident #91 was admitted to the facility on 12/1/16. Cumulative diagnoses included Alzheimer ' s disease and dementia with behavioral disturbance. An Admission Minimum Data Set (MDS) dated 12/12/16 indicated Resident #91 was moderately impaired in cognition. No mood or behaviors were noted as having occurred during the assessment period. Medications administered during the assessment period included seven days of antipsychotic medication. A Care Area Assessment (CAA) for psychotropic medication dated 12/14/16 stated Resident #91 received Seroquel (antipsychotic medication) 25 milligrams every night with no adverse reactions noted. Proceed to care plan for the use of psychotropic medications to maximize the	F 279	F 279: Develop Comprehensive Care Plans The care plan for Resident # 91 was reviewed and updated on 6/26/17 by the minimum data set (MDS) nurse with oversight of corporate consultant and included inappropriate behaviors relating to wandering in and out of other residents' rooms and exit seeking behaviors. The care plan for Resident # 76 was reviewed and updated on 6/15/17 by the MDS Nurse with oversight of corporate consultant. The care plan review incorporation of Resident #76's preadmission screening and resident review (PASRR) level II for serious mental illness to include any feelings of feeling down, depressed, hopeless, difficulty falling asleep, sleeping too much, poor appetite/over eating, appropriate behavior for use of antipsychotic medications and individualized needs for personal hygiene. The care plan for Resident # 100 was reviewed and updated on 6/7/17 by the MDS Nurse to include the use of an anticoagulant medication.	

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F 279	Continued From page 83 resident ' s functional potential and well-being while minimizing the hazards associated with the medication side effects. A care plan dated 12/14/16 indicated Resident #91 received psychotropic drugs. Interventions included, in part: Administer medications per physician orders. DISCUS (Dyskinesia Identification System condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. The care plan did not specify or identify any targeted behaviors. A nurse practitioner note dated 1/10/17 stated Resident #91 was seen for inappropriate behavior and actions. Laboratory tests were ordered and a consultation with psychiatric served was ordered at that time. A review of the medical record revealed the psychiatric consultation was not obtained. A Quarterly Minimum Data Set (MDS) dated 3/4/17 indicated Resident #91 was moderately impaired in cognition. Mood indicators stated Resident #91 was noted 2-6 days during the observation period of moving or speaking so slowly that other people could have noticed or the opposite of being so fidgety or restless and moved around a lot more than usual. No behaviors were noted as having occurred during the assessment period. On 6/6/17 at 3:33 PM, an interview was conducted with Nurse #2. She stated she worked on the dementia unit most of the time. She said	F 279	A 100% audit of all residents' care plans was completed on 6/15/17 by corporate consultants, including the plan for Resident # 91, Resident #76, and Resident #100. The audit was to ensure comprehensive care plans have been developed per the comprehensive assessment, to include any resident identified with inappropriate behaviors relating to wandering in and out of other residents rooms, exit seeking behaviors, incorporating PASRR level II for serious mental illness for any feelings of feeling down, depressed, hopeless, difficulty falling asleep, sleeping too much, poor appetite/overeating, appropriate behaviors for use of antipsychotic medications and individualized needs for personal hygiene, and/or the use of an anticoagulant medication. The care plans were updated for any identified areas of concern by the corporate consultants on 6/15/17. The MDS nurse will know to update/initiate a care plan for new behaviors/anticoagulant meds and/or PASRR level 2 when the MDS nurse and/or director of nursing (DON) reviews the pink slips (new physician order forms) during the clinical meeting. The MDS nurse will also know to updated/initiate a care plan for new behaviors and/or PASRR level 2 when the social worker forwards to the MDS any level 2 PASRRs. Recognizing that reviewing the comprehensive assessments will not ensure the deficient practice will not be repeated, any behavior noted in the	

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F 279	Continued From page 84 Resident #91 was known to have inappropriate behaviors at times. She stated Resident #91 responded to redirection most of the time. On 6/6/17 a 3:46 PM, an interview was conducted with NA #4. She stated Resident #91 had inappropriate behaviors at times. She said he wandered in and out of resident rooms. She said there was an in-service held regarding some of the inappropriate behaviors and staff were told to monitor Resident #91 closely. She was unable to remember the date of the in-service. On 6/6/17 at 5:03 PM, an interview was conducted with the Director of Nursing. She stated she would expect to see a care plan for the inappropriate behaviors exhibited by Resident #91. On 6/7/17 at 11:07 AM, an interview was conducted with MDS Nurse #1 and MDS Nurse #2. They stated they worked together to initiate and update care plans. They reviewed the care plan for Resident #91. Both stated they were not aware of the inappropriate behaviors exhibited by Resident #91 and those behaviors should have been care planned. MDS Nurse #1 said she was aware of the inappropriate behavior that occurred in May and that a care plan should have been developed at that time. b. Resident #91 was admitted to the facility on 12/1/16. Cumulative diagnoses included Alzheimer ' s disease and dementia with behavioral disturbance. An Admission Minimum Data Set (MDS) dated 12/12/16 indicated Resident #91 was moderately	F 279	progress note review will be communicated to the MDS nurse at the daily department head and/or clinical meeting. Additionally, the problem could occur from new behaviors, medications adjustments, anticoagulant medications, and/or psychotropic medications, the MDS nurses and DON will review monthly pharmacy recommendations and medication administration records. The Care Plan Team to include the MDS Nurses, DON, activity director, dietary assistant manager and social services director were in-serviced on care planning requirements, per instructions provided in the RAI Manual on 6/26/17 by the corporate consultant. The DON will review all triggered Care Area Assessments on all subsequent comprehensive assessment, 24 hour reports, shift change notes, progress notes, current interventions and physician telephone orders to ensure any newly identified areas to include wandering, exit seeking behaviors, behaviors relating to PASSRR level II for serious mental illness, antipsychotic medications, and individualized needs for personal hygiene and/or anticoagulant medications has been addressed on the residents' care plans 5 x week for 4 weeks, then audit 10% of care plans weekly x 3 months to ensure that care plans reflect the resident's current medical, nursing, mental and psychological needs utilizing a care plan audit tool. The MDS nurse will immediately update the care plan for all	

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F 279	Continued From page 85 impaired in cognition. No mood or behaviors were noted as having occurred during the assessment period. Medications administered during the assessment period included seven days of antipsychotic medication. A Care Area Assessment (CAA) for psychotropic medication dated 12/12/16 stated Resident #91 received Seroquel (antipsychotic medication) 25 milligrams every night with no adverse reactions noted. Proceed to care plan for the use of psychotropic medications to maximize the resident ' s functional potential and well-being while minimizing the hazards associated with the medication side effects. A care plan dated 12/14/16 indicated Resident #91 received psychotropic drugs. Interventions included, in part: Administer medications per physician orders. DISCUS (Dyskinesia Identification System condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. A nursing note dated 1/29/17 stated Resident #91 was in the television room of the locked dementia unit. He opened the window and climbed out of window into the fenced in area. No broken glass was noted. No injuries were noted to Resident #91. The responsible party and the physician were notified. Maintenance was called and he stated he would come to the facility and place an alarm on the window. A Quarterly Minimum Data Set (MDS) dated 3/4/17 indicated Resident #91 was moderately impaired in cognition. Mood indicators stated	F 279	identified areas of concern and provide re-education as needed. The results of the Care Plan Audit Tool will be reviewed by the Administrator weekly. The MDS nurse or the DON will review the results of the care plan audits with the monthly Quality Improvement (QI) Committee for 3 months for any recommendations, take action as appropriate, and monitor for continued compliance. The MDS nurse or the DON will review the results of the care plan audits also with the quarterly Quality Assessment and Assurance (QAA) Committee for 1 quarter for any recommendations, take action as appropriate, and monitor for continued compliance.	

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F 279	Continued From page 86	F 279		

Resident #91 was noted 2-6 days during the observation period of moving or speaking so slowly that other people could have noticed or the opposite of being so fidgety or restless and moved around a lot more than usual. No behaviors were noted as having occurred during the assessment period.

A review of the care plan for Resident #91 revealed there were no revisions or additions to the care plan until 5/8/17 when a care plan was added for wandering and/ or at risk for unsupervised exits from facility related to attempts to leave unit/ building if not redirected. Interventions included, in part, Administer medications as ordered. Check daily to ensure resident has an alarm bracelet on and that it is functioning properly. Ensure ID bracelet is in place. Ensure resident's picture and name are on wandering resident board (as consent for allows). Ensure that alarmed exits are functional.

On 6/6/17 at 3:33 PM, an interview was conducted with Nurse #2. She stated she worked on the dementia unit most of the time. She stated Resident #91 did not wander and had never been told that he tried to leave or get out of the dementia unit.

On 6/6/17 at 3:46 PM, an interview was conducted with NA #4. She stated Resident #91 wandered in and out of resident rooms but, to her knowledge, Resident #91 had never tried to exit the building and she had not heard about him going out a window and getting outside in the courtyard.

On 6/6/17 at 5:03 PM, an interview was conducted with the Director of Nursing. She

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F 279	Continued From page 87	F 279		

stated she expected to see a care plan for the elopement when Resident #91 went out of the window in the dementia unit into the enclosed courtyard.

On 6/7/17 at 11:07 AM, an interview was conducted with MDS Nurse #1 and MDS Nurse #2. They stated they worked together to initiate and update care plans. They reviewed the care plan for Resident #91. MDS Nurse #1 began working at the facility approximately 3 months ago and said she was not aware of Resident #91 exiting the building through the window. MDS Nurse #2 stated she remembered going over the episode of 1/29/17 and Resident #91 should have had a care plan for elopement at that time.

2a. Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included major depressive disorder, single episode, severe with psychotic features and dementia with behavioral disturbance.

The admission Minimum Data Set (MDS) assessment dated 8/17/16 indicated Resident #76 had moderate cognitive impairment. He was assessed as PASRR level II for Serious Mental Illness (SMI). Resident #76 indicated he felt down/depressed/hopeless, had trouble falling asleep/sleeping too much, and poor appetite/overeating on 2-6 days during the 14 day MDS review period. He was assessed with no behaviors and no rejection of care. Resident #76 received antipsychotic medication and antidepressant medication on 7 of 7 days during the MDS review period.

An MDS Care Area Assessment (CAA) related to psychotropic medications for the 8/17/16 MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 88	F 279		

indicated he received antipsychotic and antidepressant medication daily.

An interview was conducted with the Social Worker (SW) on 6/7/17 at 11:25 AM. She verified Resident #76 was a PASRR level II for SMI.

A review of Resident #76 ' s comprehensive plan of care, most recently reviewed on 5/5/17, revealed no identification or incorporation of his PASRR level II determination for SMI.

An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She indicated it was her expectation that plans of care be comprehensive, accurate, and followed. She stated MDS Nurse #1 and MDS Nurse #2 were ultimately responsible for initiating and revising the plans of care.

An interview was conducted with MDS Nurse #1 on 6/6/17 at 5:22 PM. She stated she was responsible for the oversight of MDS Nurse #2, MDS assessments, and care plans. The plan of care for Resident #76 was reviewed with the MDS Nurse #1. Resident #76 ' s level II PASRR for SMI was reviewed with MDS Nurse #1. She verified there was no incorporation of the level II PASRR in Resident #76 ' s plan of care. She indicated she was unsure who was responsible for ensuring the level II PASRR for SMI was incorporated into Resident #76 ' s plan of care. An interview was conducted with MDS Nurse #2 in 6/6/17 at 5:25 PM. The plan of care for Resident #76 was reviewed with MDS Nurse #2. Resident #76 ' s level II PASRR for SMI was reviewed with MDS Nurse #2. She verified there was no incorporation of the level II PASRR in Resident #76 ' s plan of care. She indicated she

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 _____	C 06/09/2017

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 279	Continued From page 89	F 279		

was unsure who was responsible for ensuring the level II PASRR for SMI was incorporated into Resident #76 ' s plan of care.

2b. Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included major depressive disorder, single episode, severe with psychotic features and dementia with behavioral disturbance.

The quarterly MDS assessment dated 5/4/17 indicated Resident #76 ' s cognition was intact. Resident #76 received antipsychotic medication and antidepressant medication during the MDS review period. His active diagnoses included dementia and depression.

The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care (initiated on 8/25/16 and most recently reviewed on 5/5/17) that indicated the focus area of psychotropic drugs related to the diagnosis of unsteady gait/balance.

An interview was conducted with the DON on 6/6/17 at 12:34 PM. She indicated it was her expectation that plans of care be comprehensive, accurate, and followed. She stated MDS Nurse #1 and MDS Nurse #2 were ultimately responsible for initiating and revising the plans of care.

An interview was conducted with MDS Nurse #1 on 6/6/17 at 5:22 PM. She stated she was responsible for the oversight of MDS Nurse #2, MDS assessments, and care plans. The plan of care related to psychotropic drugs for Resident #76 that indicated the psychotropic medications were related to the diagnosis of unsteady

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 _____	C 06/09/2017

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 279	Continued From page 90	F 279		

gait/balance was reviewed with MDS Nurse #1. She stated unsteady gait/balance was not an appropriate diagnosis for Resident #76 ' s psychotropic care plan. She revealed this plan of care related to psychotropic drugs was not accurate for Resident #76.

An interview was conducted with MDS Nurse #2 in 6/6/17 at 5:25 PM. The plan of care related to psychotropic drugs for Resident #76 that indicated the psychotropic medications were related to the diagnosis of unsteady gait/balance was reviewed with MDS Nurse #2. She stated unsteady gait/balance was not an appropriate diagnosis for Resident #76 ' s psychotropic care plan. She explained that when the plan of care for psychotropics was entered into the electronic medical records system a drop down box with diagnoses was available and they were required to select the related diagnosis/diagnoses. MDS Nurse #2 stated the incorrect diagnosis was selected for Resident #76 ' s care plan for psychotropic drugs. She indicated Resident #76 had multiple other diagnoses that related to his psychotropic medications, such as, depression, dementia, and a history of psychosis.

2c. Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included muscle weakness, difficulty in walking and history of cerebral infarction.
The quarterly Minimum Data Set (MDS) assessment dated 5/4/17 indicated Resident #76 ' s cognition was intact. Resident #76 was assessed as dependent on 1 staff member for personal hygiene. Resident #76 had impairment on 1 side of his upper and lower extremities and was assessed as not steady on his feet.

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 _____	C 06/09/2017

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 279	Continued From page 91	F 279		

The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care (initiated on 8/12/16 and most recently reviewed on 5/5/17) that indicated the focus area of personal hygiene. Resident #76 was noted to require assistance with makeup application.

An interview was conducted with the DON on 6/6/17 at 12:34 PM. She indicated it was her expectation that plans of care be comprehensive, accurate, and followed. She stated MDS Nurse #1 and MDS Nurse #2 were ultimately responsible for initiating and revising the plans of care.

An interview was conducted with Resident #76 on 6/6/17 at 4:58 PM. He stated he had not worn make up. Observation of Resident #76 during this interview revealed he had no makeup on.
An interview was conducted with MDS Nurse #1 on 6/6/17 at 5:22 PM. She stated that she was responsible for the oversight of MDS Nurse #2, MDS assessments, and care plans. The plan of care related to personal hygiene for Resident #76 that indicated he required assistance with makeup application was reviewed with the MDS Nurse #1. She indicated she was familiar with Resident #76 and he had not worn make up and he had not required assistance with makeup application. MDS Nurse #1 revealed this plan of care related to personal hygiene for Resident #76 was not accurate or individualized.
An interview was conducted with MDS Nurse #2 in 6/6/17 at 5:25 PM. The plan of care related to personal hygiene for Resident #76 that indicated he required assistance with makeup application was reviewed with the MDS Nurse #2. She indicated she was familiar with Resident #76 and

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 _____	C 06/09/2017

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 279	Continued From page 92	F 279		

he had not worn make up and he had not required assistance with makeup application. MDS Nurse #2 verified this plan of care related to personal hygiene for Resident #76 was not accurate or individualized.

3. Resident #100 was admitted to the facility on 4/8/16 with multiple diagnoses including cerebrovascular accident (CVA) and depression. The quarterly Minimum Data Set (MDS) assessment dated 3/24/17 indicated that Resident #100 had received an anticoagulant medications during the 7 days of the assessment period.

Review of the doctor's order revealed that Resident #100 was on Xarelto (anticoagulant drug) 15 milligrams (mgs) by mouth daily since 4/9/16 for CVA.

Resident #100's care plan dated 3/24/17 was reviewed. There was no care plan developed for the use of the anticoagulant medication.

Interview with the MDS Nurse #2 was conducted on 6/7/17 at 12:25 PM. MDS Nurse #2 stated that if a resident was on anticoagulant medication, a care plan should have been developed. She reviewed the resident's electronic care plan and stated that there was no care plan developed for the use of the anticoagulant medication, it was missed.

Interview with the Director of Nursing (DON) was conducted on 6/8/17 at 11:15 AM. The DON stated that she expected a care plan developed

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 _____	C 06/09/2017

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 279	Continued From page 93 when a resident was started on anticoagulant medication.	F 279		
F 280 SS=J	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		7/25/17

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 _____	C 06/09/2017

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 280	Continued From page 94 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280		

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 _____	C 06/09/2017

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

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F 280	Continued From page 95 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise the care plan for wandering for a cognitively impaired resident who was identified at risk for elopement, which resulted in an unsupervised exit from the facility's front door for 1 of 3 sampled residents reviewed for accidents (Resident #3.) The facility also failed to revise the care plan of a cognitively impaired resident who had repeated falls for 1 of 3 sampled residents (Resident #3) at a scope and severity of D. The facility failed to involve alert and oriented residents in the care planning process for 2 (Residents #82 & #74) of 3 sampled residents. This was at a scope and severity of D. Immediate jeopardy began on 3/4/17 when Resident #3 exited the facility unsupervised and facility failed to update the care plan. The immediate jeopardy is present and ongoing. Findings included: 1a. Resident # 3 was admitted to the facility on 7/7/16 with multiple diagnoses including pelvic fracture. The quarterly Minimum Data Set (MDS) assessment dated 3/26/17 indicated that Resident #3 had moderate cognitive impairment and was independent with locomotion on and off unit. The assessment also indicated that the resident needed extensive assistance with transfer and was using a wheelchair for mobility. The assessment further indicated that the	F 280	F280 Comprehensive Care Plan Based upon a thorough investigation that was concluded on 6/15/17, it was determined the Resident #3 had an unsupervised exit on 03/04/2017, 04/09/2017 and 05/14/2017. On 6/15/17, the Care Plan and Resident Care Guide for Resident #3 was updated by the MDS Nurse under the supervision of the MDS corporate consultant for falls and elopements. A 100% audit of all resident care plans was completed on 6/15/17 by MDS Nurse #1 and MDS Nurse #2 to ensure the care plans are reviewed and revised periodically, quarterly and annually and as needed with any changes, to include updates and revised wandering assessments and the services provided were arranged must be consistent with each resident's written plan of care. The MDS corporate consultant #1 and MDS corporate consultant #2 reviewed and validated the care plans that were completed by the MDS nurse #1 and MDS nurse #2 on 6/15/17. On 6/13/17, the MDS consultants in-serviced the care plan team members (to include the MDS nurses, Social	

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 _____	C 06/09/2017

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 280	Continued From page 96 resident had not exhibited a wandering behavior during the assessment period. Resident #3's care plan for wandering was reviewed. The wandering care plan was initiated on 8/9/16 and was reviewed on 3/28/17. One of the care plan problems described the resident at risk for wandering and for unsupervised exits from the facility related to: attempts to leave unit/building. The goal was the resident will have no episode of unsupervised exits from facility through next review. The approaches included to "allow resident to wander on units, to check daily to ensure resident has an alarm bracelet on and it is functioning properly, documents episodes of wandering per facility protocol, ensure identification (ID) bracelet is in place, ensure resident's picture and name are on the wandering resident board, ensure that alarm exits are functional, provide 1:1 staff monitoring as necessary, provide supervision during recreational programs, and provide resident with opportunities to attend group activities of choice." All of these care plan approaches were initiated/started on 8/9/16. There were no revisions to the care plan approaches after 8/9/16 or after 3/4/17 when the resident had exited the facility unsupervised. The nurse's notes dated 3/4/17 at 7:45 PM revealed "alarm sounding at front door. Upon investigating, visitor said that he had let resident (Resident #3) out of door because resident asked him to. Upon going outside, this nurse noted (name of Resident#3) in his chair within a few feet of roadway. This nurse could not get resident return to building. He was yelling "I'm not going back in the building, I'm going home." This nurse continued to hold chair to prevent	F 280	Worker, and Dietary manager) regarding updating the resident care plans and resident care guides to ensure residents at risk for falls and wandering have interventions in their comprehensive plan of care to address the potential for falls and elopement and invitation to attend the resident care plan meeting. The in-services also included when a Care Plan/Resident Care Guide (RCG) is updated: When an incident occurs (to include a fall or unsupervised exit) and an intervention is put into place, the care plan and RCG will be updated by the MDS nurse each time an incident occurs. When a new intervention is put into place by the DON or quality improvement nurse, the MDS nurse will add the new intervention to the care plan and RCG within 72 hours. The MDS nurses will attend the daily department head meetings and clinical meetings to participate in discussion related to incidents, including falls and unsupervised exits, to ensure care plans are revised in a timely manner for cognitively impaired residents at risk. The care plan/RCG will be updated at that time. Per the Resident Assessment Instrument process the care plan must be reviewed and revised periodically, quarterly and annually and as needed with any changes, to include updates and revised wandering assessment and the services provided were arranged must be consistent with each resident written plan of care. To include invitations for the alerts and oriented resident and resident	

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 _____	C 06/09/2017

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 280	Continued From page 97	F 280		

resident from entering roadway and turned on her cell phone and phoned facility. Advised staff of situation and 3 staff members came and assisted writer to get resident back into building." The notes indicated that the resident had no injuries from the incident. Nurse #1 was the author of this note.

The nurse's notes dated 4/11/17 at 4:47 PM revealed "late entry for 4/10/17 at 5:30 PM, Director of Nursing (DON) and Social Worker (SW) spoke with wife to inform her that the resident had an unsupervised exit and that the team needed to meet with her and the family to discuss the move to sparks unit (secured unit). She stated that we could go ahead and plan a meeting and she would make sure the family was present." The DON was the author of this note.

The nurse's notes dated 4/14/17 at 1:59 PM revealed resident "at front door yelling trying to get out. Redirected to lunch with good results. Returned to door, loudly yelling for his wife and son." The Quality Assurance (QA) Nurse was the author of this note.

The nurse's notes dated 4/14/17 at 3:02 PM revealed that at 2:05 PM, Resident #3 was still wanting to leave the facility. The QA Nurse was the author of this note.

The nurse's notes dated 5/15/17 at 4:26 PM revealed that "DON (Director of Nursing) was notified that resident was allowed to leave the building by a family member visiting another resident. The nurse asked the visitor not to let the resident out but they did it anyway. The resident made it out the door but not off the porch and supervised by the nurse the entire time." The

representative to attend the residents plan of care meeting.

On 6/15/2017, the Director of Nursing and Administrator reviewed the 30 day MDS Schedule to determine the future care plan meetings. The 30 day calendar indicated 26 residents that require an invitation to a care plan meeting, the Administrator verified the invitations were sent on 06/16/2016 to the respective alert and oriented residents and resident representatives. On 06/14/2017 the social worker invited alert and oriented resident #74 and #82 to the care plan meeting to be held on 06/16/2017. The care plan meeting for Residents #74 and #82 is scheduled for 06/16/2017 by the interdisciplinary care plan team to review the residents current plan of care for updates and changes as indicated.

On 6/10/17, the regional vice president, corporate consultants, and administrator, began providing oversight to the facility and monitoring to ensure the facility has systems in place to 1) honor resident's right to participate in the development and implementation of a person-centered plan of care, 2) revise care plans timely to prevent elopement, and 3) revise care plans timely to prevent accidents, including falls.

On 6/23/17, DON, QI nurse, staff facilitator, hall nurse, MDS nurse, social worker, and/or corporate consultant began auditing nurse progress notes and risk management reports in the electronic

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 _____	C 06/09/2017

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 280	Continued From page 98 DON was the author of this note. The nurse's notes dated 5/16/17 at 4:40 PM revealed "resident propelling self-up and down halls in wheelchair yelling and screaming for someone to pay him and that he needs a ride home. Resident repeatedly asking visitors to let him out so he can find a ride home." The MDS Nurse #2 was the author of this note. The nurse's notes dated 5/23/17 at 3:37 PM revealed "wife notified that the resident has been trying to exit building all day. The wife stated that she knows that he will not come back if he is allowed to exit facility." The DON was the author of this note. The nurse's notes dated 5/24/17 at 1:53 PM revealed that the resident "attempts to leave facility to vacate the premises. Is cognitively impaired and cannot make good decision to protect himself from danger." The QA Nurse was the author of this note. The nurse's notes dated 6/4/17 at 10:20 PM revealed "resident sitting in wheelchair propelling self about facility. Third shift reports that resident didn't sleep last night, he has been up all night wandering about facility in his wheelchair." Nurse #7 was the author of this note. Interview with the MDS Coordinator #1 was conducted on 6/6/17 at 3:45 PM. The MDS Coordinator stated that she started as MDS Nurse in March 2017. She stated she had no MDS experience in the past and she had received MDS training from the corporate consultant and not from the state MDS training. The MDS Nurse indicated they discussed the	F 280	medical record. The audit is to ensure all interventions are in place to prevent cognitively impaired, wandering residents from unsupervised exit/elopement, to protect residents who fall, and ensure residents/resident representatives are invited to care plan meetings. Any concerns are immediately addressed by the auditor to include reporting to the administrator and/or DON. Beginning on 6/26/17, the audit is documented on the Care Planning Participation and Revision Audit Tool, which covers: 1) if the progress notes were reviewed, 2) if the care plan assessment was completed, comprehensive, accurate, and care guide updated, and 3) if a care plan invitation postcard was offered to the resident/resident representative. The audit tool will be completed weekly x 3 months, then monthly x 3 months. On 6/26/17, the administrator, regional vice president, and/or corporate clinical director will begin a weekly review of the completed Care Planning Participation and Revision Audit Tools to ensure the systems for care plans and care planning invitations remain in place and are functioning properly. The review will be completed, as indicated by initialing the audit tool, for four weeks to ensure adequate supervision and oversight. The MDS nurse and/or the social worker will present the findings of the Care Planning Participation and Revision Audit Tool at the monthly Quality Improvement Committee meeting. The Quality	

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 _____	C 06/09/2017

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

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F 280	Continued From page 99 incident reports during their morning meeting. She stated she was aware of Resident #3's wandering episodes. The MDS Nurse had reviewed the resident's electronic care plan for wandering and stated that there were no revisions to the care plan approaches since 8/9/16. Interview with the DON on 6/8/17 at 2:15 PM was conducted. The DON stated she expected the MDS Nurse to revise the care plan after every fall or unsupervised exit. The Administrator and the DON were notified of immediate jeopardy on 6/7/17 at 1:23 PM. b. Resident # 3 was admitted to the facility on 7/7/16 with multiple diagnoses including pelvic fracture. The quarterly Minimum Data Set (MDS) assessment dated 3/26/17 indicated that Resident #3 had moderate cognitive impairment and was independent with locomotion on and off unit. The assessment also indicated that the resident needed extensive assistance with transfer and was using a wheelchair for mobility. The assessment further indicated that the resident had falls since admission or prior assessment with no injury. Resident #3's care plan for falls was reviewed. The falls care plan was initiated on 8/9/16 and was reviewed on 3/28/17. The care plan problem was "risk for falls characterized by history of falls related to: weakness, back surgery." The goal was "resident will be free of falls through next review." The approaches included "assist during transfer and mobility, bed in lowest position, encourage resident to participate in activities that promote exercise, physical activity for	F 280	Improvement Committee will review the results of the audits monthly x 6 months, identify trends, use "5 Whys" root cause analysis, and make recommendation for follow-up as needed. The MDS nurse and/or social worker will present the findings of the Care Planning Participation and Revision Audit Tool at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility's follow-up to the recommendations. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of resident's right to participate in the development and implementation of the plan of care and have the care plan revised.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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F 280	Continued From page 100	F 280		

strengthening and improved mobility, fall risk protocol, have commonly used articles within easy reach, keep assistive ambulation devise (wheelchair) within reach of the resident and keep call light within reach and answer timely." All of these approaches were initiated/started on 8/9/2016. There were no revisions to the care plan approaches after 8/9/2016 and after the incidents of falls.

Resident #3's incident reports were reviewed. The resident had 10 falls from 10/2016 through 05/2017. The dates of the falls were 10/17/16, 11/11/16, 11/17/16, 12/7/16, 12/19/16, 1/4/17, 2/7/17, 4/23/17, 4/29/17 and 5/30/17.

Interview with the MDS Coordinator #1 was conducted on 6/6/17 at 3:45 PM. The MDS Coordinator stated that she started as MDS Nurse in March 2017. She stated that she had no MDS experience in the past and she had received MDS training from the corporate consultant and not from the state MDS training. The MDS Nurse indicated the incident reports were discussed during morning meeting. She stated that she was aware of Resident #3's repeated falls. The MDS Nurse had reviewed the resident's electronic care plan for falls and stated that there were no revisions to the care plan approaches since 8/2016.

Interview with the DON on 6/8/17 at 2:15 PM was conducted. The DON stated that she expected the MDS Nurse to revise the care plan after every fall or unsupervised exit.

2. Resident #82 was admitted to the facility on

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 _____	C 06/09/2017

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F 280	Continued From page 101	F 280		

10/14/13 with multiple diagnoses including Major depressive disorder. The quarterly MDS assessment dated 4/6/17 indicated that Resident #82 had moderate cognitive impairment. The assessment also indicated that the resident had no behavior, she has clear speech, she had clear comprehension and she was able to make self - understood.

On 6/5/17 at 10:02 AM and on 6/7/17 at 12:43 PM, Resident #82 was interviewed. She stated that she didn't feel included and had not been involved in the care planning process.

The Social service progress notes were reviewed from 6/1/16 through 6/7/17. There were no notes of any care planning process held for Resident #82.

Interview with the Social Worker (SW) was conducted on 6/7/17 at 3:12 PM. The SW stated she was responsible for inviting residents and responsible party (RP) to the care plan meeting. She stated that she documented electronically when the care plan meeting was held and if the RP or the resident had attended the meeting. The SW provided additional information and stated that she could not find any documentation that a care plan meeting was held for Resident #82.

Interview with the DON was conducted on 6/8/17 at 2:15 PM. The DON stated that she expected the residents and the RP to be involved in the care planning process.

Interview with the MDS Nurse #2 was conducted on 6/8/17 at 3:20 PM. MDS Nurse #2 indicated that it has been an issue for over a year now that the interdisciplinary team (IDT) didn't meet for the

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 102	F 280		

care planning process. The SW was responsible for inviting residents and RP to the meeting but that was not happening. MDS Nurse #2 further stated that there were no meetings held with the facility's staff, residents and RPs to discuss the care planning process for over a year now. She indicated that administration was aware of this issue.

3. Resident #74 was admitted to the facility on 5/10/16 with multiple diagnoses including bipolar disorder, major depressive disorder, and anxiety disorder.

A review of Resident #3's medical record revealed his most recent care plan meeting was held on 10/18/16.

The annual Minimum Data Set (MDS) assessment dated 4/24/17 indicated Resident #74's cognition was intact.

An interview was conducted with Resident #74 on 6/5/17 at 10:17 AM. He stated he had not felt like he was included in decisions about his medicine, therapy, or other treatments. He indicated his last care plan meeting was over 6 months ago.

An interview was conducted with the Director of Nursing (DON) on 6/6/17 at 12:34 PM. She indicated the facility utilized care plan meetings to incorporate the resident and/or Responsible Party (RP) in the care planning process. She stated her expectation was for a care plan meeting to be held quarterly with the resident and/or the RP and as needed if an issue arose. She indicated the Social Worker (SW) was responsible for scheduling care plan meetings and for inviting the resident and/or RP. The DON revealed the facility had an ongoing problem with the

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 _____	C 06/09/2017

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

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F 280	Continued From page 103	F 280		

timeliness of care plan meetings.

An interview was conducted with the SW on 6/7/17 at 12:53 PM. She indicated care plan meetings were utilized to include the resident and/or RP in the care planning process. She stated care plan meetings were held quarterly and as needed if an issue arose. She reported she was responsible for scheduling the care plan meetings and for inviting the resident and/or RPs. The SW indicated she was familiar with Resident #74. She stated he was his own RP and he was to be included in all of his care plan meetings. She reported she was unsure of when Resident #74's last care plan meeting was held. She reported she needed to review her records.

A follow up interview was conducted with the SW on 6/7/17 at 3:12 PM. She revealed Resident #74's last care plan meeting was held on 10/18/16. She indicated there should have been a care plan meeting held with Resident #74 since that time. She stated she was unable to explain why Resident #74 had not had a care plan meeting since 10/18/16.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 6/8/17 at 3:21 PM. MDS Nurse #1 and MDS Nurse #2 reported that care plan meetings were utilized to incorporate the resident and/or RP in the care planning process. They both indicated care plan meetings were supposed to be held quarterly. The MDS Nurses revealed that quarterly care plan meetings were not occurring consistently. MDS Nurse #2 stated she had been in her position at the facility for about a year and this was an ongoing problem for that entire length of time.

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 _____	C 06/09/2017

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

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F 309	Continued From page 104	F 309		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		7/25/17

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 309	Continued From page 105 Based on medical record review, nurse practitioner and staff interviews, the facility failed to obtain a psychiatric consult in January 2017 as ordered for one of five residents reviewed for unnecessary medications resulting in ongoing behavioral issues (Resident #91). Findings included: Resident #91 was admitted to the facility on 12/1/16. Cumulative diagnoses included Alzheimer ' s disease and dementia with behavioral disturbance. Admission physician orders dated 12/1/16 revealed Resident #91 received Seroquel (antipsychotic medication) 25 milligrams by mouth at bedtime and Ativan (anti-anxiety medication) 1 milligram by mouth three times a day as needed for anxiety. An Admission Minimum Data Set (MDS) dated 12/12/16 indicated Resident #91 was moderately impaired in cognition. No mood or behaviors were noted as having occurred during the assessment period. Medications administered during the assessment period included seven days of antipsychotic medication. A Care Area Assessment (CAA) for psychotropic medication dated 12/14/16 stated Resident #91 received Seroquel (antipsychotic medication) 25 milligrams every night with no adverse reactions noted. Proceed to care plan for the use of psychotropic medications to maximize the resident ' s functional potential and well-being while minimizing the hazards associated with the medication side effects. A care plan dated 12/14/16 indicated Resident	F 309	F 309 Provide Care/Services for Highest Well Being On 6/8/17, the nurse practitioner (NP) was notified Resident #91 did not have the psychiatric consultation that was ordered on 1/10/17. On 6/13/17, Resident # 91 was evaluated by the psychiatric NP. On 6/14/17, the following new orders were transcribed: complete blood count with differential, Valporic Acid Level, increase Depakote to 500 mg by mouth (po) two times daily and to discontinue Seroquel. The resident is scheduled to be seen by the psychiatric NP on 07/17/17. A 100% audit was initiated by the facility consultants, director of nursing (DON), and staff facilitator of all residents, to include Resident #91, for the time period of 1/10/17- 6/31/17 to ensure all residents with a physician order for a psychiatric consultation will be evaluated by a psychiatric NP, by 7/25/17. There were 12 residents identified that require psychiatric consultation and will be evaluated by 7/25/17. Any recommendations from the psychiatric consultation will be addressed by the hall nurse, quality improvement (QI) nurse, or DON timely after the consultation. On 6/29/17, the corporate consultants and DON initiated a 100% in-service for registered nurses (RNs) and licensed practical nurses (LPNs) regarding: 1) when a resident has a physician order for a psychiatric consultation, it is the responsibility of the nurse transcribing the	

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F 309	Continued From page 106 #91 received psychotropic drugs. Interventions included, in part: Administer medications per physician orders. DISCUS (Dyskinesia Identification System Condensed User Scale) evaluation per facility protocol. Observe gait for steadiness, balance and muscle coordination, ability to position and turn. Pharmacy review of medications monthly and/or as ordered. The care plan did not specify or identify any targeted behaviors. Psychiatric consult was not added or included in the interventions. A nursing note dated 12/19/16 indicated Resident #91 displayed inappropriate behaviors. A nurse practitioner note dated 1/10/17 stated Resident #91 was seen for inappropriate behavior and actions. Laboratory tests were ordered and a consultation with psychiatric services was ordered at that time. A physician order dated 1/10/17 stated consult (name) psychiatry to review medications and manage behaviors. A nursing note dated 1/29/17 stated Resident #91 climbed out of the television room window into the enclosed courtyard. A pharmacy chart review note dated 1/30/17 stated psychiatric evaluation pending. A nursing note dated 2/11/17 stated Resident #91 displayed inappropriate behaviors. A pharmacy chart review note dated 2/27/17 stated recommendations: follow up psych consult. A Quarterly Minimum Data Set (MDS) dated	F 309	order to provide a copy of the order to the social worker for implementation of the order and 2) a copy of the order will also be provided to the DON to ensure the referral is followed up on. All newly hired RNs and LPNs will be educated during orientation by the quality improvement (QI) nurse. No nurse will be allowed to work after 7/25/17 until completing this in-service. The DON or QI nurse will review all physician orders to ensure all psychiatric consultations have been placed in the Inpatient Consultations book and referrals are completed and documented on the Consultation Audit Tool. The review will occur 5 times a week for 4 weeks, every other week for 4 weeks, then monthly for 1 month. The results of the Consultation Audit Tool will be reviewed by the Administrator weekly. The QI nurse or DON will review with the monthly Quality Improvement Committee the Consultation Audit Tool results monthly x 3 months for trending, root cause analysis and recommendations. The QI nurse or DON will review with the quarterly Quality Assessment and Assurance (QAA) Committee the Consultation Audit Tool results, QI Committee recommendations, and facility progress with recommendations for 1 quarter for additional root cause analysis, recommendations, and additional monitoring requirements as needed. The administrator is responsible for ensuring	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 309	Continued From page 107 3/4/17 indicated Resident #91 was moderately impaired in cognition. Mood indicators stated Resident #91 was noted 2-6 days during the observation period of moving or speaking so slowly that other people could have noticed or the opposite of being so fidgety or restless and moved around a lot more than usual. No behaviors were noted as having occurred during the assessment period. A physician order dated 3/9/17 stated verify psychiatry or refer to psychiatry for medication management. A pharmacy chart review dated 3/30/17 stated psych pending. A pharmacy review note dated 4/28/17 stated follow up psych/ Seroquel. A nursing note dated 5/17/17 revealed Resident #91 displayed inappropriate behaviors. A Quality Improvement note dated 5/23/17 stated Resident #91 received Seroquel 25 milligrams at bedtime for a diagnosis of Alzheimer ' s with behavioral disturbance. One episode of disturbance was noted during the month of April and two thus far in May. A review of the medical record revealed the psychiatric consultation was not obtained. On 6/6/17 at 3:33 PM, an interview was conducted with Nurse #2. She stated she worked on the dementia unit most of the time. She said Resident #91 was known to have inappropriate behaviors at times. She stated Resident #91 responded to redirection most of the time.	F 309	QAA Committee recommendations are implemented and for reporting back to the QAA Committee.	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 309	Continued From page 108	F 309		

On 6/6/17 a 3:46 PM, an interview was conducted with NA #4. She stated Resident #91 had inappropriate behaviors at times. She said he wandered in and out of resident rooms. She said there was an in-service held regarding some of the inappropriate behaviors and staff were told to monitor Resident #91 closely. She was unable to remember the date of the in-service.

On 6/6/17 at 5:03 PM, an interview was conducted with the Director of Nursing. She stated (name) psychiatric services came to the facility every other week. The Director of Nursing stated she was responsible for writing the orders for the psychiatric consultations. She said she thought Resident #91 had been seen by psychiatric services. After reviewing the medical record, she said she could not find where Resident #91 had been seen by psychiatric services.

On 6/7/17 at 10:14 AM, the Director of Nursing was re-interviewed. She stated she had notified psychiatric services yesterday and he would be seen by psychiatric services today. She said she discovered in January 2017 that many orders were being kept/ hidden under the calendar and not transcribed/ completed. She stated she removed the calendars and all physician orders from the previous day were reviewed in the morning meeting. A copy of the orders were given to the MDS nurses for care plan revisions. The Director of Nursing stated she had a charge nurse until the middle of March who had been responsible for ensuring physician orders were carried out and completed. After that time, the Director of Nursing stated she assumed the responsibility for the physician orders which

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F 309	Continued From page 109 included obtaining psychiatric consults. The Director of Nursing stated there were weeks in January when there were no psychiatric services available due to unavailability of psychiatric staff. She was unable to give exact dates when psychiatric services were unavailable. She said there were additional psychiatric services available beginning in February 2017 other than (name) psychiatric services and they continued to come to the facility. The Director of Nursing said the physician order for the psychiatric consultation must have been overlooked and the psychiatric consult should have been obtained in January as ordered. On 6/8/17 at 7:54 AM, an interview with the Nurse Practitioner was conducted. She stated, to her knowledge, there had been a problem with obtaining psychiatric services and having them come to the building. Because there was a problem with obtaining the psychiatric services, she said she was not aware that he had not been seen. The Nurse Practitioner stated she expected the order for the psychiatric consult to be followed and the psychiatric consult should have been obtained prior to now with the behaviors displayed by Resident #91. She stated she also expected the nursing staff to notify her if the orders could not be done.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		7/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 110 by: Based on observations, staff and resident interviews and record review, the facility failed to provide resident showers as scheduled for 1 of 5 residents (Resident #37) who required staff assistance with bathing and reviewed for activities of daily living (ADLs). Findings included: Resident #37 was admitted on 1/20/11 with cumulative diagnoses of dysphasia, anxiety and aphasia. Resident #37 ' s quarterly Minimum Data Set (MDS) dated 2/20/17 indicated severe cognitive impairment, physical behaviors toward others, and extensive assistance of two staff for her activities of daily living (ADLs) and total assistance of two staff with bathing. Resident #37 was last care planned on 2/21/17 for total assistance of two facility staff members to perform her showers. Her hair was to be washed on her shower days. A review of the electronic and written aide documentation for showers from 3/1/17 to present indicated the following: -Tuesday 3/7/17-no shower -Friday 3/10/17-no shower -Tuesday 3/14/17-no shower -Friday 3/17/17-no shower -Tuesday 3/21/17-no shower -Tuesday 3/28/17-no shower -Friday 3/31/17-no shower -Tuesday 4/4/17-no shower -Tuesday 4/11/17-no shower -Friday 4/14/17-no shower -Tuesday 4/18/17-no shower -Friday 4/21/17-no shower	F 312	F 312 ADL Care Provided for Dependent Residents On 6/20/17 and 6/23/17, the nursing assistant assisted dependent Resident #37 with a shower, as scheduled on Tuesday and Friday. On 6/28/17, the director of nursing (DON), quality improvement (QI) nurse, admissions coordinator, and corporate consultants initiated a 100% audit of all residents shower records for the previous 14 days to ensure residents are receiving a bath/shower according to their preference. The shower audit was completed on 6/29/17. The audit revealed several residents were not assisted with showers as scheduled and those identified residents were assisted with a bath/shower according to the resident□'s preference. When a resident refuses a shower or bath the nursing assistant will immediately notify the nurse. The nurse will immediately follow-up with the resident upon notification of refusal to ensure the resident receives a shower or document continued refusal. On 6/29/17, the director of nursing, admissions coordinator (a licensed practical nurse), quality improvement (QI) nurse, and corporate consultants initiated a 100% in-service for all nurses and nursing assistants regarding: all residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition,	

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 _____	C 06/09/2017

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

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F 312	Continued From page 111 -Tuesday 4/25/17-no shower -Friday 4/28/17-no shower Resident #37 ' s most recent Resident Care Guide dated 4/4/17 read bathing was to be completed by two staff with total dependence. A review of the Shower Schedule last revised 4/24/17 read Resident #37 was have her showers on Tuesdays and Fridays on first shift. In an observation on 6/4/17 at 5:00 PM, a family member stated Resident #37 relied on facility staff for all of her ADLs. She stated she did not think Resident #37 was getting her showers because she frequently smelled of urine and her hair appeared dirty and unwashed. She stated the facility can ' t keep staff. They are always short on the floor. Resident #37 appeared clean and well groomed on 6/4/17 at 5:00 PM. In an interview on 6/7/17 at 12:10 PM, NA #7 confirmed she was assigned Resident #37 on 4/14/17 and 4/28/17. She stated when there were call outs, she had trouble completing her assignment. NA #7 stated sometimes the shower team was pulled to the floor and that might be what happened on 4/14/17 and 4/28/17. In an interview on 6/7/17 at 12:20 PM, NA #5 stated she began working at the facility on 3/30/17 and she thought the shower team gave Resident #37 her showers. She stated she was not aware there was no shower team in March and she was unable to offer an explanation as to why Resident #37 did not receive her shower on 4/21/17. In an interview on 6/7/17 at 12:30 PM, NA #8	F 312	grooming, personal and oral hygiene, to include showers. When the nurse aide completes the resident'□s shower, the aide will initial the shower sheet posted at the nurse□ station. If the resident chooses not to be assisted with a shower, the nurse aide will notify the nurse immediately. When a resident refuses a shower or bath the nursing assistant will immediately notify the nurse. The nurse will immediately follow-up with the resident upon notification of refusal to ensure the resident receives a shower or document continued refusal. Beginning 07/17/17, charge nurse, QI nurse, admissions coordinator, DON, and/or corporate consultant will audit 5 of the residents daily with observation of bath/showers and/or review of shower documentation to validate the residents received a bath/shower according to resident preferences 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. The audits will be documented on the Bath/Shower/Choices Audit tool to ensure residents are receiving showers as scheduled based upon interview of the resident, resident'□s representative (RR) or observation of bath/shower. The results of the audit tools will be reviewed by the administrator weekly x 12 weeks and the administrator will initial the completed audit tools to signify administrator review. The QI nurse and/or DON will present the findings of the Bath/Shower/Choices Audit tool at the monthly Quality Improvement	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 312	Continued From page 112 stated when she started in January, there was a shower team that did Resident #37 ' s showers but they did away with the shower team not long after she started. NA #8 confirmed she was assigned Resident #37 on 3/14/17, 3/17/17 and 3/28/17 but due to call outs and staffing shortages, she may not have been able to complete Resident #37 ' s shower on these days. In an interview on 6/8/17 at 8:17 AM, shower aide (SA) #1 stated she started on the shower team 10/1/16. She stated there were two separate showers teams but due to staffing shortages, the shower teams were dismantled in February 2017. SA #1 stated the shower team was restarted 5/1/17 and that was when Resident #37 was added to their shower list. SA #2 stated prior to 5/1/17, the floor aides were responsible for her showers on Tuesday and Fridays. In an interview on 6/8/17 at 8:20 AM, the scheduler stated she started her position on 4/25/17. Prior to that, she was on the shower team that was dismantled in February due to staffing issues. The scheduler stated the aide assigned to Resident #37 on 3/7/17, 3/10/17, 3/21/17, 3/31/17, 4/4/17, 4/11/17, 4/18/17 and 4/25/17 was no longer employed by the facility. In an interview on 6/8/17 at 10:00 AM, NA #1 stated she started working for the facility on 12/6/16 and was hired to be on the shower team. She stated in February, the shower team was dismantled because of staff shortages. She confirmed Resident #37 was assigned to the shower team up until the first of March. In an interview on 6/8/17 at 4:10 PM, the Director of Nursing (DON) stated she started her position	F 312	Committee meeting. The Quality Improvement Committee will review the results of the audits monthly x 6 months, identify trends, use 5 Whys root cause analysis, and make recommendations for follow-up as needed. The administrator or DON will present the findings of the Bath/Shower/Choices Audit tool at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of ADL care provided for dependent residents.	

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F 312	Continued From page 113 the day after Christmas 2016 and staffing was a big issue. One the shower aides resigned in February and the other aide was needed on the floor. Resident #37 ' s showers were then completed by the floor aides. The DON stated the floor aides must have assumed there was a shower team completing her showers. The DON stated it was her expectation that Resident #37 should have gotten her showers as scheduled.	F 312		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to check gastrostomy tube placement before administering	F 322	F322 NG Treatment /Services Restore Eating Skills	7/25/17

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F 322	Continued From page 114 medications via gastrostomy tube for one of one sampled residents observed during medication pass observation (Resident #49). Findings included: Resident #49 was readmitted to the facility 3/8/17 with a diagnosis of cerebrovascular accident and aphasia. An Annual Minimum Data Set 5/16/17 indicated Resident #49 was severely impaired in decision-making. He required extensive assistance with eating. Diagnoses included cerebrovascular accident and aphasia (trouble speaking). Feeding tube was checked with food and fluid intake 51-100%. A review of physician orders revealed all of the resident's medications were to be administered via the gastrostomy tube. There was not an order to restrict fluids via the gastrostomy tube. On 6/7/17 at 8:00 AM, Nurse #8 was observed during medication pass. Nurse #8 used her stethoscope and listened to all four stomach quadrants for bowel sounds. She attached a 60 milliliter syringe to the gastrostomy tube opening and pulled back on the syringe checking for residual. Nurse #8 poured 30 milliliters of water into the gastrostomy tube and administered the medications. On 6/7/17 at 9:04 AM, an interview was conducted with Nurse #8. She stated she verified placement when she aspirated and pulled back on the gastrostomy tube. On 6/7/17 at 9:56 AM, an interview was conducted with the Director of Nursing. She stated she expected the nursing staff to follow the policy for administration of oral medications	F 322	On 6/7/17, Resident # 49 received medications via the gastrostomy tube from the hall nurse. On 6/23/17, the physician was notified by the Director of Nursing (DON) that the resident's gastrostomy tube was not properly checked for placement prior to medication administration on 6/7/17. On 6/23/17, the corporate consultant verified the resident had a stabilized gastrostomy tube. A 100% audit of all residents with gastrostomy tubes, to include resident #49, was completed by the DON and quality improvement (QI) nurse to ensure that no resident had experienced any complications related to gastrostomy tube placement or medication administration through a gastrostomy tube. The audit was completed on 7/6/17 and no areas of concern were identified with the gastrostomy tubes. On 7/14/17 through 7/15/17, the audit was repeated by the corporate consultants to ensure residents with a gastrostomy tube are receiving the appropriate treatment and services to prevent complications related to enteral feeding and medication administration. The second audit identified no areas of concern. On 6/27/17, the corporate consultants, DON, and QI nurse provided an in-service for 100% of licensed nurses, to included Nurse #8. The in-service reviewed the facility policy: 1) for stabilized Gastrostomy Tubes (surgically placed or stabilized by external device), pour small amount of water, 1-2 ounces (30- 60 ml)	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 322	Continued From page 115 through a gastrostomy tube which included to check the tube for placement prior to med administration by aspirating for stomach contents and instilling water into the tube prior to giving medications.	F 322	into the syringe to verify tube patency and moisten tubing to prevent feeding/medication from adhering to the tube, 2) for unstabilized Gastrostomy Tubes: test for placement by aspiration of stomach contents. Verify tube patency by instilling small amount of water, 1-2 ounces (30-60 ml) in the syringe. The in-service will be completed by 7/17/17. On 6/27/17, a 100% audit of observations of all Licensed Nurses was initiated by the corporate consultants, DON, and QI nurse to ensure all nurses can correctly verify placement of gastrostomy tubes prior to medication administration that was completed on 7/6/17. All new hires will be educated during orientation by the quality improvement nurse. No nurse will be allowed to work until proper demonstration of gastrostomy tube placement prior to medication administration is verified. The DON or QI nurse will observe 5 nurses weekly for 4 weeks to include weekends (Saturday and Sunday) and all shifts, then every other week for 4 weeks, then monthly for 1 month to ensure that proper verification of placement of gastrostomy tube is completed prior to administration of medication. The audits will be documented on the Gastrostomy Tube Verification Audit Tool. The results of the audits will be reviewed by the Administrator weekly. The QI nurse or Director of Nursing will review the Gastrostomy Tube Verification Audit Tool results with the monthly QI Committee	

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F 322	Continued From page 116	F 322	monthly for 3 months for any recommendations, take action as appropriate and to monitor for continued compliance. The QI nurse or DON will review the results with the quarterly Quality Assurance and Assessment (QAA) Committee for further recommendations and follow-up as indicated.	
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		7/25/17

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F 323	Continued From page 117 Based on record review, observation and staff interview, the facility failed to prevent a cognitively impaired resident from exiting the facility unsupervised (Resident #3) and also failed to prevent a cognitively impaired resident from bed entrapment between the mattress and the foot board (Resident #80). The facility also failed to reassess and to intervene to prevent repeated falls (Resident #3) at a scope and severity of D. These were evident for 2 (Residents #3 and #80) of 3 sampled residents reviewed for accidents. Immediate jeopardy began on 3/4/17 when Resident #3 exited the building unsupervised. Immediate jeopardy began on 5/1/17 when Resident #80's head was found caught between the foot board and the mattress causing a bruise to the back of neck. Immediate jeopardy is present and ongoing. Findings included: 1. Resident #80 was admitted to the facility on 1/23/17 with multiple diagnoses including Alzheimer's disease. The quarterly MDS assessment dated 4/25/17 indicated that Resident #80 had memory and decision making problems and needed extensive assistance with bed mobility. Resident #80 resided in the secured unit. Resident #80's care plan dated 4/25/17 was reviewed. The care plan problem was resident was at risk for falls and the goal was the "resident will be free of falls through the next review." The approaches included to assist during transfer and mobility, ensure environment free of clutter,	F 323	F323 Accidents On 1/23/17, Resident #80 was admitted to the facility's secured dementia unit. On 4/15/17, the licensed practical nurse (LPN) completed a work order for Resident #80'□s bed with a broken footboard. On 6/12/17, the maintenance assistant was in-serviced by the regional vice president (RVP) on the "Dimensional Limits for Identified Entrapment Zones" per the Food and Drug Administration Guidelines. The footboard was missing two screws on the right side of the board, thus causing a gap between the mattress and footboard. The identified gap between the footboard and mattress for Resident #80'□s bed impeded the resident's ability to rise from the bed. The footboard for Resident #80 was repaired by the maintenance assistant by placing two screws on the right side of the board and securing to the frame and eliminating the footboard as a restraint on 6/8/17. On 6/9/17, hospice offered to provide Resident #80 with a newer style bed and mattress for comfort, not because it was broken. On 6/27/17, the resident was placed on a new bed owned by the facility for continued safety and comfort. On 05/01/17, Nurse #1 entered Resident #80□'s room and observed Resident #80 facing the foot board of the bed with Resident #80'□s head wedged between the footboard and the mattress. Nurse #1, a medication aide, and a nursing assistant helped remove Resident #80□'s head from the footboard and mattress by lifting	

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F 323	Continued From page 118 administer medications as ordered and have commonly used articles within easy reach. The care plan did not address the resident's bed mobility. Resident #80's incident report dated 5/1/17 at 4:42 AM was reviewed. The report revealed" resident observed by writer facing the base board of their bed with their head wedged between the base board and the mattress. Writer, nurse, medication aide and Nursing aide (NA) helped remove resident's head from being wedged between base board and mattress by lifting resident's body and pulling mattress out from under resident to make room to slide resident's head out from under base board of their bed. Bruise noted to back of neck. (Name of physician) was notified. RP notified." The incident report revealed that Resident #80 resided in room 413 B on 5/1/17. Resident #80's nurse's notes were reviewed. The notes dated 5/1/17 at 4:40 AM revealed "resident observed by writer facing the base of their bed with their head wedged between the base board and the mattress. Write asked resident "what are you doing?" Resident stated "trying to get up." Writer, nurse, medication aide and NA helped remove resident's head from being wedged between base board and the mattress by lifting resident's body and pulling the mattress out from under the resident to make room to slide resident's head out from under the base board. Bruise noted to back of neck. Physician notified and responsible party (RP) notified. No change in resident's base line, level of consciousness (LOC), pupils equal, round, reactive to light and accommodation (PERRLA). Able to move all extremities within resident's normal base line.	F 323	Resident #80'□s body and pulling the mattress out from under the resident to make room to slide Resident #80'□s head from under the footboard. Resident #80 was assessed by the nurse with observation of a bruise to the back of the neck. Resident #80 denied pain or discomfort. No changes were noted during the assessment by the Nurse #1 in Resident #80□'s level of consciousness, pupils were equal, round and reactive to light and accommodation (PERRLA). Resident #80 was able to exhibit movement in all extremities without pain. On 5/1/17, the Nurse #1 notified the Medical Director by leaving a telephone message. On 5/1/17, Nurse #1 notified the resident representative (RR) by a telephone call. A full body audit was completed on Resident #80 on 5/16/17, 5/24/17, 5/30/17, and 6/12/17 by the treatment nurse with no negative findings of injuries related to restraints, entrapment/gap or falls. On 6/9/17, the Director of Nursing (DON) notified the physician concerning the incident of Resident #80□'s head being wedged between the mattress and the footboard. 100% of all residents□ beds, to include Resident #80, were audited by the maintenance assistants on 6/13/17 to ensure there were no identified risks for falls, entrapment zones/gaps or potential risk for restraining the resident (the rail, entrapment under the rail, between the rail supports or next to a single support, entrapment between the rail and the mattress, entrapment under the rail, at the	

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F 323	Continued From page 119	F 323		

Skin warm and dry to touch. Respiration even and unlabored. Lung sounds clear. No shortness of breath noted. Denies any pain or discomfort. No adverse reaction noted. Vital signs (VS) 126/66, 72, 18, 98.2." The nurse's notes dated 5/3/17 at 10:39 PM revealed that "swelling noted to right (R) check and R lip. Physician and RP notified."

Interview with NA #3 (assigned to Resident #80) was conducted on 6/7/17 at 5:40 PM. NA #3 stated that that the resident was independent with bed mobility, transfer and ambulation but he needed constant reminder due to his confusion.

Interview with the Director of Nursing (DON) was conducted on 6/7/17 at 5:50 PM. The DON stated that she was not aware of an incident with Resident #80 on 5/1/17. The DON was asked to read the electronic nurse's notes dated 5/1/17. The DON read the nurse's notes loudly with the Administrator and Corporate staff member in the room. The DON and the Administrator stated that they were not aware of the 5/1/17 incident.

On 6/8/17 at 7:55 AM, Nurse #2 was interviewed. Nurse #2 was assigned to Resident #80 on 4/30/17 (night shift). Nurse #2 stated that she was checking the rooms and she found Resident#80's head stuck under the base board of the bed. She clarified that she meant the base board as foot board. The resident was facing the floor and his neck was under the base of the foot board and his head was hanging out. The resident's body was in bed in downward facing position. He was not talking but he was alert. Four staff members helped to get the resident's head out from the foot board by lifting his body up and pulling the mattress out under him. Nurse #2 end of the rail, entrapment between the bed rails, and entrapment/gap between the end of the rail and the side edge of the head or footboard).

On 6/13/17, the corporate consultants completed a 100% audit of residents while in bed to ensure the resident is free from physical restraint while lying on the mattress. The corporate consultants also ensured the resident was provided enough space while moving around in the bed for repositioning and the bed was not a restraining device at the mattress, footboard and headboard. The audits completed by the maintenance assistants and RN facility consultants resulted in 3 resident beds being removed from service to eliminate the unintended restraining devices. The 3 residents identified in the audit were provided a bariatric bed on 6/13/17 for their comfort and safety. 1 resident was provided a new mattress per the resident request by the RVP and corporate consultant on 06/13/17.

On 6/16/17, the corporate consultants completed a 100% review of nursing progress notes and risk management reports from 3/1/17 through 6/16/17. The review covered injuries of unknown origin, entrapment, restraints and residents that had fallen. The review ensured provision of appropriate interventions and notification of the physician and resident representative via voice to voice conversation. All identified areas of concern were addressed by the corporate consultant and/or Director of Nursing

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

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F 323	Continued From page 120 stated that she called the attending physician of Resident #80 and not the on-call and left a message on his voice mail. She further stated that she was told to always call the resident's attending physician and not the after-hours access line. Nurse #2 further stated she was not aware that the attending physician of Resident #80 was on vacation at that time. Interview with the Physician was conducted on 6/8/17 at 9:58 AM. He stated that he was not informed of the incident with Resident #80 which happened on 5/1/17. He stated that he was on vacation the last week of April and was back to work the morning of 5/1/17. He stated that he expected the nurse to call the Nurse Practitioner or the on call physician. At 4:40 PM, the Physician indicated that his work phone was showing that the facility had called on 5/1/17 at 4:15 AM and left a message on his voice mail. He stated that he was unable to retrieve the message on his voice mail. On 6/8/17 at 8:08 AM, room 413 B (the room where Resident #80 resided on 5/1/17) was observed to measure the gap between the mattress and the foot board but the bed was already removed from the room. Nurse #2 had identified the same bed Resident #80 was using during the 5/1/17 incident. The bed mattress was small for the bed and there was a big gap between the bed frame (under the mattress) and the foot board. The nurse demonstrated how she found the resident in bed. Interview with the Maintenance director was conducted on 6/8/17 at 8:15 AM. He stated that he didn't know the incident with Resident #80 until yesterday 6/7/18. He indicate that he didn't know	F 323	(DON) with appropriate investigation and interventions implemented to decrease the number of falls and eliminate entrapment and deter elopement. The resident care plan and resident care guide updates were completed by the minimum data set (MDS) nurses and corporate consultants by 07/01/17. On 06/15/17, the corporate consultants, DON, and quality improvement (QI) nurse initiated an in-service for 100% of registered nurses (RN), licensed practical nurses (LPN), and nursing assistants (NA) on restraints. This in-service included the resident assessment instrument (RAI) and regulatory definition of a restraint and examples of restraints to include: 1) broken equipment that restricts freedom of movement, 2)side rails that keep residents from getting out of bed, 3)tucking in or using Velcro to hold a sheet, 4)tightly restraining fabric or clothing so that a resident'□s movement is restricted, 5)using trays, tables, bars or belts that the resident cannot remove easily, and 6) any item that could prevent the resident from rising, 7) placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or getting out of the bed. The in-service was completed on 7/1/17. Any RN, LPN, or NA not completing the in-service by 7/1/17, was required the complete the in-service prior to returning to a work assignment. All newly hired RN, LPN, or NA is required to complete the training from the DON or QI nurse prior to completing new employee orientation.	

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 _____	C 06/09/2017

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F 323	Continued From page 121 what kind of bed he was on but he thought he was on a hospice bed. The Maintenance director claimed that he didn't know who removed the bed from room 413 B. He added that he didn't know that he had to check the gaps between mattress, foot board, head board and side rails and he was not told to check them. On 6/8/17 at 8:25 AM, the beds in the secured unit were observed with the Maintenance director. In room 418 A, the foot board was loose, two screws were missing. In room 421 A, the hospice bed had a gap of 5 inches from the mattress to the foot board. In room 423 B, a regular bed had a gap of 4 inches between the mattress and the foot board. The distance between the bed frame (under the mattress) and the foot board was 7 and ¼ inches. A follow up interview with the DON was conducted on 6/8/17 at 9:27 AM. The DON stated she was not informed of the incident with Resident #80 that occurred on 5/1/17. She indicated that she had signed off the incident report dated 5/1/17 but she didn't think it was that bad but when she read the nurse's notes yesterday (6/7/17), she said "oh my God." The DON further indicated as far as she knew nothing had been done after the incident. She further stated that she didn't know what kind of bed the resident was on. The DON revealed that the resident was moved to another room per the family request but she was not sure of this. The DON stated that nobody was checking the gaps between the mattress and the foot board. Interview with the Administrator was conducted on 6/8/17 at 9:37 AM. The Administrator stated that she didn't read the incident report dated	F 323	A 100% all staff in-service was initiated on 6/15/17 and completed on 7/1/17 by the corporate consultant on: Entrapment/Gaps □Bed entrapment-an occurrence involving a resident who is caught, trapped, or entangled in the bed system to include the spaces in or around the bed rail, bed mattress, or bed frame, to include the foot board. 100% of all staff responded to questionnaires given by the Administrator in Training (AIT), Facility Consultants, and Director of Nursing initiated on 06/12/17 and completed by 6/22/17 for validation of understanding regarding entrapment to include: 1. What do you do if you find broken or faulty equipment? 2. What is entrapment? 3. Can a bed cause entrapment? 4. What do you do if you suspect or observe entrapment? 5. Who is at risk for entrapment? 6. What are some things that can contribute to entrapment? 7. If entrapment occurs, what can you do to ensure the resident'□s safety? 8. Who needs to be notified immediately if a resident is unsafe in bed due to space between that mattress and bed? All staff have successfully completed the entrapment questionnaires. By 6/16/17, the licensed nurses were tested on their knowledge of what a restraint is and examples of restraints. Any nurse, unable to pass the test, will be retrained and retested. If upon the second attempt, if the nurse is unable to successfully pass the Restraint Test the	

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F 323	Continued From page 122 5/1/17 because the DON and the QA (Quality Assurance) nurse had already signed it off. She indicated that she expected the maintenance director to check the gaps between the mattress and the foot board at least monthly but she didn't know if the maintenance director was doing it or not. The facility's wandering risk potential protocol dated 1/16/16 was reviewed. The protocol read in part "the purpose of this protocol is to implement guidelines to identify a resident's risk for inappropriate wandering within or outside the facility and to ensure a resident's safety in regards to the identified behavior. To identify this behavior and to ensure a resident's safety, utilization of the wandering risk potential protocol should occur as indicated. These guidelines apply to all residents within the facility including this residents who may reside on secured dementia units." The purpose of the protocol were "to prevent the resident's unsupervised exit and to plan for the resident's safety and well-being within the facility." The procedure included "implement preventative interventions up to or including the application of an alarm bracelet, monitoring the care plan, etcetera (etc.)." 2 a. Resident # 3 was admitted to the facility on 7/7/16 with multiple diagnoses including pelvic fracture. The quarterly Minimum Data Set (MDS) assessment dated 3/26/17 indicated that Resident #3 had moderate cognitive impairment and was independent with locomotion on and off unit. The assessment also indicated that the resident needed extensive assistance with transfer and was using a wheelchair for mobility.	F 323	nurse will be removed from the schedule until remediation is provided. By 6/16/17, the RN facility consultant completed 100% retraining of the nursing assistants on restraints and examples of restraints. The nursing assistants will be tested on their knowledge of the subject matter of restraints. Any nursing assistant that is unable to pass the test will be retrained and retested. If upon the second attempt the nursing assistant is unable to successfully pass the restraint test, the nursing assistant will be removed from the schedule until remediation is provided. As of 7/14/17, all nurses and nursing assistants have successfully passed the restraint testing. On 3/4/17, Nurse #1 assessed Resident #3 for signs of injury, related unsupervised exit. Nurse #1 immediately placed Resident #3 on 1:1 constant supervision (to prevent any further attempts to exit the facility), by a Nursing Assistant until resident #3 was placed in bed at approximately 8:30 pm. Nurse #1 determined Resident #3, while in bed, was no longer at risk of exiting the facility unsupervised during the shift related to the resident #3 inability to ambulate or rise from the bed without extensive assistants. The resident representative was notified at 7:35 pm on 03/04/2017 of the occurrence and the licensed nurse documented per the time stamp at 7:45pm. On 3/4/17, Nurse #1 notified Resident #3 physician of the resident exiting the facility by leaving a message due to no injury to the resident. Nurse #1	

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F 323	Continued From page 123 The assessment further indicated that the resident had not exhibited a wandering behavior during the assessment period. Resident #3's wandering risk evaluations were reviewed. The risk evaluation form indicated that a resident with a score of greater than 5 was at risk for wandering. The wandering risk evaluation form dated 10/7/17 revealed that Resident #3 was at risk for wandering with a score of 16. The form indicated that the resident has had one or more attempts to leave home/facility and or wander in the past 3 months. The form also indicated that the resident had made verbal statement of desire or intent to leave the facility. The wandering risk evaluation form dated 3/23/17 and 5/18/17 revealed that Resident #3 was at risk for wandering with a score of 19. The form indicated that the resident has had one or more attempts to leave home/facility and or wander in the past 3 months. The form also indicated that the resident had made verbal statement of desire or intent to leave the facility. Resident #3's care plan for wandering was reviewed. The wandering care plan was initiated on 8/9/16 and was reviewed on 3/28/17. One of the care plan problems was wandering and or at risk for unsupervised exits from facility related to: attempts to leave unit/had building. The goal was the resident will have no episode of unsupervised exits from facility through next review. The approaches included to "allow resident to wander on units, to check daily to ensure resident has an alarm bracelet on and it is functioning properly, documents episodes of wandering per facility	F 323	was drug tested and suspended per facility policy on 6/10/17 related to neglect. A 24 hour report was completed by the Administrator and faxed to the Health Care Personnel related to Neglect on 6/10/17. On 6/10/17, an investigation was initiated by the Regional Vice President, Corporate Clinical Directors, Administrator, and Director of Nursing related to resident #3 Neglect and exiting the facility. On 4/9/17, an unidentified staff person of which the DON does not remember, reported to the DON that Resident #3 had an unsupervised exit through the front door. The previous employee (DON unable to remember the employee) witnessed Resident #3 heading towards the facility□'s front door. The local Emergency Services was entering the facility and while coming through the front door, the resident exited out with the assistance of the EMT. The unidentified staff member immediately redirected Resident #3 back into the facility. The wander guard did enunciate, but the door was already open by the EMT□s thus allowing the resident to cross the threshold, but was immediately redirected by a staff member back into the facility upon identification. On 4/10/17, the DON spoke in person with Resident #3□s residents representative and requested the resident representative to attend a 4/11/17, 11am care plan meeting. The resident representative declined to attend the care plan meeting.	

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F 323	Continued From page 124 protocol, ensure identification (ID) bracelet is in place, ensure resident's picture and name are on the wandering resident board, ensure that alarm exits are functional, provide 1:1 staff monitoring as necessary, provide supervision during recreational programs, and provide resident with opportunities to attend group activities of choice". All of these care plan approaches were initiated/started on 8/9/16. There were no revisions to the approaches as of 6/9/17. The nurse's notes dated 3/4/17 at 7:45 PM revealed "alarm sounding at front door. Upon investigating, visitor said that he had let resident (Resident #3) out of door because resident asked him to. Upon going outside, this nurse noted (name of Resident#3) in his chair within a few feet of roadway. This nurse could not get resident return to building. He was yelling "I'm not going back in the building, I'm going home." This nurse continued to hold chair to prevent resident from entering roadway and turned on her cell phone and phoned facility. Advised staff of situation and 3 staff members came and assisted writer to get resident back into building." The notes indicated that the resident had no injuries from the incident. The nurse's notes dated 4/11/17 at 4:47 PM revealed "late entry for 4/10/17 at 5:30 PM, Director of Nursing (DON) and Social Worker (SW) spoke with wife to inform her that the resident had an unsupervised exit and that the team needed to meet with her and the family to discuss the move to sparks unit. She stated that we could go ahead and plan a meeting and she would make sure the family was present." The nurse's notes dated 4/14/17 at 1:59 PM	F 323	On 5/14/17, at approximately 4:00pm, the assigned hall Nurse #1 was at the nurse station and observed resident #3 at the front door. Nurse #1 overheard resident #3 stating let me out to a visitor. Nurse #1 yelled at the visitor not to let resident #1 out but the visitor held the front door open for resident #3 and resident #3 wheeled out of the facility. The alarm was sounding when resident #3 exited the facility. Nurse #1 immediately went outside to retrieve Resident #3 and observed resident #3 on the front porch. Nurse #1, CNA #1, and CNA #2 hear the alarm and came outside to assist Nurse #1 with brining resident #3 back into the facility. Resident #3 was combative with the staff when attempting to assist back in the facility. Resident #3 was brought back into the facility by Nurse #1, Nurse #2, CNA #1, and CNA, #2 approximately 10 minutes later related to resident being combative. On 5/14/17, upon returning resident #3 to the room, Nurse #1 assessed Resident #3 with no injuries observed. On 5/14/17, Nurse #1 notified the physician and Resident Representative (RR) of resident #3 exiting out of the facility. On 5/15/17, the social worker (SW) requested Resident #3s RR/family for a care plan meeting to be held 5/17/17 to discuss. The RR/family agreed, but did not attend the 5/17/17 care plan meeting. On 5/18/17, the Minimum Data Set (MDS) Nurse updated the care guide for resident #3, adding that Resident #3 is at risk for wandering, written in all capital letters for immediate recognition. On 5/18/17, Resident #3s RR stated to the Director of Nursing	

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F 323	Continued From page 125	F 323		

revealed resident "at front door yelling trying to get out. Redirected to lunch with good results. Returned to door, loudly yelling for his wife and son."

The nurse's notes dated 4/14/17 at 3:02 PM revealed that at 2:05 PM, Resident #3 was still wanting to leave the facility.

The nurse's notes dated 5/15/17 at 4:26 PM revealed that "DON was notified that resident was allowed to leave the building by a family member visiting another resident. The nurse asked the visitor not to let the resident out but they did it anyway. The resident made it out the door but not off the porch and supervised by the nurse the entire time."

The nurse's notes dated 5/16/17 at 4:40 PM revealed "resident propelling self-up and down halls in wheelchair yelling and screaming for someone to pay him and that he needs a ride home. Resident repeatedly asking visitors to let him out so he can find a ride home."

The nurse's notes dated 5/23/17 at 3:37 PM revealed "wife notified that the resident has been trying to exit building all day. The wife stated that she knows that he will not come back if he is allowed to exit facility."

The nurse's notes dated 5/24/17 at 1:53 PM revealed that the resident "attempts to leave facility to vacate the premises. Is cognitively impaired and cannot make good decision to protect himself from danger."

The nurse's notes dated 6/4/17 at 10:20 PM revealed "resident sitting in wheelchair propelling

(DON) that she would seek alternate placement due to RR/family decision to avoid secured dementia placement which is recommended by facility and the residents attending physician. On 6/7/17, the Social Worker (SW) followed-up with Resident #3□s RR/family about placement of Resident #3 to another facility.

On 6/7/17, the family made no decision regarding alternate facility placement for Resident #3 but continued to refuse for the resident to be moved to the secured unit. On 6/7/17, at approximately 2:00pm, the administrator directed the DON to place Resident #3 on 1:1 constant observation while the resident is out of bed. The residents RR agreed to move the resident to the designated locked dementia care unit on 06/14/2017 to prevent further elopement occurrences from the front door. The resident will remain on 1:1 supervision until he has adjusted to the room change and to provide for his psychosocial wellbeing.

Resident #3 last fall was 06/26/17. At that time, the resident was assessed by the Director of Nursing and new interventions after a medication review and adjustments made by physician. The residents care plan and care guide was updated on 07/08/17 to include the fall prevention interventions by the MDS nurse.

On 6/9/17, notification was sent to 100% of alert and oriented residents and 100% of resident representatives via the US Mail

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F 323	Continued From page 126 self about facility. Third shift reports that resident didn't sleep last night, he has been up all night wandering about facility in his wheelchair." The incident reports were reviewed. There was no incident report completed for the incidents that occurred on 3/4/17 and 4/10/17. The daily staffing sheets were reviewed. The staffing sheets revealed that there was one NA assigned on the hall where Resident #3 resided on 3/4/17 and 5/14/17 on the second shift. A family member of Resident #3 was interviewed on 6/5/17 at 4:15 PM. The family member indicated that the resident had exited the facility 4 times but the family member was unable to remember the exact dates. The family member stated that the facility indicated that a visitor, other resident and or the emergency medical services (EMS) had opened the front door for the resident to go out. Resident #3 was observed up in wheelchair in his room on 6/5/17 at 4:20 PM. A wander guard was observed attached to his wheelchair. Interview with the Social Worker (SW) was conducted on 6/6/17 at 11:55 AM. The SW stated that she had known Resident #3 as a wanderer and had wandered outside 2-3 times. She indicated that the family of the resident had refused to move him to the secured unit. She had scheduled a meeting with the family but they kept rescheduling or canceling the meeting. The SW claimed that most of his wandering incidents occurred during the weekends. Interview with NA #1 (assigned to Resident #3 on	F 323	regarding Do not assist any resident out of the facility, if you are unsure if the person is a resident please ask a staff member by the business office manager. The Monthly newsletter for June/July was revised by the Activity Director on 6/11/17 with an increased in font size (26 font) to stress the importance of before assisting a resident out of the building, you check with a staff member. Also, please be sure that doors close completely behind you upon your exit so a resident is not able to follow you outside. Also the order of the newsletter was revised to address this important message first. The newsletter will be mailed to all the alert and oriented residents and 100% of resident representatives by the Activities Director by 6/13/17. On 6/11/17, the MDS nurse #1, MDS nurse #2, Admission□s Coordinator, and treatment nurse completed 100% audit of all residents□ progress notes and behaviors sheets to include resident #3 for the past six months to identify residents with exit seeking behaviors to include wandering in and out of resident□s' rooms, wandering around the facility, and making comments about exiting the facility to ensure appropriate interventions were put into place for the prevention of actual elopement. Interventions will be put into place to include 1:1 constant supervision as necessary immediately during the audit by the Maintenance Director and/or the MDS nurse #1, MDS nurse #2, Admission□s Coordinator, and treatment nurse for any identified areas of concern. By 6/16/17 the	

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F 323	Continued From page 127 first shift) on 6/6/17 at 12:05 PM was conducted. NA #1 stated that Resident #3 was independent with locomotion using a wheelchair. She stated that the resident was always out of bed around 10 in the morning and he propelled his wheelchair around facility talking to other residents. NA #1 revealed that the resident was a wanderer and she heard that he had wandered outside during the second shift but she didn't know the date of the incident. NA #1 stated that she was the only NA on the hall. An interview with Nurse #1 was conducted on 6/6/17 at 2:10 PM. Nurse #1 stated that she worked second shift. She indicated that she heard and responded to a front door alarm twice (didn't remember the dates). She indicated that a family member had let Resident #3 out the door. Nurse #1 didn't remember the exact time but it was late in the evening. She found the resident on the road towards the highway (highway 177) in his wheelchair. The resident refused to come back. She had to use her cell phone to call the facility to get help because the resident would not return back to facility. The nurse stated that she didn't know how long the resident was outside and how long the alarm was sounding before she answered it. Nurse #1 further revealed that she had responded also to another front door alarm and found the resident on the porch. She stated that a family member had let the resident out. Nurse #1 stated that she didn't know how long the resident was outside on the porch. She also indicated that she didn't remember the dates and times of the incidents. Nurse #1 also stated that she didn't remember if she was assigned to the resident on the days Resident #3 was found outside.	F 323	Facility Consultants will complete 100% audit of all residents to include resident #3 progress notes and incident reports from 3/1/17 to present for residents with actual supervised and unsupervised exits to ensure any resident that had exited the facility was not neglected (the exit could not have been prevented by staff, the exit was appropriately handled and appropriate interventions were put into place) and that an investigation was completed to determine the root cause of the supervised or unsupervised exit. There were 2 identified unsupervised exits and appropriate interventions were put in place by DON. 100% of all residents Wandering Assessments were reviewed by the MDS nurses by 6/9/17 for accuracy. All inaccurate wandering risk assessments were revised on 6/9/17 by the MDS nurses. A second audit of the wandering assessments was completed on 6/11/17 and compared to the resident progress notes and behavior sheet for accuracy and revised on second time 6/11/17 by the MDS nurses. There was one wandering assessment was updated by the MDS nurse on 6/11/17. By 6/12/17, the MDS nurses updated the residents□ care plans, and care guides as appropriate for all residents identified as at risk for wandering and to ensure appropriate interventions were addressed on the resident care plan and resident care guide with oversight by the MDS Consultant. A total of twenty-six (26) residents were identified as at risk for wandering.	

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F 323	Continued From page 128 An interview with the Director of Nursing (DON) was conducted on 6/6/17 at 2:50 PM. The DON stated that Resident #3 had went out the door 4 times (didn't remember the exact dates). She indicated that she had asked the resident's family member to move him to the secured unit but the family member had refused. She reviewed the electronic nurse's notes and indicated that the resident had exited the front door on 3/4/17, 4/10/17 and 5/14/17. The DON indicated that out of the 3 wandering episodes, she had only one incident report dated 5/14/17. She indicated that there was no incident report for the wandering incidents on 3/4/17 and 4/10/17 and she didn't know how the resident had exited the front door. She stated that she posted a sign on the door reminding visitors not to let any resident out, but this didn't work. She also stated that the resident had a wander guard. Interview with NA #2 was conducted on 6/6/17 at 3:40 PM. NA #2 was assigned to Resident #3 on 3/4/17 and 4/10/17 on the second shift. NA #2 stated that she had known Resident #3 as a wanderer. She stated that the resident propelled his wheelchair around facility. She indicated that she observed the resident propelled his wheelchair to the front door all the time. She stated that she had heard him out of the facility twice but she had never witnessed him going out. NA #2 stated that on 3/4/17, she saw the resident last at the nurse's station but she could not remember the time. NA #2 revealed that she was the only NA on the hall that day. Interview with the Administrator was conducted on 6/6/17 at 4:46 PM. The Administrator stated that this was the time of the day that Resident #3's behavior was worst, trying to leave the	F 323	As of 06/15/2017, the MDS Nurse and the RN facility consultant notified the direct care staff (nurses, nursing assistants, activity staff, social worker, dietary administrator and DON) A staff member was placed at the front door 24 hours a day and 7 days a week to monitor prevent unsupervised exits from the facility. Beginning on 6/12/17 at approximately 12 noon. An in-service was initiated by the RN-nurse consultants with all staff to include licensed nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, bookkeeping, payroll, maintenance staff, receptionist, and supply clerk on 6/12/17 regarding the front door will have a person to monitor it 24 hours a day. The monitor will ensure that no resident exits the facility unsupervised. At no time will the monitor turn their back away from the front door. The front door monitor must be in eyes view at all times. The front door monitor cannot leave the monitoring station until there is relief. If the monitor is found in violation of appropriately monitoring the front door at any time, retraining and disciplinary action will be taken. There will be a notebook kept at the monitoring station to identify residents that are unable to exit the facility without supervision. The root cause analysis identified the visitor lack of safety awareness with the supervision of impaired wandering residents. Visitors and residents are limited to entering and exiting through the front door. As a precautionary measure all	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 323	Continued From page 129 facility. She stated that she had met with the family who gave her permission to move the resident to the secured unit if it was necessary but she felt that the resident was safe if only the staff were monitoring him and responding to the door alarm immediately. The Administrator further stated that there was a staff member (receptionist) in the lobby until 9 PM every day who could monitor the front door. The Administrator stated that she expected the staff to complete an incident report when an incident happened so the incident could be investigated. The administrator and the DON were notified of immediate jeopardy on 6/7/17 at 1:23 PM for Resident #3 and on 6/8/17 at 12:06 PM for Resident #80. b. Resident # 3 was admitted to the facility on 7/7/16 with multiple diagnoses including pelvic fracture. The quarterly Minimum Data Set (MDS) assessment dated 3/26/17 indicated that Resident #3 had moderate cognitive impairment and was independent with locomotion on and off unit. The assessment also indicated that the resident needed extensive assistance with transfer and was using a wheelchair for mobility. The assessment further indicated that the resident had falls since admission or prior assessment with no injury. Resident #3's care plan for falls was reviewed. The falls care plan was initiated on 8/9/16 and was reviewed on 3/28/17. The care plan problem was "risk for falls characterized by history of falls related to: weakness, back surgery." The goal was "resident will be free of falls through next	F 323	other exit door alarms are being audited daily since they remain secured to validate they remain secured. An in-service was initiated by the RN-nurse consultant on 6/12/17 and will be completed by 6/16/17 with 100% of all staff to include license nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, bookkeeping, payroll, maintenance staff, receptionist, and supply clerk by the Administrator in Training (AIT), Facility Consultants, RN Nurse, and Director of Nursing regarding elopement supervision is a critical component to a safe nursing home facility. It is every staff□ person's responsibility to ensure that nursing home residents do not enter into situations which may put themselves or others at risk of bodily harm. Residents who have full mobility but impaired mental function may be prime candidates for elopement, and thus need to be carefully monitored by nursing home staff. ELOPMENT PREVENTION: The single greatest factor which can prevent elopement is proper training and vigilance on the part of nursing home staff. Residents who suffer from mental issues that increase their likelihood of elopement need to be more closely watched. Also a resident may wander more a certain time of the day and need to be watched more closely at that particular time of the day. When elopement does take place, it is often a result of too little supervision. Exits which are not intended to be operated by	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 323	Continued From page 130	F 323		

review." The approached included "assist during transfer and mobility, bed in lowest position, encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, fall risk protocol, have commonly used articles within easy reach, keep assistive ambulation devise (wheelchair) within reach of the resident and keep call light within reach and answer timely." All of these approaches were initiated/started on 8/9/2016 and there were no revisions as of 6/9/17.

Resident #3's incident reports were reviewed. The resident had 10 falls in the last 6 months. The report dated 10/17/16 revealed that the resident was found on the floor on the side of his bed and wheelchair. The resident stated that he slid off the bed. Immediate action taken the resident was assessed with no injuries and was put back to bed and placed the call bell within reach and bed alarm was attached.

The report dated 11/11/16 at 2:17 PM revealed that the resident was found on the floor in his bathroom. There was no injury noted. The immediate action taken the resident assessed for injuries and none noted. The resident was lifted off floor and placed on commode.

The report dated 11/17/16 at 3:04 PM revealed that resident was observed on the floor in the bathroom in front of wheelchair. Immediate action taken the resident was assessed and no injuries notes and resident was placed back into wheelchair. Wheelchair alarm in wheelchair.

The report dated 12/7/116 at 9:01 PM revealed that the resident was found on floor in front of

nursing home residents should be either locked securely or equipped with alarms. In addition to keeping a close eye on residents, it is important for nursing home staff to make sure that the alarms on exits work correctly. It is also the responsibility of nursing home staff to respond promptly in the event that a door alarm goes off. Wandering can also trigger a series of injuries such as falls, bruises, and broken bones. Elopement could even be fatal in some cases, thus the importance of prevention. Facility staff needs to ensure that all cases of elopement or potential elopement are reported immediately to the nurse. CODE ORANGE/PREVENTION OF ELOPMENT: Provide diversional activities for residents with behaviors to include residents who attempt to exit the facility to prevent actual unsupervised exits. If a resident is constantly exit seeking and/or commenting on leaving the facility, diversional activities are to be provided such as snacks, activities of resident'□s interest, family involvement, past life experience activities and/or socially appropriate interactions in a group setting. The exit seeking behavior must be reported to the nurse immediately. It is the nurse'□s responsibility to assess the resident to find out the cause of the exit seeking behavior and ensure appropriate interventions are provided and document in the medical records. It is also the responsibility of ALL nursing home staff to respond promptly in the event that a door alarm goes off. If you observe a resident exiting the facility but cannot respond in a

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F 323	Continued From page 131 chair with small skin tear to front of head. Immediate action taken was to "clean area on forehead and apply dry dressing and did neuro check." The report dated 12/19/16 at 10:07 PM revealed that resident was found lying on the floor in front of wheelchair. Resident stated that he slid out the wheelchair. Immediate action taken resident was assessed with no injuries noted. The report dated 1/4/17 at 8:16 PM revealed that the resident was found on the floor beside the bed and the wheelchair. Immediate action taken the resident was assessed with no injuries noted. The report dated 2/7/17 at 1:17 AM revealed that resident was found on the floor beside the bed and in front of the wheelchair. The resident stated the he slid out of the wheelchair. Immediate action taken was resident was assessment with no injuries and the resident was put back to bed. The report dated 4/23/17 at 10:27 PM revealed that at approximately 10:20 PM, the alarm sounded and the resident was found sitting on the floor. The resident stated that he slid off the bed. Immediate action taken the resident was assessed and no injuries noted. The report dated 4/29/17 at 8:06 PM revealed the resident was found on floor between his wheelchair and stationary chair. Immediate action taken the resident was assessed and no injuries noted. The report dated 5/30/17 at 8:00 PM revealed that the resident was found on the floor in front of his wheelchair.	F 323	timely manner then a code orange must be called. A code orange is an emergency situation that indicates missing resident/resident elopement and summons medical aides as indicated by using a room number or location. Again, a code orange is used to alert staff and/or summons help. The unsupervised exit must be reported to the nurse immediately. An in-service was initiated with 100% of license nurses on 6/12/17 and will be completed by 6/16/17 by the Facility Consultants, RN Nurse, and Director of Nursing regarding NURSES RESPONSIBILITIES FOR SUPERVISED OR UNSUPERVISED EXITS. Questionnaires were initiated on 6/12/17 and will be completed by 6/16/17 with 100% of all staff by the Administrator in Training (AIT), Facility Consultants, RN Nurse, and Director of Nursing for validation of understating regarding elopement to include 1. What is Elopement? 2. If a resident feet crosses over the threshold what is that called? 3. If a resident is trying to exit the facility or constantly commenting on leaving the facility, what are some things that you can do? 4. What code is utilize to alert staff and summons help for a missing resident/elopement. 5. How often should there be a monitor at the front door? 6. When should you report to the nurse that a resident has exit seeking behavior, commenting on leaving the facility, or actually exited the facility?	

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F 323	Continued From page 132 Resident #3 was observed up in wheelchair in his room on 6/5/17 at 4:20 PM. A wander guard was observed attached to his wheelchair and a family member was in the room with him. Interview with the MDS Nurse #1 was conducted on 6/6/17 at 3:40 PM. The MDS Nurse stated that she started as MDS Nurse in March 2017. She stated that she had no MDS experience in the past and she had received MDS training from the corporate consultant and not from the state MDS training. The MDS Nurse indicated that they discussed the incident reports on their morning meeting. She stated that she was aware of Resident #3's repeated falls. The MDS Nurse had reviewed the resident's electronic care plan for falls and stated that there were no revisions on the care plan approaches since 8/2016. Interview with the Quality Assurance (QA) Nurse was conducted on 6/8/17 at 2:40 PM. The QA Nurse indicated that she started as QA Nurse in March 2017. She stated that she had no guidance or training regarding QA but she was learning. She added that she had no monitoring tool to monitor the resident's falls. She also indicated that they (department heads) reviewed the incident reports on their morning meeting but she didn't remember what happened after that. Interview with the Administrator was conducted on 6/8/17 at 3:05 PM. The Administrator stated that the QA Nurse and the DON were responsible for the incident/accident reports.	F 323	A 100% of the licensed nurses, nursing assistants and non-licensed staff will have their questionnaires reviewed by the RN-nurse consultant. The subject matter that is reviewed on the questionnaire will be reviewed by the RN-nurse consultant. Any identified licensed nurses, nursing assistants and non-licensed staff member that are unable to pass the test will be retrained and retested. If upon the second attempt the licensed nurses, nursing assistants and non-licensed staff member is unable to successfully pass the significant change test will be removed from the schedule until remediation is provided. A 100% of the Nursing Assistants and non-nursing staff will be in serviced by the RN Facility Consultant by 06/16/2017 on Observing and Reporting Change□s in Residents Condition. The nursing assistants and non-nursing staff will be tested on their knowledge of the subject matter of observing and reporting changes in resident'□s condition. Any nursing assistant or non-licensed staff that is unable to pass the test will be retrained and retested. If upon the second attempt the nursing assistant or non-licensed staff is unable to successfully pass the significant change test will be removed from the schedule until remediation is provide. On 6/7/17, the regional vice president completed a 100% re-training for all department Managers (administrator, DON, QI nurse, MDS nurses, treatment	

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F 323	Continued From page 133	F 323	nurse, SW, maintenance director, medical records, accounts payable, accounts receivable, admissions director, activity director, dietary manager, environmental services director, and therapy manager) regarding the Action Check list for unsupervised exits. Beginning on 6/7/17, for all unsupervised exits, the facility will complete the Action Checklist for Unsupervised Exit for Nursing Staff to ensure supervising the resident at risk of exiting the building and also what to do when the alarm sounds to make sure a thorough search is done, to make sure the staff find the resident if they exited the door. An in-service was initiated with all license nurses on 6/13/17 by the Facility Consultants and will be completed by 6/16/17 regarding the Action Checklist for Unsupervised Exit for Nursing Staff to ensure license nurses are aware of responsibilities during an unsupervised exit. On 6/13/17, the unsupervised exit checklist for licenses nurses was posted at the nurse□ station by the Facility Consultant as a guide and quick reference for nurses when a resident exits the facility. On May 1, 2017, at approximately 4:40 am, Nurse # 1 entered Resident #80 room and observed Resident #80 facing the foot board of the bed with Resident #80 head wedged between the foot board and the mattress. Resident #80 was trying to get up per the hall nurse. Nurse #1, a Med Aide, and a Nursing Assistant helped to remove resident #80 head from being	

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F 323	Continued From page 134	F 323	wedged between the foot board and mattress by lifting Resident #80 body and pulling the mattress out from under the resident to make room to slide Resident #80 head out from the foot board. Resident # 80 was assessed by the hall nurse with observation of a bruise to the back of the neck, resident #80 denied pain and discomfort. Vital signs were obtained for resident #80 on 5/1/17 by the hall nurse with a blood pressure of 126/68, pulse of 72, respirations of 18 and temperature of 98.2. No changes were noted during the assessment by the hall nurse in resident #80 level of consciousness, Pupils Equal Round and Reactive to light and Accommodation, able to move all extremities within baseline. The Medical Director was notified by phone and message left on 5/1/17 at 4:50am by the hall nurse, Resident Representative (RR) was notified by phone and informed of incident by the hall nurse on 5/1/17 at 4:50am. A Full Body audit was completed on resident #80 on 5/16/17, 5/24/17, 5/30/17, and 6/12/17 by the Treatment Nurse with no negative finding of injuries related to entrapment. The Director of Nursing (DON) notified the Medical Director on 6/9/17 concerning the incident of resident #80 head being wedged between the mattress and the foot board. Resident #80 received a new bed with a properly fitting mattress on 6/9/17 per Hospice. Resident #80 was re-assessed by the DON on 6/12/17 with no bruises or other injuries noted to neck. .	

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F 323	Continued From page 135	F 323	Beginning on 6/10/17, the Registered Nurse Facility Consultants and Regional Vice President began to provide daily oversight to the facility to ensure that the facility used its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident and reviewed systems to include monitoring restraints and entrapment to ensure policies and procedures were being followed. On 6/13/17, the Regional Vice President reviewed the policy for restraints per the Nursing Policy Manual with the Administrator, Director of Nursing, and Quality Improvement Nurse (QI Nurse) to include it is the policy of the facility that in order to prevent possible injury or entrapment, the facility will provide an organized and systemic method for body positioning and bed measurements per FDA guidelines for hospital beds for the residents. By 6/16/17, the Regional Vice President reviewed the Quality Improvement System for restraints per the Quality Improvement Manual with the Administrator, Director of Nursing and QI nurse to include the purpose in monitoring residents with high potential for entrapment, to ensure that physical restraints are used only as prescribed by the Nursing Policy, that the resident has a medical symptom which may require the use of a physical restraint for safety, that the physical restraints are applied only with a physician'□s order (except in cases of emergency), and that physical	

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F 323	Continued From page 136	F 323		

restraints are reviewed on a monthly basis. The Administrator, Director of Nursing and Quality Improvement Nurse are to ensure systems are initiated, functional and maintained to include compliance with equipment checks, assessments of residents that are high risk for entrapment and documentation, initiation and updates to the resident care plans, and to ensure that high risk for entrapment residents are reviewed on a regular basis through the care plan process. The DON, Administrator and QI nurse will review the incident report form and ensure there is proper investigation and follow up to include have appropriate interventions been initiated, was required documentation completed in the medical records, was it necessary to revise the care plan, review of the chart, review of the resident, collect witness statements from employees, residents, or family, education and documentation, and other related investigation documentation such as copies of nursing or social progress notes, care plan revisions, referrals, or maintenance work orders.

100% of all residents beds, to include: resident #80 was audited by the maintenance assistants on 6/13/17 to ensure that there were no identified risks for entrapment zones, to include, entrapment between head or foot board and the mattress end, entrapment within the rail, entrapment under the rail, between the rail supports or next to a single support, entrapment between the rail and the mattress, entrapment under

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F 323	Continued From page 137	F 323		

the rail, at the end of the rail, entrapment between the splint bed rails, and entrapment between the end of the rail and the side edge of the head or foot board. There were 2 mattress that the mattress flaps were adjusted to correct distance between headboard and mattress by the maintenance assistances on 6/13/17.
100% of all resident were observed for body positioning in bed by the Facility Consultant on 6/13/17, for any potential risk for entrapment. There were no identified negative findings for body positioning in bed during the audit.

100% of all residents, to include resident #80, nurse progress notes and risk management reports from 3/1/17 to present were reviewed by the corporate consultant for bruises and/or entrapment incidents. The review was completed by 6/16/17, to ensure all identified residents with bruises and/or entrapment incidents were assessed and provided appropriate interventions and the physician and resident representative were notified via phone, with voice to voice conversation, no message left for the physician, and appropriate documentation is in the medical records. By 6/16/17, all identified areas of concern will be addressed by the corporate consultant or DON with the resident representative and attending physician. The notifications will be documented in the electronic medical record.

A laminated bright colored sign was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 138	F 323		

posted by the corporate consultant at each nurse station on 6/13/17, as a visual guideline for responsibility of the nurse, for voice to voice notification to the physician for incidents, to include entrapment and changes in resident condition.

On 6/13/17, an in-service was initiated with all license nurses by the Facility Consultants and RN Nurse regarding Completion of resident Incident/Event Reporting Form which is to occur when an event or incident arises that is not consistent with the expected care and treatment of a resident to include entrapment or that may cause loss, damage, or violation of a residents right. The nurse is to initiate the QI reporting form, the nurse is to notify the Administrator and/or Director of Nursing for any event/incident requiring medical attention; injury of unknown origin, allegation of abuse, neglect, or misappropriation of property and entrapment is to occur.

An in service was initiated by the Facility Consultant on 6/12/17, to be completed by 6/16/17, for 100% of all staff on Entrapment Bed entrapment-an occurrence involving a resident who is caught, trapped, or entangled in the bed system, which includes the spaces in or around the bed rail, bed mattress, or bed frame, to include the foot board. Entrapped body parts associated with risk for severe injury include the head, neck, and chest. Who is at risk for entrapment?

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(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 323	Continued From page 139	F 323	Residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of: timely toileting, position change, and frequent individualized care are factors that may also contribute to the risk of entrapment. The risk may also increase due to technical issues to include, improperly sized mattresses or broken equipment. These technical issues must be reported to the nurse and maintenance director immediately and work order must be completed per policy. Interventions/What to do to ensure that the mattress fits the bed if unsure notify the Maintenance Director and nurse immediately to assess the mattress. If a resident is noted to have a body part, to include the head/neck, entrapped in any part of the bed system, to include the foot board, immediately call for assistance and ease the entangled body part out of area. Assess the resident for injuries, CALL and speak with the attending physician, or the on-call physician, to notify of what occurred and your assessment. Initiate any orders if given. Call the Residents Representative (RR) and notify them of what occurred and that the attending physician was notified and any orders or recommendation that was given. Document ALL in the residents chart. Make sure that an incident report is completed along with witness statements from all staff involved. Administrator/DON	

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F 323	Continued From page 140	F 323	need to be notified. Prevention□: If a resident'□s body position is unsafe in the bed at any time due to space between the mattress and bed or any other reason, the nurse must be notified immediately. The nurse must find out the root cause (the cause of the change) of why the resident is in that position and provide appropriate interventions to ensure the resident safety, such as therapy referral, taking the resident to the bathroom, maintenance work slips, wedges, new bed and/or new mattress, transfer out of the bed per resident'□s choice. Take the bed out of service if broken or unrepairable. Questionnaires were initiated on 6/12/17 and will be completed by 6/16/17 with 100% of all staff to include license nurses, nursing assistants, housekeeping staff, therapy staff, dietary staff, activity staff, geriatric care aides, social worker, book keeping, pay roll, maintenance staff, receptionist, and supply clerk by the Administrator in Training (AIT), Facility Consultants, RN Nurse, and Director of Nursing for validation of understating regarding entrapment to include 1. What do you do if you find broken or faulty equipment? 2. What is entrapment? 3. Can a bed cause entrapment? 4. What do you do if you suspect or observe entrapment? 5. Who is at risk for entrapment? 6. What are some things that can contribute to entrapment? 7. If entrapment occurs, what can you do to ensure the resident'□s safety? 8. Who needs to be notified immediately if a resident is unsafe in bed due to space	

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F 323	Continued From page 141	F 323	between that mattress and bed? In-servicing of 100% of all licensed nurses was initiated on 6/12/17 by the DON and completed by 6/16/17 regarding: Notification of Physician for Changes in Resident'□s Condition. Notify Physician (speak with the physician) by telephone: Acute Change in Resident Condition occur, Changes in Cognitive Status occur, Changes in Behavior occur, Changes in Oral Intake to include fluids occur, Changes in Immune System occur, Changes in Normal Body Functioning occur, PANIC laboratory values occur, Resident'□s Condition Warrants based upon nurse□s assessments. Incidents to include, bruises of unknown origin, entrapment, elopement, and initiation of restraints. If you are unable to reach Attending Physician, you may call the On-call for physician. If you are unable to reach attending or on-call physician, you may call the facility'□s Medical Director. Notification of the physician of these types of changes in a resident'□s condition by fax or leaving a message is not acceptable! Documentation of the notification of the attending physician will be documented in the residents chart. No license nurse will be allowed to work until receiving the in-service on Notification of Physician for Changes in Resident'□s Condition and Documentation of the notification of the attending physician will be documented in the residents chart. If unable to reach, voice to voice, the attending physician, the on-call or the medical director, the DON MUST be	

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F 323	Continued From page 142	F 323	notified for further intervention. The licensed nurse is responsible to assess, document, provide appropriate interventions and notify Attending Physician and Resident Representative of any acute changes in condition, to include bruises of unknown origin, entrapment, and/or any other significant clinical information, noted. If the licensed nurse is unable to reach the attending physician, the on-call Medical Director must be called. If unable to contact the attending or the on-call Medical Director, the nurse must call the Medical Director. If unable to reach, voice to voice, the attending physician, the on-call or the medical director, the DON MUST be notified. The licensed nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and RR. On 6/10/17, the regional vice president, corporate clinical director, and corporate consultants, began providing oversight to the facility and monitoring to ensure the facility has systems in place to 1) provide an environment as free from accident hazards as is possible, including bed entrapment, 2) provide adequate resident supervision and assistance to prevent accidents, including unsupervised exits and repeated falls. On 6/23/17, DON, QI nurse, staff facilitator, hall nurse, MDS nurse, social worker, and/or corporate consultant began auditing nurses progress notes and risk management reports in the	

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F 323	Continued From page 143	F 323	electronic medical record for injuries of unknown origin, fall, entrapment and elopement. These audits revealed two elopements by resident #3 that have been investigated, reported and revised intervention implemented by the Administrator, DON, RVP, licensed nurses, nursing assistants. The audit is to ensure all interventions are in place to prevent cognitively impaired, wandering residents from unsupervised exit/elopement, to protect residents who fall, and bed entrapment. Any concerns are immediately addressed by the auditor to include reporting to the administrator and/or DON. Beginning on 6/26/17, the audit is documented on the Accident Hazards/Supervision Audit Tool, which covers: 1) if the progress notes were reviewed for incidents/accidents, 2) if the risk management/incident reports were reviewed for appropriate interventions, 3) if the 24 hour reports were reviewed in the daily clinical meeting, 4) if the maintenance work orders were completed by the maintenance assistant, 5) if preventative maintenance logs are complete. The audit tool will be completed weekly x 3 months, then monthly x 3 months. The maintenance director will complete a monthly preventative maintenance checklist and safety audit checklist to audit the beds for entrapment hazards, wheel chairs, Geri chairs and other medical equipment for deficit or non-working issues. All identified areas of safety or non-working equipment will be	

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F 323	Continued From page 144	F 323	removed from service until repaired or replaced. On 6/26/17, the administrator, regional vice president, and/or corporate clinical director will begin a weekly review of the completed Accident Hazards/Supervision Audit Tool to ensure the systems for a safe environment, proper application of devices, and supervision for resident safety remain in place and are functioning properly. The review will be completed, as indicated by initialing the audit tool, for four weeks to ensure adequate supervision and oversight. The QI nurse and/or the maintenance assistant will present the findings of the Accident Hazards/Supervision Audit Tool, preventative maintenance, and safety audit tool at the monthly Quality Improvement Committee meeting. The Quality Improvement Committee will review the results of the audits monthly x 6 months, identify trends, use 5 Whys root cause analysis, and make recommendation for follow-up as needed. The QI nurse and/or maintenance will present the findings of the Care Planning Participation and Revision Audit Tool at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility'□s follow-up to the recommendations. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight.	

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F 323	Continued From page 145	F 323	The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of Free of Accident Hazards/Supervision/Devices.	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329		7/25/17

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F 329	Continued From page 146 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, Nurse Practitioner interview, pharmacist interivew, physician interview and record review the facility failed to administer a diuretic medication as prescribed and to obtain weights for the purpose of diuretic dose titration for 1 of 6 residents (Resident #135), failed to administer antidepressants as ordered for 1 of 6 residents (Resident #74) and to complete the Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 6 Residents (Resident #76), and failed to obtain a blood pressure as ordered for medication monitoring for 1 of 6 residents reviewed for unnecessary medications (Resident #91). The findings included: Resident #135 was admitted on 4/3/17 and readmitted on 4/13/17 with diagnoses including chronic kidney disease, pneumonia, atrial fibrillation and heart failure. Review of the Physician ' s Orders dated 4/13/17 revealed an order for Lasix/Furosemide (a medication that increases the amount of fluid excreted from the body) 20 mg (milligrams) by mouth daily. The administration time of day indicated with the order was 8:00 AM.	F 329	F 329 Free from Unnecessary drugs On 5/13/17, Resident #135 was discharged from the facility. On 5/17/17, the director of nursing (DON) obtained a clarification order for Resident #74□s Cymbalta. The clarification order was to discontinue previous Cymbalta orders and to decrease Cymbalta to 60mg daily. On 6/7/17, the DON completed a Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment for Resident #76. The results of the DISCUS assessment indicated Resident #76 has no involuntary movements for a person on antipsychotic medication. Resident #76 has had no changes in the antipsychotic medication Risperdal 2mg since 4/20/17. On 6/7/17, 6/13/17, 7/5/17, and 7/6/17, the nurse and/or the nursing assistant obtained Resident #91□s blood pressure reading. On 6/13/17, the nurse	

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F 329	Continued From page 147 Review of the Medication Administration Record (MAR) from 4/13/17 through 4/24/17 revealed Lasix 20 mg was signed off as given from the 15th through the 24th. The reason why the medication was not signed off as given on the 14 was not determined. A 4/24/17 order written by the Nurse Practitioner revealed "daily weights x (times) 1 week then q (every) 3 days & (and) titrate Lasix accordingly". Further review of the Physician ' s Orders from 4/24/17 through 4/30/17 revealed that an original order to clarify the titration dose was not present. Review of the MAR from 4/24/17 through 4/30/17 revealed a hand written entry for daily weights for 7 days starting on 4/25/17. There was one weight of 203 pounds written in the allotted space on 4/25/7 but there were no other weights listed for 4/26/17 through 4/30/17. Further review of the Medical Record revealed no additional weights documented for this time period. Lasix 20 mg per day at 8:00 AM remained on the MAR for 4/24/17 - 4/30/17 and was signed off as given daily during this time. Review of the MAR did not reveal a dosage titrated based on the resident ' s weight. Further review of the Physician ' s Orders from 4/30/17 through the resident ' s discharge on 5/13/17 revealed that an original order to clarify the titration dosage was not present. Review of the Physician ' s Orders summary from 5/1/17 through 5/31/17 revealed the following typewritten order "Lasix 20 mg Furosemide Tab (tablet) 20 mg 1 by mouth daily for wt (weight) gain of more than 2 lbs (pounds) in a day; or more than 5 lbs in a week, double dose for 2	F 329	practitioner assessed Resident #91, no new physician orders. On 6/29/17, the corporate clinical director completed a psychiatric consult audit which revealed psychiatric consults had not been completed. On 6/29/17, the DON developed a list of residents for a psychiatric consult upon the provider'□s next visit on 7/12/17. On 6/30/17, the director of nursing (DON), minimum data set (MDS) nurses, and corporate consultants completed a 100% audit of physician orders to ensure physician orders for weights are noted correctly on the medication administration record (MAR), to ensure physician orders for blood pressures are noted correctly on the MAR, the weights and blood pressures are being taken, and DISCUS were completed according to DISCUS assessment policy. The audit revealed weights and blood pressures were not taken as ordered by the physician and DISCUS assessments were not completed according to DISCUS assessment policy for several residents. As of 6/30/17, the DON and quality improvement (QI) nurse determined there were no residents who have medication dosage adjusted based on the resident□'s weight. Beginning 6/29/17, the corporate facility consultant in-serviced the DON, registered nurses (RNs), and licensed practical nurses (LPNs) on: 1) antipsychotic drug therapy/DISCUS	

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F 329	Continued From page 148 days". Review of the May 207 MAR revealed the following was signed off as given daily at 8:00 AM from 5/1/17 through 5/12/17: "Lasix 20 mg Furosemide Tab 20 mg 1 by mouth daily for wt gain of more than 2 lbs in a day; or more than 5 lbs in a week, double dose for 2 days". Further review of the MAR for May 2017 revealed a hand written entry for daily weights for 7 days. Weights for the resident were documented in the allotted space for 5/2/17 through 5/8/17. There were no weights after 5/8/17. The weights in pounds showed a weight gain of 2 pounds on 5/4/17. No other weight gain of two pounds or more was documented. The weights were recorded as follows: 5/2 - 200 5/3 - 198 5/4 - 200 5/5 - 199 5/6 - 199 5/7 - 200 5/8 - 200 On 6/8/17 at 3:15 PM the Director of Nursing (DON) was interviewed and reviewed the above noted orders and MAR documentation. She stated that the original order for titration of the Lasix should have been clarified for specific dosage instructions. She acknowledged that the order appeared to have been clarified at some point before 5/1/17 because specific dosage instructions were in the order summary and MAR at this time. She did not know why that clarification order could not be located in the	F 329	(Dyskinesia Identification System Condensed User Scale) assessment, 2) physician orders requiring appointments, 3) pneumococcal vaccination. On 6/30/17, the DON, corporate clinical director, and regional vice president (RVP) met with the clinical director of pharmacy services to review the outcome of the pharmacy consultants 6/29/17-6/30/17 audit findings, discuss recommendations, and identify a root cause. It was determined communication is a root cause of several issues related to drug regimen being free from unnecessary drugs. On 6/30/17, the corporate clinical director worked with the DON, quality improvement (QI) nurse, and minimum data set (MDS) nurses to perform a root cause analysis (RCA) of why the physician orders were not clarified, why weights were not recorded on the MAR, and why medication was not administered as ordered. The RCS determined communication was the root cause of the problem. On 6/30/17, the DON re-established the weekly weight meeting to ensure weights are being obtained as ordered by the physician and documented in the electronic health record. On 7/13/14 the weekly weight committee reviewed resident weights and determined several residents no longer met the criteria for weekly weights and identified those resident requiring continued weekly weights. As of 7/17/17, residents with a	

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F 329	Continued From page 149 medical record. However she indicated that the way the order was written in the MAR was like a "whole protocol" used in the hospital. She indicated the 2 pound weight gain administration versus any 5 pound weight gain should have had separate rows for documenting administration if given. She acknowledged it was confusing looking and in addition appeared that the medication had been given without weights and/ or without weight gain. The DON also acknowledged that there was no discontinuation order for the Lasix 20 mg daily order written 4/13/17, although it was no longer on the MAR after 4/30/17. She indicated that although the resident received the Lasix that was for weight gain, even when she did not have weight gain, the outcome was a continued dose as if she was on the Lasix 20mg for her entire stay and therefore there was no negative outcome for the resident. On 6/8/17 at 4:28 PM a telephone interview was conducted with the Nurse Practitioner. She recalled Resident #135 and recalled writing a clarification for the 4/24/17 Lasix titration order. She revealed she based the titration specifying weights and dosage on what the resident had been receiving in the hospital. The NP thought that the original scheduled order for Lasix 20 mg would have been ongoing and that the additional Lasix would only be given for weight gain. Since the resident ' s weight remained stable she did not feel the resident had a negative outcome however she acknowledged daily weights should have been done to comply with an order based on daily weight. On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she	F 329	physician order for weekly weights are being weighed weekly as ordered by the physician. On 7/17/17 through 7/21/17, the DON, pharmacy consultant, MDS nurses, admissions nurse, and quality improvement nurse will complete a DISCUS audit to ensure all resident DISCUS are updated according to the DISCUS assessment policy. Any resident requiring an updated DISCUS assessment will be assessed by the DON, MDS nurse, admissions nurse, or quality improvement nurse no later than 7/21/17 and the physician notified of any changes in a resident□'s DISCUS assessment. On 7/14/17, the DON, QI nurse, and corporate consultants initiated an in-service for all nurses and medications aides. The in-service is a communication focused in-service, interactive using the MARs and pharmacy recommendations, to further educate and explain the importance of documenting weights, documenting blood pressures, and performing DISCUS assessments in an effort to maintain drug regimens free from unnecessary drugs. By 7/25/17, the DON, QI nurse, and/or corporate consultants will present this in-service to all facility and agency nurses and medication aides, including all newly hired nurses and medication aides. After 7/25/17, no nurse or medication aide will be allowed to work until completing the in-service. The DON and/or QI nurse will use the Unnecessary Drugs Audit tool to complete a 100% review of pink slips in the clinical	

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F 329	Continued From page 150 had worked on first shift (7:00 AM - 3:00 PM) on Resident #135 ' s hall and did recall the resident. She acknowledged she would have given the resident her morning Lasix but she could not recall the dates. She stated she did not recall giving any medication that was supposed to be based on weights. When the 4/24/17 order to titrate Lasix based on weights Nurse #6 indicated that an order like that would require clarification because were not able to decide on dosage without specifications. When the following was read to her: "Lasix 20 mg Furosemide Tab 20 mg 1 by mouth daily for wt gain of more than 2 lbs in a day; or more than 5 lbs in a week, double dose for 2 days" she indicated that she thought it was poorly written and still required clarification. She stated she did not know why she had not noticed but said the resident ' s weights should have been done every morning before determining if the medication should be given. When she was informed that the weights that were completed were listed on a separate page of the MAR than the Lasix was on she said having the weights under the Lasix would draw more attention to it and work better. Lastly she acknowledged that there should have been a clarification regarding whether the original daily scheduled Lasix was supposed to be discontinued. 2. Resident #74 was admitted to the facility on 5/10/16 with multiple diagnoses including major depressive disorder. The plan of care for Resident #74 included the focus area of psychotropic medications. This focus area was initiated on Resident #74's care plan on 5/11/16.	F 329	meetings 5 times weekly on an ongoing basis. Also, the DON and/or QI nurse will audit for any missing weights that should be recorded on the MAR at the weekly weight meeting for 8 weeks then every-other-week for 4 weeks to ensure residents are not given unnecessary drugs. The DON and/or QI nurse will complete the pharmacy recommendations and DISCUS assessment audits monthly on an ongoing basis to ensure residents have drug regimens free from unnecessary drugs. The results of the audits will be presented by the DON and/or QI nurse at the monthly QI Committee meeting x 3 months for further review and recommendations. The results of the audits will be presented by the DON and/or QI nurse at the quarterly quality assessment and assurance (QAA) Committee meeting for 1 quarter for review of trends, root cause analysis, and any additional recommendations to sustain compliance in the area of maintaining a drug regimen free of unnecessary drugs.	

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 151	F 329		

A physician's order dated 2/28/17 indicated Cymbalta (antidepressant medication) 30 milligrams (mg) once daily at night for Resident #74.

A physician's order dated 3/28/17 indicated Cymbalta 60mg once daily in the morning for Resident #74.

The April 2017 physician's orders for Resident #74 indicated Cymbalta 60mg once daily in the morning and 30mg once daily at night.

The annual Minimum Data Set (MDS) assessment dated 4/24/17 indicated Resident #74's cognition was intact. Resident #74 received antidepressant medication during the MDS review period.

A review of the April 2017 Medication Administration Record (MAR) for Resident #74 indicated he received Cymbalta 60mg once daily in the morning and Cymbalta 30mg once daily at night and as ordered by the physician.

A review of the May 2017 MAR for Resident #74 indicated he received Cymbalta 60mg once daily in the morning as ordered by the physician. This MAR revealed Resident #74 had also received Cymbalta 60mg once daily in the evening on 13 administrations rather than the 30mg that was ordered.

A physician's order dated 5/17/17 indicated a decrease in Cymbalta to 60mg once daily for Resident #74.

An interview was conducted with the Director of Nursing (DON) on 6/8/17 at 2:35 PM. The

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 152	F 329		

physician's orders for Cymbalta that coincided with the May 2017 MAR for Resident #74 were reviewed with the DON. She revealed there was a handwritten transcription error on the May 2017 MAR for the night time dose of Cymbalta for Resident #74. She stated Resident #74 should have received 30mg once daily at night (rather than 60mg once daily at night) along with the 60 mg once daily the morning until the 5/17/17 physician's order that decreased the Cymbalta to 60mg once daily. She stated she was unable to determine who had made the transcription error. The DON revealed she was working on the floor one evening in May and she identified the error when she reviewed Resident #74's MAR. She reported she had contacted the physician and obtained a clarification order on 5/17/17. The DON confirmed Resident #74 had received a greater dose of Cymbalta than he was ordered on 13 administrations. She indicated it was her expectation for medications to be administered as ordered.

A phone interview was conducted with Resident #74's physician on 6/8/17 at 2:56 PM. The physician's orders for Cymbalta that coincided with the May 2017 MAR for Resident #74 were reviewed with the physician. The 13 administrations of Cymbalta in which a greater dose was given than was ordered for Resident #74 was reviewed with the physician. He reported he believed he was informed of this error, but he was unable to recall when he was informed. He indicated it was his expectation for medications to be administered as ordered.

3. Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included

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 _____	C 06/09/2017

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

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F 329	Continued From page 153	F 329		

major depressive disorder, single episode, severe with psychotic features and dementia with behavioral disturbance.

A physician's order dated 8/10/16 indicated Risperdal (antipsychotic medication) 3 milligrams (mg) once daily at night for Resident #76.

An Abnormal Involuntary Movement Scale assessment (AIMS - an assessment utilized to monitor involuntary movements for persons on antipsychotic medication) was completed on 8/11/16 for Resident #76 with a score of 0 (no involuntary movements identified).

The admission Minimum Data Set (MDS) assessment dated 8/17/16 indicated Resident #76 had moderate cognitive impairment. He was assessed as PASRR level II for Serious Mental Illness (SMI). Resident #76 received antipsychotic medication during the MDS review period.

An MDS Care Area Assessment (CAA) related to psychotropic medications for the 8/16/16 MDS indicated he received antipsychotic medication daily.

A physician's order dated 4/6/17 indicated a decrease in Risperdal to 2.5mg (from 3mg) once daily at night for Resident #76.

A physician's order dated 4/20/17 indicated a decrease in Risperdal to 2mg (from 2.5 mg) once daily at night for Resident #76.

The quarterly MDS assessment dated 5/4/17 indicated Resident #76's cognition was intact. Resident #76 received antipsychotic medication

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 154	F 329		

during the MDS review period.

The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care, most recently reviewed on 5/5/17, which indicated the focus area of psychotropic drugs.
A review of the medical record on 6/6/17 revealed an AIMS assessment had not been conducted for Resident #76 since 8/11/16.

An observation was conducted of Resident #76 on 6/5/17 at 12:25 PM with no involuntary movements noted.

An interview was conducted with the Director of Nursing (DON) on 6/7/17 at 8:58 AM. She indicated her expectation was for an AIMS assessment to be conducted for all residents on antipsychotic medications upon admission, quarterly, and with any dosage change of the antipsychotic medication. She stated the Admissions Nurse was responsible for completing the AIMS assessment on admission, the charge nurse was responsible for completing the AIMS assessment quarterly, and if a physician's order changed the dosage of an antipsychotic medication the nurse who completed that order was responsible for completing the AIMS assessment. The DON revealed she was aware the facility had a problem with the timely completion of AIMS assessments. She indicated she had been aware of this problem since February 2017. The DON reported she had a meeting with the pharmacist in February 2017 and this was one of the areas that was discussed. She revealed the timeliness of AIMS assessments had not improved since the February 2017 meeting.

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 _____	C 06/09/2017

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

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F 329	Continued From page 155	F 329		

The interview with the DON continued on 6/7/17 at 9:03 AM. The AIMS assessment dated 8/11/16 for Resident #76 was reviewed with the DON. The medical record which contained no additional AIMS assessments completed after 8/11/16 for Resident #76 was reviewed with the DON. She stated this was not a surprise to her. She indicated Resident #76 should have had an AIMS assessment completed since 8/11/16. She revealed the pharmacist had requested an AIMS assessment for Resident #76 following his February 2017 pharmacy review. She verified this pharmacy request had not been completed.

A phone interview was conducted with the pharmacist on 6/7/17 at 9:47 AM. He stated his expectation was for an AIMS assessment to be completed for all residents on antipsychotic medications on admission and at 6 month intervals thereafter. He reported he also expected an AIMS assessment to be conducted if an antipsychotic medication was newly initiated. He indicated he reviewed the AIMS assessments when he conducted his monthly pharmacy reviews. The AIMS assessment dated 8/11/16 for Resident #76 was reviewed with the pharmacist. The medical record which contained no additional AIMS assessments completed after 8/11/16 for Resident #76 was reviewed with the pharmacist. He revealed he had requested an AIMS assessment to be conducted for Resident #76 following his 2/24/17 pharmacy review and his 4/28/17 review. He indicated he had not repeated the request following his March 2017 review or his May 2017 review. He revealed if the AIMS assessment had not been completed for Resident #76 prior to his June 2017 review (scheduled for 6/26/17) he planned to repeat his request.

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 _____	C 06/09/2017

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

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F 329	Continued From page 156	F 329		

An interview was conducted with the Nurse Practitioner on 6/8/17 at 7:54 AM. She stated she expected the AIMS assessment to be completed for all residents on antipsychotic medication as per the facility and pharmacy protocol.

4. Resident #91 was admitted to the facility 12/1/16. Cumulative diagnoses included hypertension.

A Quarterly Minimum Data Set dated 3/4/17 indicated Resident #91 was moderately impaired in cognition. Diagnoses included hypertension.

A physician order dated 3/9/17 stated to monitor blood pressure (BP) weekly for amlodipine use (hypertensive medication). Resident #91 had a physician order for amlodipine 10 milligrams by mouth daily.

A review of the March 2017, April 2017 and May 2017 Medication Administration Record (MAR) revealed no documentation of blood pressures recorded.

A review of vital signs recorded in the computer medical record revealed one blood pressure documented on 4/9/17 of 102/ 84.

A review of the nursing notes revealed no documentation of blood pressures recorded from March 2017 through June 9, 2017.

On 6/8/17 at 7:54 AM, an interview was conducted with the Nurse Practitioner. She stated she expected nursing staff to follow physician orders and obtain the blood pressure

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 _____	C 06/09/2017

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 329	Continued From page 157 as ordered. On 6/8/17 at 2:54 PM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to follow the physician orders, obtain the blood pressure as ordered and document the results on the MAR.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate at 5% or below by not following doctor's order and by not flushing the gastrostomy (G) tube with water between medications. There were 4 errors of 25 opportunities for error resulting in a 16% error rate. This was evident for 2 of 4 residents observed during the medication pass (Resident #74 & Resident # 49). Findings including: 1a. Resident #74 had a doctor's order dated 5/30/17 for Lasix (a diuretic) 20 milligrams (mgs) by mouth daily for Hypertension. On 6/7/17 at 8:00 AM, Nurse #7 was observed during the medication pass. She was observed to prepare and to administer Resident #74's medications including one tablet of Lasix 40 mgs.	F 332	F 332 Free of Medication Error Rates of 5% or More On 6/7/17, Resident #74'□s Lasix 20 mg was discontinued by the physician order. On 6/7/17, Resident #74'□s potassium chloride 20 meq by mouth on Monday, Wednesday, and Friday was discontinued. On 6/7/17, the physician gave a new order for Resident #74 to continue on potassium chloride 40 meq by mouth every day. On 6/7/17, the director of nursing (DON) updated Resident #74□'s medication administration record (MAR) to reflect the new orders. On 6/24/17, Resident #49'□s physician order noted to flush gastrostomy tube with 15 ml of water between each medication. The order for Resident #49 was transcribed and placed on the MAR. On 6/24/17, Resident #49□'s MAR was noted with physician order for Miralax 17	7/25/17

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 _____	C 06/09/2017

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

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F 332	Continued From page 158 On 6/7/17 at 8:30 AM, Nurse #7 was interviewed. She acknowledged that she had administered one tablet of Lasix 40 mgs to Resident #74. She added that she didn't know that the order for the Lasix was changed to 20 mgs. On 6/8/17 at 2:15 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to administer medications as ordered. b. Resident #74 had a doctor's order dated 5/30/17 for Potassium Chloride (Potassium supplement) 40 milliequivalents (meq) by mouth daily and 20 meq by mouth on Monday, Wednesday and Friday. On Wednesday, 6/7/17 at 8:00 AM, Nurse #7 was observed during the medication pass. She was observed to prepare and to administer Resident #74's medications including one tablet of Potassium Chloride 20 meq. On 6/7/17 at 8:30 AM, Nurse #7 was interviewed. She acknowledged that she had administered one tablet of Potassium Chloride 20 meq to Resident #74. She added that she didn't know that there was another order to give Potassium Chloride 40 meq in addition to the 20 meq on Monday, Wednesday and Friday. On 6/8/17 at 2:15 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to administer medications as ordered. 2 a. Resident #49 was readmitted to the facility	F 332	grams, mix in 8 ounces of liquid. On 6/28/17 through 6/29/17, the corporate consultants completed a 100% audit of a comparison of resident MARs compared to current physician orders. The audit was to ensure physician orders are being transcribed correctly regarding medication administration and medication specific instructions (mixing with correct amounts of water and flushing the gastrostomy tube with 15 ml of water after each medication is administered). The audits identified transcription errors and variances from the physician orders and MAR□s. By 7/11/17, the quality improvement (QI) nurse, DON, and corporate consultants obtained any needed clarification orders, corrected inaccurate MARs with the appropriate medication and dosage, and completed medication error reports. On 6/29/17 through 7/17/17, the QI nurse, DON, and corporate consultants will in-service 100% of all registered nurses (RNs), licensed practical nurses (LPNs) and medication aides regarding the 6 rights of medication administration, reading the MAR, accurately administering the medication per the physician order, medications with specific instructions, mixing medications with the correct amount of water and flushing the gastrostomy tube with 15 ml of water after each medication is administered. On 6/16/17, the RN pharmacy consultant in-serviced the DON and QI Nurse on	

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 _____	C 06/09/2017

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 332	Continued From page 159 3/8/17 with a diagnosis of cerebrovascular accident and aphasia. An Annual Minimum Data Set dated 5/16/17 indicated Resident #49 was severely impaired in decision-making. He required extensive assistance with eating. Cumulative diagnoses included: CVA (cerebrovascular accident) with hemiplegia (partial paralysis) and gastrostomy (GT-a feeding tube inserted into the abdominal area). A review of physician orders revealed the following medications were to be administered at 8:00 AM-Aspirin chewable 81 milligrams via GT, Miralax powder (laxative) 17 grams and mix in 8 ounces of liquid and give via GT, Plavix (blood thinner) 75 milligrams via GT, Carvedilol (for hypertension and heart failure) 6.25 milligrams via GT, Valproic acid syrup (for seizures) 250 milligrams/ 5 milliliters-give 12 milliliters (600 milligrams) via GT. There was also a physician order to administer Zantac (for heartburn relief) 150 milligrams via GT to be administered at 9:00 AM. There was no order to restrict fluids for Resident #49. On 6/7/17 at 8:00 AM, Resident #49 was observed during medication pass. Nurse #8 crushed each medication separately and added 10 milliliters of water to each individual medication. Nurse #8 administered 30 milliliters of water in the GT, administered all of the medications one at a time and flushed the GT with 30 milliliters of water at the end of the medication administration. Nurse #8 did not flush with water between each medication. On 6/7/17 at 9:04 AM, an interview was conducted with Nurse #8. She stated she flushed the GT before and after medication administration	F 332	correctly performing a medication pass. The DON and QI nurse were able to pass a medication pass audit with less than a 5% medication pass error rate. On 6/29/17 through 7/25/17, a 100 % observation of RNs, LPNs, and medication aides for medication administration will be conducted by the DON, QI nurse, facility consultant, or pharmacy consultant utilizing the Medication Pass Audit Tool to ensure all medications are being administered per the physician orders and medication specific instructions, mixing with correct amount of water and flushing the gastrostomy tube with 15 ml of water after each medication is administered. Starting 7/25/17, the DON, QI nurse, pharmacy consultant, and/or corporate consultants will complete a Medication Pass Audit Tool on 10% of RNs, LPNs, and medication aides weekly for 8 weeks then monthly for 1 month, to include all shifts and weekends. The administrator will review the results of the medication pass audits weekly to ensure RNs, LPNs, and medication aides have medication error rates less than 5%. The QI nurse or DON will review with the monthly Quality Improvement Committee the Medication Pass Audit Tool discrepancies and medication error rate audit results monthly x 3 months for trending, root cause analysis and recommendations. The QI nurse or DON will review with the	

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 _____	C 06/09/2017

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

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F 332	Continued From page 160 and did not give any extra water because she knew Resident #49 would not tolerate any more fluid. She stated he would vomit if she gave any more fluid. Nurse #8 acknowledged she did not have a physician ' s order to restrict the fluid. On 6/7/17 at 9:56 AM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to give medications as ordered by the physician. She said she expected staff to follow the policy for administration of oral medications through a gastrostomy tube which included flushing the GT with at least 15 ml of water between each medication. On 6/7/17 at 2:56 PM, a phone interview was conducted with the physician who stated he expected physician orders to be followed. b. Resident #49 was readmitted to the facility 3/8/17 with a diagnosis of cerebrovascular accident and aphasia. An Annual Minimum Data Set dated 5/16/17 indicated Resident #49 was severely impaired in decision-making. He required extensive assistance with eating. Cumulative diagnoses included: CVA (cerebrovascular accident) with hemiplegia (partial paralysis) and gastrostomy (GT-a feeding tube inserted into the abdominal area). A review of physician orders revealed an order for Miralax powder (laxative) 17 grams. Mix in 8 ounces of liquid and give via GT. There was no order to restrict fluids for Resident #49. On 6/7/17 at 8:00 AM, Resident #49 was observed during medication pass. Nurse #8 measured out 17 grams of Miralax and mixed the	F 332	quarterly Quality Assessment and Assurance (QAA) Committee the Medication Pass Audit Tool discrepancies and medication error rate audit results, QI Committee recommendations, and facility progress with recommendations for 1 quarter for additional root cause analysis, recommendations, and additional monitoring requirements as needed. The administrator is responsible for ensuring QAA Committee recommendations are implemented and for reporting back to the QAA Committee.	

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 _____	C 06/09/2017

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

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F 332	Continued From page 161 medication with 10 milliliters of water (0.33 ounces of water). She administered the Miralax and did not add any additional water to the Miralax. On 6/7/17 at 9:04 AM, an interview was conducted with Nurse #8. She stated she did not mix the Miralax with 8 ounces of water because she knew Resident #49 would not tolerate any more fluid. She stated he would vomit if she gave any more fluid. Nurse #8 acknowledged she did not have a physician ' s order to restrict the fluid. On 6/7/17 at 9:56 AM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to give medications as ordered by the physician. On 6/7/17 at 2:56 PM, a phone interview was conducted with the physician who stated he expected physician orders to be followed.	F 332		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 334		7/25/17

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 _____	C 06/09/2017

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

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F 334	Continued From page 162 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334		

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F 334	Continued From page 163 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to administer pneumonia vaccine on admission as ordered on admission for 3 (Resident #98, Resident #3 and Resident #9) 5 residents reviewed for immunizations. Findings included: A review of the facility "Consent/Release Form" last revised 9/20/12 read the pneumonia vaccine would be given on admission unless medically contraindicated. The consent form offered an acceptance or refusal option to be reviewed and signed by the resident of or the responsible party (RP). 1. Resident #98 was admitted 6/16/16. Her annual MDS dated 5/6/17 indicated moderate cognitive impairment. Her RP signed the consent on 6/16/16 authorizing the facility to administer the pneumonia vaccine. A review of the Resident #98 ' s immunization records revealed no evidence the vaccine was given. 2. Resident #3 was admitted 7/7/16. His quarterly MDS dated 3/29/17 indicated moderate cognitive impairment. His RP signed the consent on 7/7/16	F 334	F 334 Influenza and Pneumococcal Immunizations On 6/6/17, Resident #98 was offered the pneumonia vaccination and provided the Centers for Disease Control required education prior to administering vaccinations. The licensed nurse administered the pneumonia vaccination to Resident #98 and documented on the Medication Administration Record (MAR) and electronic medical record (EMR). On 7/1/17, Resident #9 was offered the pneumonia vaccination and provided the Centers for Disease Control required education prior to administering vaccinations. The licensed nurse administered the pneumonia vaccination to Resident #9 and documented on the MAR and EMR. On 7/10/17, the director of nursing (DON) obtained a declination from Resident #3□s resident representative (RR) after being provided the Centers for Disease	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 334	Continued From page 164 authorizing the facility to administer the pneumonia vaccine. A review of the Resident #3 ' s immunization records revealed no evidence the vaccine was given. 3. Resident #9 was admitted 2/28/17. Her quarterly MDS dated 3/21/17 indicated moderate cognitive impairment. Her RP signed the consent on 2/28/17 authorizing the facility to administer the pneumonia vaccine. A review of the Resident #9 ' s immunization records revealed no evidence the vaccine was given. In an interview on 6/6/17 at 4:55 PM, the Quality Assurance (QA) Nurse stated she started her position on 1/26/17 and it was her responsibility to ensure residents received the immunizations as ordered. In another interview on 6/7/17 at 1:30 PM, the QA Nurse stated Resident #15, Resident #98, Resident #3 and Resident #9 received their pneumonia vaccines on 6/7/17. In an interview on 6/8/17 at 2:22 PM, the Administrator stated it was her expectation that consenting residents be giving their pneumonia vaccines on admission.	F 334	Control required education prior to administering vaccinations. On 6/29/17, the quality improvement (QI) nurse completed a 100% audit of all resident medical records to determine if the pneumonia vaccination had been administered or declined. 30 residents have received the pneumonia vaccination. 34 residents/RRs have refused the pneumonia vaccination. The QI nurse interviewed the 34 residents/RRs and provided the education. After receiving the pneumococcal immunization education, the QI nurse received consents, administered, and documented pneumococcal vaccinations. On 6/29/17, the DON and corporate consultant initiated a 100% in-service for all registered nurses (RNs) and licensed practical nurses (LPNs): 1) each resident is offered a pneumococcal vaccination upon admission, 2) the nurse must review the Consent to Treat form in the health record to determine if consent was given, 3) It is the responsibility of the quality improvement (QI) nurse/infection control nurse to review all admissions' immunization records and ensure all pneumococcal vaccines are given if there is consent. On 7/12/17, the corporate consultant competed a second 100% pneumococcal immunization audit to ensure timely and appropriate administration of pneumococcal immunizations. The audit determined there were 40 residents	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 334	Continued From page 165	F 334	without documentation supporting why a pneumococcal immunization was not given. By 7/25/17, the DON, QI nurse, admissions nurse will provide pneumococcal immunization for all residents or provide supporting documentation in the health record supporting why the immunization was not given. The QI nurse/infection control nurse and admissions coordinator (a LPN) will review all admissions weekly for 8 weeks then monthly for 1 month to ensure all residents with authorization to receive the pneumococcal vaccination are administered a pneumococcal vaccination. The audit will be documented on a Pneumococcal Vaccine Audit tool. The DON will review all audit tools weekly. The QI nurse or DON will present the results of the pneumococcal vaccine audits at the monthly QI committee for 3 months for any recommendations, take action as appropriate, and monitor for continued compliance. The QI nurse or DON will present the findings of the pneumococcal vaccine audits at the quarterly executive quality assessment and assurance (QAA) Committee meeting. The QAA committee will review the QI committee recommendations and facility's follow-up to the recommendations. The administrator is accountable for ensuring QAA Committee recommendations are	

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F 334	Continued From page 166	F 334	implemented and newly implemented processes are sustained to maintain regulatory compliance in the area of influenza and pneumococcal immunizations.	
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 353		7/25/17

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

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F 353	Continued From page 167 (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review, the facility failed to provide sufficient staff to provide showers as scheduled for residents who required staff assistance with bathing for 1 (Resident #37) of 5 residents reviewed for activities of daily living (ADLs). Findings included: This citation is cross referenced to: F312: Based on observations, staff and resident interviews and record review, the facility failed to provide resident showers as scheduled for 1 (Resident #37) of 5 residents who required staff assistance with bathing and reviewed for activities of daily living (ADLs). In an interview on 6/6/17 at 12:34 PM, the Director of Nursing (DON) stated there was a problem with residents getting their shower due to staff shortages and management was aware of the problem. The DON stated the facility was budgeted for 9 aides on first shift, 8 aides on second shift and 6 aides on third shift. She stated	F 353	F 353 Staffing On 6/20/17 and 6/23/17, the nursing assistant assisted dependent Resident #37 with a shower, as scheduled on Tuesday and Friday. 100% audit was completed by the regional vice president (RVP) looking back at the last 14 days of staffing records to ensure sufficient staffing was in place to provide resident showers and to provide for resident care based upon acuity level indicated from the Minimum Data Set Case Mix Index. No sufficient staffing issues were identified in audit. On 6/29/17, the director of nursing (DON) completed a 100% audit of the previous 14 days of shower/bathing records for all residents to ensure residents were provided a shower/bath according to their preference. The audit revealed 75% of	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 353	Continued From page 168 when she started took the position of DON on 12/26/16, there was 4 aides assigned to do showers and 2 more aides in the secured unit doing the showers. Once she started, a lot of staff were terminated or resigned. She stated problems with staffing due to call outs resulted in the shower teams being pulled to the floor. She stated she interviewed nursing assistants every day and they worked along enough to go through orientation and then they would quit. The DON stated the facility recently hired 4 geriatric care aides (GCAs). She stated they can clean cluttered night stands, make unoccupied beds, push residents to activities and assist with passing trays. The DON stated she recently started asking the aides to turn in a note letting her know if a resident refused a shower. In an interview on 06/6/17 at 3:46 PM, Nursing Assistant (NA) #4 stated she worked almost 3 years on second shift. She stated sometimes she was the only person in the secured unit when the nurse was passing medications and the other aide was in a room providing care. She stated she did not do her showers until she knew that either the nurse or the other aide was present. In an interview on 6/7/17 at 10:39 AM, NA #12 stated she had worked at the facility for about 2 years. She revealed there had been times when she was not able to complete the showers that were assigned to her due to time limitations. She reported that sometimes her resident assignment had a lot of high needs residents which made it difficult to complete showers as scheduled. NA #12 revealed this was an ongoing problem, but she had done the best she could to complete her assigned tasks.	F 353	residents had not been assisted with two showers per week for the previous 14 days. Any resident that did not receive a shower or bath was provided one upon review. On 6/29/17, the DON ensured each resident not receiving two showers weekly in the previous 14 days was offered a shower/bath. The DON documented the audit on the electronic health record look-back report. On 7/10/17 through 7/11/17, the corporate consultant and DON updated the shower schedule to ensure adequate staffing is scheduled to assist residents with bathing/showers. On 7/10/17, the administrator and DON continued discussing staffing related business at the morning department head meetings and/or clinical meetings to ensure the scheduler was providing the administrator and/or DON the opportunity to review staffing schedules three days in advance. On 7/11/17 through 7/14/17, the quality improvement (QI) nurse facilitated new employee orientation. On 7/13/17, nursing staff reported they were pleased to see the new employees coming onboard and showers were given according to the resident preferences. On 7/12/17, the corporate human resources representative continued assisting the facility with nursing staff recruitment during an in-site visit, meeting new employees, reviewing applications, and scheduling interviews.	

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F 353	Continued From page 169 In an interview on 6/7/17 at 12:10 PM, NA #7 stated she was hired 3/30/17. She stated, when there were call outs, she had trouble completing her assignment. NA #7 stated sometimes the shower team was pulled to the floor so she was responsible for her own showers and she could not complete her assignment. She stated management was aware of the staffing problems and hired GCAs but they cannot assist with direct resident care. In an interview on 6/7/17 at 12:30 PM, NA #8 stated when she started in January, there was a shower team that assisted with resident showers. NA #8 stated due to call outs and staffing shortages, she was not always able to complete her assignment. She stated she would let her charge nurse know and the DON was aware. In an interview on 6/8/17 at 8:17 AM, shower aide (SA) #1 stated she started on the shower team 10/1/16. She stated there were two separate showers teams but due to staffing shortages, the shower team was dismantled in February 2017. SA #1 stated the shower team was restarted 5/1/17 when SA #2 was hired in April. In an interview on 6/8/17 at 8:20 AM, the scheduler stated she started her position on 4/25/17 but has worked at the facility for seven years as a floor aide. She confirmed the shower team started on 5/1/17 and prior to that, the aides on the floor were responsible for giving showers. She stated staffing was a big problem and she had never seen staffing shortages this bad. She stated the DON hired aides weekly. They would be hired if they could pass the drug test, then only stay a few weeks.	F 353	On 7/17/17, the administrator, DON, scheduler, corporate consultants, and RVP continued weekly review of the daily census, 24 hour documentation, incident/accident reports, resident grievances, resident council concerns, daily nursing staffing sheets, and nursing staff assignment sheets, to determine trends and ensure appropriate staffing is provided to meet resident needs. The DON will immediately address all identified areas of concern with staffing levels and make staffing level adjustment or staffing assignment changes as needed upon consideration of facility census, resident needs. The administrator and/or RVP will review Daily Nursing Staffing audit reviews and follow-up with the DON to ensure adequate staffing and follow up for any identified concerns. The QI nurse or DON will review with the monthly QI Committee the results of the Dignity/Staffing Audit Tool and the results of the Daily Nursing Staffing audit reviews for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The QI nurse or DON will present the Dignity/Staffing Audit Tool findings, Daily Nursing Staffing audit review findings, and the QI Committee recommendations to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight regarding	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 353	Continued From page 170 In an interview on 6/8/17 at 4:10 PM, the Director of Nursing (DON) stated it was her expectation the residents receive a shower a minimum of twice per week or more often if requested.	F 353	appropriate staffing to meet the needs of the residents.	
F 354 SS=D	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to staff a Registered Nurse (RN) for eight consecutive hours, seven days a week for 4 of 40 days reviewed for RN coverage. Finding included: A review of the staffing sheets from 5/1/17 to 6/8/17, revealed the following: -5/13/17 Saturday-no RN coverage -5/14/17 Sunday-no RN coverage -5/27/17 Saturday-no RN coverage -5/28/17 Sunday-no RN coverage A review of the facility ' s census from 5/1/17 through 6/9/17 revealed the census never dropped below 60 resident with the daily average of 97 residents.	F 354	F 354 Waiver RN □ 8 Hrs 7 Days per Week, Full Time DON On 6/30/17, the director of nursing (DON), administrator, and regional vice president (RVP) began aggressively recruiting, interviewing, and hiring additional registered nurses (RNs). The newly hired registered nurses will work to assist residents with care and medications thus allowing the director of nursing (DON) to perform the duties of the director of nursing on a fulltime basis. The RVP, administrator, DON, scheduler,	7/25/17

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 _____	C 06/09/2017

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F 354	Continued From page 171 In an interview on 6/8/17 at 8:20 AM, the scheduler stated she was aware that a RN was needed to be staffed on weekends but she did not have a RN available. She stated the Director of Nursing (DON) was aware of the lack of RN coverage. In an interview on 6/8/17 at 5:00 PM, the DON stated she had been serving as the required RN coverage and was not aware she or the Minimum Data Set (MDS) Nurse did not meet that requirement. In an interview on 6/8/17 at 5:05 PM, the Administrator stated it was her expectation there be a RN staff 8 consecutive hours daily.	F 354	and/or corporate consultants will review the Nurse Schedules, Daily Staffing Sheets, and/or Daily Nurse Staffing sheets by 7/25/17 to determine appropriate RN coverage is assigned, to include providing a registered nurse at a minimum of 8 hours per day 7 days a week. The RN coverage will be provided by the RN Minimum date set (MDS) Nurse, RN quality improvement (QI)/staff development nurse, RN treatment nurse, and/or RN supervisor to ensure RN coverage 7 days a week until more RNs are hired. While at the facility performing oversight, the RN MDS nurse, QI nurse and/or RN supervisor will assist with the supervision of the other nurses and not perform their regular duties until increased RN hours by RN staff nurses can be achieved. On 6/30/17, the administrator began aggressively recruiting, interviewing, and hiring additional nurses, nursing assistants, and geriatric assistants for the nursing department. The newly hired staff will work to assist residents with care and medications thus allowing a fulltime registered nurse function as a full time director of nursing or a RN as assigned. By 6/30/17, the administrator in-serviced the administrative nurses (director of nursing, quality improvement nurse, treatment nurse, MDS nurses) and nursing staff scheduler that a RN must be assigned on the daily assignment sheet to	

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F 354	Continued From page 172	F 354	ensure there is a RN supervising the facility per the Medicare guideline of 8 hours RN onsite RN coverage 7 days a week. After 6/30/17, no administrative nurse or the scheduler will be allowed to work until this in-service is completed. All new administrative nurses and schedulers will receive this in-service during new employee orientation. On 6/29/17, the RVP in-serviced the administrator and DON on ensuring RN coverage 8 hours per day, 7 days per week. The administrator, director of nursing (DON), quality improvement (QI) nurse and/or scheduling coordinator will ensure a registered nurse provides onsite supervision and coverage 8 hours a day 7 days a week through appropriate scheduling and staff assignments. The RVP will review the Sufficient Staffing Audit Tool weekly for 12 weeks and follow up with the administrator and DON to ensure daily 8 hour RN coverage seven days per week. The administrator or DON will present the results of the Sufficient Staffing Audit Tool to the monthly QI committee, monthly for 3 months. The QI committee will offer recommendations, take action as appropriate, and monitor for continued compliance. The administrator or DON will present the results of the Sufficient Staffing Audit Tool to the quarterly executive quality assessment and assurance (QAA)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 354	Continued From page 173	F 354	committee meeting. The QAA committee will review the QI committee recommendations and facility's follow-up to the recommendations. The administrator is accountable for ensuring QAA Committee recommendations are implemented and newly implemented processes are sustained to maintain regulatory compliance in the area of daily 8 hour RN coverage, seven days per week.	
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements.	F 356		7/25/17

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 _____	C 06/09/2017

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F 356	Continued From page 174 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to accurately post staff hours by including non-resident care staff calculated into the direct care resident care hours for 5 of the 8 days reviewed for acute staff posting. Findings included: In an interview on 6/6/17 at 12:34 PM, the Director of Nursing (DON) stated the facility recently hired 4 geriatric care aides (GCAs). She stated they can clean cluttered night stands, make unoccupied beds, push residents to activities and assist with passing trays. A review of the Daily Nursing Staffing hours	F 356	F 356 Posted Nurse Staffing The Federal Posting was corrected and the Geriatric Care Aides hours were removed from the Daily Nursing Staffing sheet during the annual/complaint survey on 6/8/17 by the receptionist. On 6/29/17, the regional vice president (RVP) in-serviced the administrator, director of nursing (DON), and scheduler regarding not including non-licensed and non-certified staff (non-resident care staff) on the required Daily Nursing Staffing sheet, according to the regulatory	

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F 356	Continued From page 175 indicated the following: -On 6/3/17, two GCAs working 8 hours each were calculated with 16 hours into the direct resident care hours. -On 6/4/17, one GCA working 8 hours each were calculated with 8 hours into the direct resident care hours. - On 6/5/17, two GCAs working 8 hours each were calculated with 16 hours into the direct resident care hours. - On 6/6/17, four GCAs working 8 hours each were calculated with 32 hours into the direct resident care hours. - On 6/8/17, three GCAs working 7.5 hours each were calculated with 22.5 hours into the direct resident care hours. In an interview on 6/8/17 at 12:00 PM, GCA #1 stated she recently started but she was not allowed to do any resident care. She stated she could take residents to activities, pass trays, make beds and run errands. In an interview on 6/8/17 at 12:10 PM, the receptionist stated she completed the Daily Nursing Staffing sheets. She stated she added the GCAs to the hours but was never told to do it. She stated she assumed they counted as staffing hours. In an interview on 6/8/17 at 2:22 PM, the Administrator stated it was her expectation that the GCAs not be calculated in with the Daily Nursing Staffing hours since they had no direct resident care responsibilities.	F 356	guidelines. On 6/30/16, the director of nursing (DON) in-serviced the receptionist and third shift nurses regarding: 1) the Daily Nursing Staffing sheets are to be completed in pencil, 2) when staff hours change, corrections are made to the Daily Nursing Staffing sheet to reflect actual hours, and 3) Non-licensed and non-certified staff (non-resident care staff) are not included on the nursing staffing sheet, according to the regulatory guidelines. On 7/10/17, the corporate consultant re-educated the receptionist (for posting) and nursing staffing scheduler (for the completion of the federal posting sheet) regarding maintaining the Daily Nursing Staffing sheets, including the proper calculation of hours and to not include non-licensed and non-certified staff (non-resident care staff), according to the regulatory guidelines. The administrator, DON, quality improvement (QI) nurse and/or corporate consultant will audit and initial the Daily Nursing Staffing sheets to ensure accurate completion of staffing sheets and to ensure non-nursing and non-certified staff (non-resident care staff) are not included in the calculations according to the regulatory guidelines. The audit will be completed, 5 times weekly for 4 weeks (to include Saturday and Sunday), then 3 times a week for 4 weeks, then 1 time weekly for 4 weeks. The receptionist or scheduler will be	

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F 356	Continued From page 176	F 356	immediately re-educated by the administrator, DON, QI Nurse and/or corporate consultant for any noted incorrect Daily Nursing Staffing sheets. The QI nurse or DON will review with the monthly Quality Improvement Committee the results of the Daily Nursing Staffing audit reviews monthly for 3 months for trending, root cause analysis and recommendations. The QI nurse or DON will review with the quarterly Quality Assessment and Assurance (QAA) Committee the results of the Daily Nursing Staffing audit reviews, QI Committee recommendations, and facility progress with the QI Committee recommendations for 1 quarter for additional root cause analysis, recommendations, and additional monitoring requirements as needed. The administrator is responsible for ensuring QAA Committee recommendations are implemented and for reporting back to the QAA Committee.	
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:	F 412		7/25/17

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F 412	Continued From page 177 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide routine dental services for 1 (Resident #71) of 3 residents reviewed for dental services. Findings included: Resident #71 was admitted 9/4/14 with cumulative diagnoses of cerebral vascular accident (CVA), hemiplegia and contractures. His significant change MDS assessment dated 5/17/17 indicated moderate cognitive impairment and no behaviors. He required extensive assistance with his hygiene. Resident #71 ' s last care plan revised on 5/23/17 read he required assistance with mouth care daily. Staff were to assist Resident #71 with his hygiene and grooming as needed. Resident #71 last care plan revised on 5/23/17 included his refusal of activities of daily living with	F 412	F 412 Routine /Emergency Dental Services On 7/6/17, the dental services provider was scheduled to provide dental services for Resident #71. On 6/29/17, the RN Corporate Consultant completed a 100% audit to ensure all residents have a dental consultation within a year. Twenty-one residents did not receive a dental consult. For residents not requiring a dental consultation within a year, the social worker and/or admissions coordinator will interview residents or contact the resident'□s representative (RR) by 7/10/17 and offer the service of a dental consult. Any resident/RR requesting dental services consult will be scheduled at that time for a consult. Any	

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F 412	Continued From page 178 interventions to include flexibility and return and offer assistance in 5-10 minutes. In an observation and interview on 6/5/17 at 1:13 PM, Resident #71 stated he was experiencing no discomfort with his teeth or gums. He stated he did not know the last time he saw a dentist and the facility had not ever told him they offered dental services. On observation, his teeth were noted discolored with multiple missing teeth. He stated he could brush his own teeth if staff set up the toothbrush. In an interview on 6/8/17 at 11:55 AM, the Social Worker (SW) stated she was not responsible for setting up dental services but rather the medical records (MR) person did it. The SW stated the facility found an in-house dental provider in April 2017. Prior to April, residents had to go out to their own dentist. In an interview on 6/8/17 at 2:13 PM, the MR person stated she was filling in and she was not told she needed to set up a dental assessment for #71 with the in-house dentist. She stated she found no evidence that Resident #71 had been evaluated by a dentist since he was admitted 9/4/14. In an interview on 6/8/17 at 2:22 PM, the Administrator stated it was her expectation Resident #71 would have received dental services annually unless refused. In an interview on 6/8/17 at 2:53 PM, nursing assistant (NA) #6 stated Resident #71 refused to let staff brush his teeth. She stated she had not reported his refusal and she had not been asked if he refused.	F 412	resident that requires dental services will have services provided by 7/26/17. On 6/29/17, the regional vice president (RVP) in-serviced the social worker, admissions coordinator, administrator, and director of nursing (DON) that the facility must, according to regulations, provide or obtain from an outside resource: 1) emergency dental services, 2) assist in making appointments, and 3) assist to apply for reimbursement of dental services as an incurred medical expense under the State plan. The Dental Services in-service also included the expectation that the social worker and/or admissions coordinator will monitor dental services to ensure all residents are offered services yearly and as needed. Beginning on 7/17/17, the social worker and/or admissions coordinator will use the Dental Services audit tool to monitor residents: 1) with a request for dental services, 2) with a physician'□s order for dental services, and 3) that have not had a dental consult within the past 12 months. Upon identification of a dental consult need, the social worker and/or admissions coordinator will assist the resident in making appointments, assist with arranging for transportation if needed. The Dental Services Audit tool will be completed once weekly for 4 weeks, then once every 2 weeks for 4 weeks, then once monthly x 2 months. The social worker and/or admissions coordinator will present the findings of the	

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F 412	Continued From page 179	F 412	Dental Services audits, monthly for 3 months, to the monthly QI Committee for review, root cause analysis, and recommendations. The social worker and/or admissions coordinator will present the finding of the Dental Services audits, the root cause analysis, and the follow-up to the QI Committee recommendations at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility□'s follow-up to the recommendations for one quarter. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of dental services.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 428		7/25/17

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F 428	Continued From page 180 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 428		

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F 428	Continued From page 181 This REQUIREMENT is not met as evidenced by: Based on observation, record review, pharmacist interview, Nurse Practitioner interview, and staff interview, the facility failed to complete the pharmacists request to conduct an Abnormal Involuntary Movement Scale assessment (an assessment utilized to monitor involuntary movements for persons on antipsychotic medication) for 1 of 6 residents reviewed for unnecessary medications (Resident #76). The findings included: Resident #76 was admitted to the facility on 8/9/16 with multiple diagnoses that included major depressive disorder, severe with psychotic features, and dementia with behavioral disturbance. A physician ' s order dated 8/10/16 indicated Risperdal (antipsychotic medication) 3 milligrams (mg) once daily at night for Resident #76. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 8/11/16 for Resident #76 with a score of 0 (no involuntary movements identified). The admission Minimum Data Set (MDS) assessment dated 8/17/16 indicated Resident #76 had moderate cognitive impairment. Resident #76 received antipsychotic medication during the MDS review period. An MDS Care Area Assessment (CAA) related to psychotropic medications for the 8/17/16 MDS indicated he received antipsychotic medication daily.	F 428	F 428 Drug Regimen Review, Report Irregular, Act On On 6/29/17, the director of nursing (DON) completed an antipsychotic drug therapy/DISCUS (Dyskinesia Identification System Condensed User Scale) assessment on Resident #76. On 6/29/17, the corporate clinical director completed a psychiatric consult audit which revealed psychiatric consults had not been completed on several residents. On 6/29/17, the DON developed a list of residents for a psychiatric consult for these residents to be seen upon the health care provider'□s next visit on 7/12/17. On 6/29/17, the director of nursing (DON) and corporate consultants completed a 100% audit of physician orders to ensure residents on antipsychotic medication have a DISCUS completed according to the facility pharmacy policy. The audit revealed additional DISCUS assessments were required for four (4) residents. On 6/30/17, the DON, registered nurses, and licensed practical nurses completed required DISCUS assessments. Beginning 6/29/17, the corporate facility consultant in-serviced the DON, registered nurses (RNs), and licensed practical nurses (LPNs) on: 1) antipsychotic drug therapy/DISCUS (Dyskinesia Identification System	

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F 428	Continued From page 182 A physician ' s order dated 4/6/17 indicated a decrease in Risperdal to 2.5mg from (3mg) once daily at night for Resident #76. A physician ' s order dated 4/20/17 indicated a decrease in Risperdal to 2mg from (2.5 mg) once daily at night for Resident #76. The quarterly MDS assessment dated 5/4/17 indicated Resident #76 ' s cognition was intact. Resident #76 received antipsychotic medication during the MDS review period. The plan of care for Resident #76 was reviewed. Resident #76 had a plan of care, most recently reviewed on 5/5/17, which indicated the focus area of psychotropic drugs. A review of the medical record on 6/6/17 revealed an AIMS assessment had not been conducted for Resident #76 since 8/11/16. An observation was conducted of Resident #76 on 6/5/17 at 12:25 PM with no involuntary movements noted. An interview was conducted with the Director of Nursing (DON) on 6/7/17 at 8:58 AM. She indicated her expectation was for an AIMS assessment to be conducted for all residents on antipsychotic medications upon admission, quarterly, and with any dosage change of the antipsychotic medication. She stated the Admissions Nurse was responsible for completing the AIMS assessment on admission, the charge nurse was responsible for completing the AIMS assessment quarterly, and if a physician ' s order changed the dosage of an antipsychotic medication the nurse who completed that order was responsible for completing the AIMS	F 428	Condensed User Scale) assessment, and processing physician orders requiring further appointments. On 6/30/17, the DON, corporate clinical director, and regional vice president (RVP) met with the clinical director of pharmacy services to review the outcome of the pharmacy consultants 6/29/17-6/30/17 audit findings and discuss and follow the recommendations if approved by the attending physician. All pharmacy recommendations will be reviewed by the attending physician by 7/17/17. The approved, revised or denied recommendation will be transcribed and entered into the medical record and medication administration record as needed. The DON and/or QI nurse will use the Unnecessary Drugs/DISCUS Audit tool to complete a 100% review of pink slips in the clinical meetings 5 times weekly on an ongoing basis. Also, the DON and/or QI nurse will audit the electronic health record and pharmacy recommendations for any missing DISCUS, to be done once weekly for 8 weeks then every-other-week for 4 weeks to ensure residents are being assessed for abnormal involuntary movement using the DISCUS. The results of the audits will be presented by the DON at the monthly Quality Improvement Committee meeting for 3 months for further review and recommendations. The DON will present the audit results to the quality assessment	

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F 428	Continued From page 183 assessment. The DON revealed she was aware the facility had a problem with the timely completion of AIMS assessments. She indicated she had been aware of this problem since February 2017. The DON reported she had a meeting with the pharmacist in February 2017 and this was one of the areas that was discussed. She revealed the timeliness of AIMS assessments had not improved since the February 2017 meeting. The interview with the DON continued on 6/7/17 at 9:03 AM. The AIMS assessment dated 8/11/16 for Resident #76 was reviewed with the DON. The medical record which contained no additional AIMS assessments completed after 8/11/16 for Resident #76 was reviewed with the DON. She stated this was not a surprise to her. She indicated Resident #76 should have had an AIMS assessment completed since 8/11/16. She revealed the pharmacist had requested an AIMS assessment for Resident #76 following his February 2017 pharmacy review. She verified this pharmacy request had not been completed. A phone interview was conducted with the pharmacist on 6/7/17 at 9:47 AM. He stated his expectation was for an AIMS assessment to be completed for all residents on antipsychotic medications on admission and at 6 month intervals thereafter. He reported he also expected an AIMS assessment to be conducted if an antipsychotic medication was newly initiated. He indicated he reviewed the AIMS assessments when he conducted his monthly pharmacy reviews. The AIMS assessment dated 8/11/16 for Resident #76 was reviewed with the pharmacist. The medical record which contained no additional AIMS assessments completed after 8/11/16 for	F 428	and assurance (QAA) Committee for 1 quarter for additional review and recommendations to ensure new systems remain in place to sustain regulatory compliance.	

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F 428	Continued From page 184 Resident #76 was reviewed with the pharmacist. He revealed he had requested an AIMS assessment to be conducted for Resident #76 following his 2/24/17 pharmacy review and his 4/28/17 review. He indicated he had not repeated the request following his March 2017 review or his May 2017 review. He revealed if the AIMS assessment had not been completed for Resident #76 prior to his June 2017 review (scheduled for 6/26/17) he planned to repeat his request. An interview was conducted with the Nurse Practitioner on 6/8/17 at 7:54 AM. She stated she expected the AIMS assessment to be completed for all residents on antipsychotic medication as per the facility and pharmacy protocol.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		7/25/17

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 _____	C 06/09/2017

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	Continued From page 185 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 observation, manufacturer's instruction and staff interview, the facility failed to discard expired medications on one of four medication carts (dementia unit medication cart). The facility also failed to label and date opened medications	F 431	F431 Drug Records Label Store Biologicals On 6/8/17, the nurse removed expired medications from the medication cart	

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 186 on three of four medication carts (dementia unit, 400 hall and 200 hall medication carts) and in one of one medication rooms and failed to store a medication according to manufacturer ' s instructions on 1 of 4 medication carts (400 hall). The findings included: 1. An observation of the dementia unit medication cart was conducted on 6/8/17 at 2:00 PM with Nurse #6 and revealed the following: one bottle of Uti-Stat (medication for urinary tract health) liquid with approximately 120 milliliters of liquid in the bottle. The bottle was undated with an expiration date of 5/17. The Uti-Stat bottle revealed instructions that specified the medication should be discarded 3 months after opening. There was one bottle of loperamide (used to treat diarrhea) with an expiration date of 2/17. There was a bottle of Xalatan 0.005% eye drop medication opened and undated. Instructions on the eye medication stated the medication expired 6 weeks after opening. On 6/8/17 at 2:00PM, Nurse #6 stated the expired medications should have been discarded and the eye drop medication should have been dated when it was opened. On 6/8/17 at 2:16 PM, an interview was conducted with the Director of Nursing. She said the third shift (11:00 PM-7:00 AM) was supposed to check the medication carts and the medication rooms every night for expired medications and that medications were dated when opened. She stated she expected medications to be discarded if expired, dated when opened and the manufacturer ' s instructions were followed regarding dating.	F 431	upon discovery. On 6/8/17, the director of nursing (DON) discarded the expired medications per pharmacy protocol. On 6/22/17, the corporate consultant completed a 100% audit of all medication rooms and medication refrigerators to ensure medications were not expired and were dated upon opening if required. The audit determined there were multiple expired/unlabeled medications in the medication rooms and medication refrigerators. For the expired and unlabeled medications identified during the audit, the corporate consultants immediately removed, discarded, and reordered the medications from the pharmacy. On 6/28/17, the corporate consultants removed from the medication carts all expired and unlabeled medications, to include UTI stat, Prostat, Loperamide, Xalatan eye drops, DuoNeb solution and Tuberculin solution. On 6/28/17, the corporate consultants also discarded the expired medications per pharmacy protocol. Starting on 6/28/17, the corporate consultants, DON, and or quality improvement (QI) nurse/staff facilitator in-serviced 100% of registered nurses (RNs), licensed practical nurses (LPNs), and medication aides regarding medication discard dates and which medications must be dated upon opening, to include UTI stat, Prostat, Loperamide, Xalatan eye drops, DuoNeb solution and	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

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

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F 431	Continued From page 187 2. An observation of the medication room was conducted on 6/8/17 at 2:16 PM with Nurse #7 and revealed an opened undated vial of Tuberculin Purified Protein Derivative (Mantoux) -- a vaccine used to aid diagnosis of tuberculosis infection. Manufacturer's instructions for Tuberculin Purified Protein Derivative stated the medication should be discarded 30 days after opening. On 6/8/17 at 2:16 PM, Nurse #7 said the Tuberculin Purified Protein Derivative should have been dated when it was opened. She said, if she had opened it, she would have dated it. On 6/8/17 at 2:16 PM, an interview was conducted with the Director of Nursing. She said the third shift (11:00 PM-7:00 AM) was supposed to check the medication carts and the medication rooms every night for expired medications and that medications were dated when opened. She stated she expected medications to be discarded if expired, dated when opened and the manufacturer ' s instructions were followed regarding dating. 3. An observation of the 400 hall medication cart was conducted on 6/8/17 at 1:40 PM with Nurse #7 and revealed the following: one opened bottle of Uti-Stat (medication for urinary tract health) that was not dated with the opened-on date, one opened bottle of Prostat (a liquid protein supplement) that was not dated with the opened-on date and approximately 10 vials of Duoneb (an inhaled medication to make breathing easier) outside the foil packaging that it came in without a date indicating when it had been removed from the foil pouch. Further inspection of the Uti-Stat bottle revealed	F 431	Tuberculin solution . This in-servicing will be completed by 7/25/17. The DON or QI nurse will train all newly hired RNs, LPNs, and medication aides during orientation regarding medication discard dates and which medications must be dated upon opening, to include UTI stat, Prostat, Loperamide, Xalatan eye drops, DuoNeb solution and Tuberculin solution. The DON, QI nurse, treatment nurse, admissions nurse, pharmacy consultants, and/or corporate consultants will monitor medication carts and medication rooms for dating of medications upon opening if required and expired medications to include UTI Stat, Prostat, Loperamide, Xalatan eye drops, DuoNeb solution and Tuberculin solution. The monitoring will be documented on the QI Expired\ Undated Medication audit tool weekly x 8 weeks and monthly x 1 month. The licensed nurses will be re-educated by the QI Nurse, DON, pharmacist, or corporate consultant for any identified areas of concern during the audit. The DON will review and initial the QI Expired\ Undated Medication audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The QI nurse or DON will present the findings of the audits to monthly QI committee. The committee will review the QI Expired\Undated Medication Audit Tool results for 3 months and address any issues, concerns and\or trends and make changes as needed, to include continued	

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 _____	C 06/09/2017

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

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F 431	Continued From page 188 instructions that specified the medication should be discarded 3 months after opening. The Prostat bottle also had instructions to discard it after 3 months and the Duoneb foil packaging had instructions to discard the medication after being outside the foil pouch for 2 weeks. On 6/8/17 at 1:45 PM Nurse #7 was interviewed and stated that if she had opened the Uti-Stat or Prostat she would have dated it and that she felt it was good practice to date all medications when opened. She also indicated that she was aware the Uti-Stat and Prostat expired after a period of being opened and since she did not know when they were opened she would need to discard them. Nurse #7 also said she had not been aware that there was Duoneb in the medication cart that was not inside the foil pouch it came in. She stated she was aware the medication expired after a period of being outside the foil pouch and since it was not dated and she did not know when or why that had occurred she would need to discard it. On 6/8/17 at 2:16 PM, an interview was conducted with the Director of Nursing. She said the third shift (11:00 PM-7:00 AM) was supposed to check the medication carts and the medication rooms every night for expired medications and that medications were dated when opened. She stated she expected medications to be discarded if expired, dated when opened and the manufacturer ' s instructions regarding dating and storage were followed. 4. An observation of the 200 hall medication cart was conducted on 6/8/17 at 1:49 PM with Nurse #2 and revealed the following: one opened bottle of Uti-Stat that was not dated with the opened-on	F 431	frequency of monitoring. The QI nurse or DON will present the findings of the audits to quarterly quality assessment and assurance (QAA) committee. The QAA committee will review the QI Expired\Undated Medication Audit Tool results for 1 quarter and address any issues, concerns and\or trends and make changes as needed, to include continued frequency of monitoring to sustain regulatory compliance.	

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 _____	C 06/09/2017

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

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F 431	Continued From page 189	F 431		

date and one Advair Discus (a breathing treatment medication) that was not in its foil packaging and that was not dated with the opened-on date. The Advair Discus inhaler doses left counter indicated there were 58 doses left in the inhaler. Further inspection of the Uti-Stat bottle revealed instructions that specified the medication should be discarded 3 months after opening. The Advair Discus manufacturer ' s instructions (Highlights of Prescribing Information, Revised February 2017) indicated "ADVAIR DISKUS should be stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0" (after all blisters have been used), whichever comes first." The prescribing information also revealed that when unused - the inhaler counter would show 60 doses left.

Interview with Nurse #2 on 6/8/17 at 1:55 PM revealed she was not aware the Advair Discus needed to be dated when opened but she then noted the pharmacy had placed a sticker on the clear plastic storage pouch with the prescription information that indicated the medication was to be discarded 30 days after opening. She acknowledged the Advair Discus had already been opened and indicated she would discard it and order another one. Nurse #2 was aware the Uti-Stat should be dated. She was not sure why it wasn ' t and said that she was not typically the Nurse who worked on that cart. Nurse #2 stated all Nurses were responsible to check the medication carts for expired and undated medications when passing medications.

On 6/8/17 at 2:16 PM, an interview was

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 _____	C 06/09/2017

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

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F 431	Continued From page 190 conducted with the Director of Nursing. She said the third shift (11:00 PM-7:00 AM) was supposed to check the medication carts and the medication rooms every night for expired medications and that medications were dated when opened. She stated she expected medications to be discarded if expired, dated when opened and the manufacturer ' s instructions regarding dating and storage were followed.	F 431		
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to ensure the safe function of wheelchair brakes for 1 of (Resident #37) 26 sampled residents reviewed to safe resident equipment. Findings included: Resident #37 was admitted on 1/20/11 with cumulative diagnoses of contractures, abnormal posture and muscle weakness. A review of an Occupational Therapy (OT) treatment note dated 2/9/17 specified a work order was completed on 2/8/17 which requested maintenance to fix Resident #37 ' s broken wheelchair brake. Further review of the resident '	F 456	F456 Essential Equipment On 6/7/17, the maintenance supervisor tightened Resident #37□s wheelchair right brakes. On 6/10/17, the central supply clerk completed a 100% audit of all wheelchairs to ensure: 1) the brakes were functional, 2) the wheelchair was clean, 3) the wheelchair was in good repair, and 4) the wheelchair arm rests were intact. This audit included Resident #37□s wheelchair. The audit of Resident #37□s wheelchair revealed: 1) the brakes were in working order, 2) the wheelchair was in	7/25/17

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 _____	C 06/09/2017

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

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F 456	Continued From page 191 s OT notes revealed the following: A review of an OT treatment note dated 2/10/17 read the right side wheelchair brake was still broken. A review of an OT treatment note dated 2/14/17 read the right side wheelchair brake was still broken. A review of an OT treatment note dated 2/15/17 read the right side wheelchair brake was still broken. A review of an OT treatment note dated 2/16/17 read the right side wheelchair brake was still broken. A review of an OT treatment note dated 2/23/17 read the right side wheelchair brake was still broken. A review of an OT treatment note dated 2/27/17 read the right side wheelchair brake was still broken. Resident #37 ' s quarterly Minimum Data Set (MDS) dated 5/22/17 indicated severe cognitive impairment. She was coded for extensive assistance of 2 staff for transfers, non-ambulatory and coded for the use of a wheelchair for mobility. Resident #37 was last care planned on 5/23/17 for two staff assistance using a mechanical lift and mobility assistance using a "scoot" chair. (A scoot chair is a wheelchair designed to promote increased mobility while reducing fall risk). In an interview on 6/4/17 at 5:00 PM, a family	F 456	good repair, and 3) the arm rests were intact. Several other wheelchairs and geriatric chairs required repair as identified from the audit completed on 6/10/17. Any chair needing work identified in the 6/10/17 audit was put on a repair schedule, some chairs were repaired, parts were ordered, and some chairs were cleaned. By 7/25/17, all wheelchairs, geriatric chairs, and bed repair work orders will be completed. On 7/13/17, the administrator in-serviced the maintenance worker: 1) ensuring the safe function of wheelchairs, 2) completion of work orders, 3) preventative maintenance schedules, and 4) preventative maintenance schedules are to be adhered to and weekly preventative maintenance rounds are to be completed to ensure equipment is in proper working order. Starting 7/13/17, all staff were in-serviced by the quality improvement nurse (QI) nurse/staff facilitator and/or administrator regarding: 1) examples of equipment issues that need a work order, 2) where blank work orders are located, 3) how to fill out a work orders, and 4) where to place work order requests. This work orders in-service will be completed by 7/25/17. The maintenance director will complete the Wheelchair Audit tool to include 5 wheelchairs each day for 5 days a week for 4 weeks, 5 wheelchairs each day 3 days a week for 4 weeks, then 5	

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	345293	A. BUILDING _____ B. WING _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 456	Continued From page 192 member stated Resident #37 ' s wheelchair brakes had been broken for almost 6 months did not lock. Observation on 6/4/17 at 5:05 PM, Resident #37 ' s wheelchair revealed the right side brakes appeared loose and when pushed to lock the right wheel, the brake lever did not prevent the right wheel of the wheelchair from rolling. The left side of the wheelchair brake functioned properly. In an interview on 6/7/17 at 12:10 PM, Nursing Assistant (NA) #7 stated she began working at the facility 3/30/17 and as long as she had worked with Resident #37, her ride side wheelchair brake did not lock. She stated Resident #37 was transferred using a mechanical lift so one of the staff had to hold the wheelchair steady while putting her in the chair. NA #7 stated she personally had not reported the broken brake but knew the Maintenance Supervisor (MS) was aware. She stated the family had complained about the broken right side wheelchair brake multiple times. In an interview on 6/7/17 at 12:30 PM, NA #8 stated she started working at the facility in January 2017. She stated she knew about Resident #37 ' s right wheelchair brake not locking. She stated she had not completed a work order because she thought the MS knew about it. In an interview on 6/7/17 at 3:20 PM, the Rehabilitation Manager, who was an OT, stated Resident #37 ' s broken wheelchair brake was reported to the MS on numerous occasions. She stated at the time of Resident #37 ' s discharge from therapy on 3/8/17, she did not recall if the	F 456	wheelchairs weekly for 4 weeks. The administrator, DON, regional vice president, and/or nurse consultant will sign off the audits weekly for 3 months. The administrator, DON, regional vice president, and/or nurse consultant will initial completed work orders to signify the review was completed. The administrator or maintenance worker will present the findings from the Wheelchair Audit tool at the monthly QI committee meetings for three months for further recommendations. Also, the administrator or maintenance worker will present findings at the quarterly quality assessment and assurance (QAA) committee meeting for further recommendations, follow up as needed, or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	

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 _____	C 06/09/2017

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

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F 456	Continued From page 193 right wheelchair brake was repaired. In an interview on 6/7/17 at 3:35 PM, the MS stated he tightened Resident #37 ' s ride side wheelchair brake today and was unable to provide evidence of any work orders completed by the staff or rehabilitation. He stated it was possible he tightened her right side wheelchair brake and it came loose again. The MS stated he did not do a monthly rounds and he did not have check off list of items he should be evaluating routinely. In an interview on 6/8/17 at 3:05 PM, the Administrator provided a blank copy of Maintenance Department Rounds Checklist and stated it was her expectation that Resident #37 ' s right side wheelchair brake be fixed timely and monthly rounds be completed by the MS to ensure proper and safe function of resident equipment.	F 456		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident, staff, Nurse Practitioner and Physician interview, the facility administration failed to provide the leadership and management necessary to ensure resident's needs were met.	F 490	F490 Administration On 6/9/17, the regional vice president (RVP) and the corporate clinical director met with the administrator and director of nursing (DON) to review the significance	7/17/17

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 _____	C 06/09/2017

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 490	Continued From page 194 Immediate jeopardy began on 3/4/17 when Resident #3, a cognitively impaired resident and was identified as a wanderer, had exited the facility unsupervised. Immediate jeopardy began on 5/1/17 when Resident #80 was caught between the bed's mattress and the foot board causing a bruise to the back of his neck. The immediate jeopardy is present and ongoing. Findings included: This tag is cross referred to: 1. F157 - Based on record review and staff, Nurse Practitioner and Physician interview, the facility failed to notify the physician when a cognitively impaired resident was entrapped between the mattress and the foot board causing a bruise to the back of the resident's neck. This was evident for 1 of 3 sampled residents reviewed for accidents (Resident #80). Immediate jeopardy began on 5/1/17 when Resident #80 was found entrapped between the mattress and the foot board and the facility did not notify the physician. The immediate Jeopardy is present and ongoing. 2. F221 -Based on record review, observation and staff interview, the facility utilized a device (foot board) in bed without considering it to be a restraint and without a medical symptom. Resident #80's head was caught between the bed's mattress and the foot board causing a	F 490	of immediate jeopardy and expedited protection of the residents. On 6/9/17, the RVP and corporate clinical director addressed communication breakdown during an in-service with the administrator and DON on the significance of conducting the standup/daily clinical meeting with administrative nurses to review the incidents and accidents or significant occurrences identified in the resident electronic medical records. The administrator and DON were further in-serviced on performing root cause analysis to determine potential systematic failure and implement an immediate plan to protect the residents through effective communication. Corporate, (RVP, clinical director, policy director, and/or facility consultants) is providing daily off-site and on-site review of the electronic health record for nursing progress notes and incident and accident reports. On 6/9/17, the RVP in-serviced the administrator and DON related to ensuring the resident environment remains free of hazards, ensuring staff are trained on entrapment, restraints, critical thinking, and unsupervised exits. Communication was determined to be the key problem and was address with the administrator and DON. Communication is improving through the use of: 1) a newly added structured daily standup meeting, 2) newly structured daily clinical meeting with end of day follow-up, 3) review of the 24 hour report sheets, 4)	

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 _____	C 06/09/2017

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 490	Continued From page 195	F 490		

bruise to the back of the resident's neck. This was evident for 1 of 3 sampled residents reviewed for accidents (Resident #80).

Immediate jeopardy began on 5/1/17 when Resident #80 was found with his head entrapped between the mattress and the foot board causing a bruise to the back of the resident's neck.

The immediate Jeopardy is present and ongoing.

3. F224- Based on record review, observation and staff interview, the facility neglected to supervise a cognitively impaired resident who was identified as a wanderer which resulted in an unsupervised exit from the facility for 1 of 3 sampled residents reviewed for accidents (Resident #3). Resident #3 was found a few feet to the road heading towards a busy highway. Resident #3 had to go through a parking lot to get to the road.

Immediate jeopardy began on 3/4/17 when Resident #3 exited the building unsupervised.

Immediate jeopardy is present and ongoing.

4. F280 - Based on record review and staff interview, the facility failed to revise the care plan for wandering for a cognitively impaired resident who was identified at risk for elopement, which resulted in an unsupervised exit from the facility's front door for 1 of 3 sampled residents reviewed for accidents (Resident #3.) The facility also failed to revise the care plan of a cognitively impaired resident who had repeated falls for 1 of 3 sampled residents (Resident #3) at a scope and severity of D. The facility failed to involve alert and oriented residents in the care planning

use of accident and incident reports, 5) maintenance work order process and follow through, 6) care plan meeting attendance, 7) care plan invitations, 8) new informative signage on elopement, 9) notification to family members in regards to facility security for elopement, 10) visitor postcard on safety for elopement provided upon entrance, 11) physician notification procedures, and 12) implementation of wandering board and binders (with resident information).

On 6/9/17, Corporate began providing daily onsite (including weekends and holidays) support of the facility administrative staff to ensure the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial wellbeing of the residents. Corporate is supporting the facility by directing and providing the education of all staff and testing their recall and demonstration through questionnaires and interviews.

On 6/9/17, the RVP, administrator, DON, and corporate clinical director discussed the deficient practices regarding Resident #3'□s unsupervised exits and Resident #80□'s entrapment by a bed'□s foot board. Discussions and reviews of investigative files, nurse progress notes, resident medical records, incident/accident reports, and interviews with staff determined the facility administration was not following

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 _____	C 06/09/2017

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 490	Continued From page 196 process for 2 (Residents #82 & #74) of 3 sampled residents. This was at a scope and severity of D. Immediate jeopardy began on 3/4/17 when Resident #3 exited the facility unsupervised and the facility failed to update the care plan. Resident #3 had an unsupervised exit on 3/4/17 and had several attempts of leaving the facility after the 3/4/17 incident and the care plan for wandering was not revised since 8/9/2016. The immediate jeopardy is present and ongoing. 5. F323 - Based on record review, observation and staff interview, the facility failed to prevent a cognitively impaired resident from exiting the facility unsupervised (Resident #3) and also failed to prevent a cognitively impaired resident from bed entrapment between the mattress and the foot board (Resident #80). The facility also failed to reassess and to intervene to prevent repeated falls (Resident #3) at a scope and severity of D. These were evident for 2 (Residents #3 and #80) of 3 sampled residents reviewed for accidents. Immediate jeopardy began on 3/4/17 when Resident #3 exited the facility unsupervised. Immediate jeopardy began on 5/1/17, when Resident #80 was caught between the foot board and the mattress causing a bruise to the back of his neck. Immediate jeopardy is present and ongoing.	F 490	policies/procedures. It was also determined the facility systems were not functioning as designed, as evidenced by failure to complete and record preventative maintenance rounds (beds and wheel chairs, room temperatures, security on windows), and failure of the nursing staff to follow through with the unsupervised exit checklists. On 6/9/17, the RVP and administrator directed the initiation of door audits, resident bed audits to include head board and foot boards, room temperature audits, wheelchair/Geri chair audits, door and window security audits to see if other residents had been affected. The results of the audits demonstrated the facility found three beds that were identified as restraints. The maintenance assistants immediately removed the beds from the resident care area. On 6/10/17, the quality improvement (QI) committee members (administrator, DON, QI nurse, MDS nurses, social worker, maintenance assistants) discussed: Abuse/Neglect policy and procedure, elopement prevention interventions, wandering risk assessments, audit and safety of equipment, and effectiveness of the quality improvement program. On 6/12/17, the RVP and clinical director assisted the administrator and DON in the daily clinical meeting. The daily corporate onsite provided it to ensure a systematic approach and effective communication in the review of the accident/incident reports	

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 _____	C 06/09/2017

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

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F 490	Continued From page 197	F 490		

and occurrences from the electronic health record. For the support and supervision of the facility, the corporate nurse consultant has attended the daily clinical meeting to ensure the administrator and DON are identifying a systematic approach in the review and root cause analysis of incidents/accidents.

On 6/12/17, the quality assurance assessment (QAA) Committee members (medical director, administrator, DON, Q/Infection Control Nurse, MDS nurses, social worker, maintenance assistants) met and discussed what went wrong, why, and performed a 5 Whys root cause analysis (RCA) and determined communication as the root cause of system breakdown. The Committee recommended continued in servicing and implementation of the following to ensure the safety of the residents: 1) a newly added structured daily standup meeting, 2) newly structured daily clinical meeting with end of day follow-up, 3) review of the 24 hour report sheets, 4) use of accident and incident reports, 5) maintenance work order process and follow through, 6) care plan meeting attendance, 7) care plan invitations, 8) new informative signage on elopement, 9) notification to family members in regards to facility security for elopement, 10) visitor postcard on safety for elopement provided upon entrance, 11) physician notification procedures, and 12) implementation of wandering board and binders (with resident information).

On 6/10/17, the regional vice president,

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 _____	C 06/09/2017

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

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F 490	Continued From page 198	F 490		

corporate clinical director, and corporate consultants, began providing oversite to the facility and monitoring to ensure the facility has systems in place to provide the leadership and management necessary to meet resident needs by 1) providing adequate resident supervision to prevent unsupervised exits and entrapment, 2) providing an environment as free from accident hazards as is possible, including safe beds, 3) notifying the physician when a resident is involved in an incident/accident, including entrapment or elopement, 4) removing restraints unless there is a physician order with medical symptom, including bed foot boards, 5) revising care plans to promote safety, including inviting residents/resident representatives to care plan meetings.

On 6/23/17, DON, QI nurse, staff facilitator, hall nurse, MDS nurse, social worker, and/or corporate consultant began auditing nurses progress notes and risk management reports in the electronic medical record. The audit is to ensure all interventions are in place to prevent cognitively impaired, wandering residents from unsupervised exit/elopement, to protect residents who fall, and bed entrapment. Any concerns are immediately addressed by the auditor to include reporting to the administrator and/or DON. Beginning on 6/26/17, the audit is documented on the Accident Hazards/Supervision Audit Tool, which covers: 1) if the progress notes were reviewed for incidents/accidents, 2) if the risk management/incident reports were

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 _____	C 06/09/2017

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 490	Continued From page 199	F 490	reviewed for appropriate interventions, 3) if the 24 hour reports were reviewed in the daily clinical meeting, 4) if the maintenance work orders were completed by the maintenance assistant, 5) if preventative maintenance logs are complete. The audit tool will be completed weekly x 3 months, then monthly x 3 months. On 6/23/17, the administrator, DON, QI nurse, MDS registered nurse, and/or corporate facility consultants continued monitoring the facility in-services, questionnaires, wandering boards and books, resident beds, facility exit doors, work orders, and audit tools to validate completion/updates/proper functioning. The administrator and DON also continue to verbally quiz staff (nurses, nursing assistants, dietary, environmental services, therapy, maintenance, social services, bookkeeping, receptionist) to confirm understanding of expectations related to: resident safety, prevention of accidents, code orange for unsupervised exit, reporting of incidents to DON/administrator, notification of physicians and resident representatives, and documentation. On 6/26/17, the corporate regional vice president, corporate consultant, and/or corporate clinical director (Corporate) will begin attending the facility department head meetings, QI meetings, and QAA meetings. The purpose of meeting attendance is to provide additional oversight and guidance. Corporate	

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 _____	C 06/09/2017

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

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F 490	Continued From page 200	F 490	attendance at the facility meetings will occur five times weekly for two weeks, three times weekly for two weeks, twice weekly for four weeks, and at least once weekly for 16 weeks. On 6/26/17, the administrator, regional vice president, and/or corporate clinical director will begin a weekly review of completed audit tools (Accident Hazards/Supervision Audit Tool, Progress Note Audit Tool, Unsupervised Exit Audit Tool, Planning Participation and Revision Audit Tool) to ensure the systems for a safe environment, proper application of devices, staff supervision for resident safety, care planning invitations, and care plan revisions remain in place and are functioning properly. The review will be completed, as indicated by initialing the audit tools, for four weeks to ensure adequate supervision and oversight. The DON, QI nurse, MDS nurse, social worker, and/or the maintenance assistant will present the findings of the audit tools (Accident Hazards/Supervision Audit Tool, Progress Note Audit Tool, Unsupervised Exit Audit Tool, Planning Participation and Revision Audit Tool) at the monthly Quality Improvement Committee meeting. The Quality Improvement Committee will review the results of the audits monthly x 6 months, identify trends, use 5 Whys root cause analysis, and make recommendation for follow-up as needed. The DON, QI nurse, MDS nurse, social worker, and/or maintenance will present	

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 _____	C 06/09/2017

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

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F 490	Continued From page 201	F 490	the findings of the audit tools (Accident Hazards/Supervision Audit Tool, Progress Note Audit Tool, Unsupervised Exit Audit Tool, Planning Participation and Revision Audit Tool) at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. The QAA Committee will review the QI Committee recommendations and facility□s follow-up to the recommendations. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of effective administration/resident well-being.	
F 498 SS=E	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must-	F 498		7/25/17

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 _____	C 06/09/2017

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

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F 498	Continued From page 202 (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide evidence of dementia training for 4 of 4 aides currently employed as nursing assistants (NA). The findings included: The business office manager (BOM) provided a list of all current employees on 6/6/17 at 3:00 PM indicating the following: -NA #2 hire date-11/4/11 -NA #4 hire date- 8/12/14 -NA #9 hire date- 2/19/13 -NA #12 hire date- 6/23/15 In an interview on 6/6/17 at 3:40 PM, NA #2 stated she did not recall any recent in-service or training on the care of residents with dementia. In an interview on 6/6/17 at 3:46 PM, NA #4 stated she normally worked in the secured dementia unit and did not recall any recent in-service or training on the care of residents with dementia. In a telephone interview on 6/8/17 at 11:35 AM, NA #9 stated she did not recall any recent in-service or training on the care of residents with dementia.	F 498	F 498 Proficiency of Nurse Aides On 6/29/17, the director of nursing (DON) began ensuring nurse aides are able to demonstrate competency in skills and techniques necessary to care for resident needs, as identified through resident assessments, and described in the plan of care. On 6/29/17, the consultants initiated Hand in Hand dementia training to nurse aides. This is to be completed for all current nurse aides by 7/25/17 and upon hire for new nurse aides, including agency aides, instructed by the quality improvement (QI) nurse/staff facilitator. The corporate consultants, regional vice President (RVP) and payroll/bookkeeper completed a 100% audit of nurse aide training records to identify who had received the Hand in Hand dementia training. None were found. Beginning 7/3/17, the DON, payroll/bookkeeper, and/or corporate	

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 _____	C 06/09/2017

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

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F 498	Continued From page 203 In an interview on 6/9/17 at 11:40 AM, NA #12 stated she normally worked in the secured dementia unit and did not recall any recent in-service or training on the care of residents with dementia. In an interview on 6/8/17 at 3:05 PM, the Administrator stated she was unaware the staff had not received mandatory in-servicing on dementia and her expectation was that staff be trained upon hire and then annually thereafter on dementia. In an interview on 6/9/17 at 12:30 PM, the Quality Assurance (QA) Nurse stated she started her position January of 2017. She stated her responsibilities included ensuring mandatory in-services for the NA ' s was completed. She stated the facility used a video in-service about working dementia residents. The QA Nurse stated she was still learning her role and provided evidence of the last dementia in-servicing dated 2015 prior to her employment.	F 498	consultants will review the nurse aide training records. 5 nurse aide training records will be reviewed weekly for 4 weeks, 2 times monthly for 2 months to ensure that nurse aides have successfully completed the Hand in Hand dementia training resulting in the ability to demonstrate competency in skills and techniques necessary to care for resident needs. This review will be documented on the Nurse Aide Competency Audit tool. The results of the Nurse Aide Competency Audit tool will be reviewed by the administrator weekly. The QI nurse/staff facilitator or DON will present the audit findings to the monthly QI Committee for 3 months for further recommendations, take action as appropriate, and to monitor continued compliance. The QI nurse/staff facilitator or DON will present the audit findings and the progress made with the QI Committee's recommendations to the quarterly Quality Assurance and Assessment (QAA) Committee for 1 quarter. The QAA Committee will perform additional root cause analysis as needed and make recommendations for sustaining regulatory compliance in the area of nurse aide competency.	
F 516 SS=E	483.20(f)(5)(i)(ii); 483.70(i)(3) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS 483.20(f)(5) Resident-identifiable information.	F 516		7/17/17

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 _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 516	Continued From page 204 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical records in a secure location. The findings included: On 6/8/17 at 4:35 PM, a tour of the storage area that contained resident medical records was conducted with the Director of Nursing. It was observed that the medical records were stored in a wooden storage building outside the facility in the middle of the lawn in an unsecured area. The building could be locked but was left unlocked without any staff present. The medical records were in cardboard boxes; notebooks were stacked on top of the boxes. It could not be determined what years were being stored because, when the door of the storage building was opened, a large swarm of wasps exited the building. The Director of Nursing stated she expected the building to be locked. On 6/8/17 at 4:44 PM, an interview was conducted with the Administrator who stated she expected medical records to be secured with a lock at all times. She stated they did a tour about	F 516	F 516 Safeguard of Clinical Records On 06/09/17, the maintenance staff secured and locked the medical records storage building. On 6/30/17, the maintenance worker installed a new hasp and lock on the medical records storage building. On 06/12/17, the administrator, maintenance worker, and regional vice president (RVP) worked with the corporate office and determined to acquire bids for repair or replacement of the medical records storage building. On 06/29/17, the administrator and director of nursing were in-serviced by the RVP. The in-service covered safeguarding clinical records information against loss, destruction or unauthorized use. On 06/30/17, the facility had one estimate	

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 _____	C 06/09/2017

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

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F 516	Continued From page 205 3 weeks ago and the maintenance supervisor was supposed to get bids for new buildings.	F 516	and was awaiting another estimate for repair or replacement of the medical records storage unit. On 06/30/17, the administrator, maintenance worker, RVP, and/or corporate consultant will conduct one audit per week for 4 weeks then one time monthly for 2 months to ensure the medical records storage unit is secured and locked to prevent loss, destruction, or unauthorized use. The audit will be documented on the Safeguard Clinical Record Audit tool. The administrator or maintenance worker will present the findings of the Safeguard Clinical Record Audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly x 3 months, identify trends, use 5 Whys root cause analysis, and make recommendation for follow-up as needed.	
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		7/25/17

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 _____	C 06/09/2017

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

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F 520	Continued From page 206 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility's Quality Assessment and Assurance Committee failed to determine a root cause analysis in relation to elopement and bed entrapment. Resident #3 exited the facility unsupervised on 3/4/17 and the facility failed to investigate the root cause and to develop plan of action to prevent further unsupervised exits. Resident #80 was observed with his head	F 520	F 520 QAA On 6/9/17, the Quality Improvement Committee Chairperson/administrator reviewed with the regional vice president (RVP) and corporate clinical director the identified areas of concern from the complaint/annual survey that lead to the deficient practices for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 207 entrapped between the bed's mattress and the foot board and the facility failed to investigate the root cause and to develop plan of action to prevent further bed entrapment. This was evident for 2 of 3 sampled residents reviewed for accidents (Resident #3 and Resident #80.) Immediate jeopardy began on 3/4/17 when Resident #3 exited the facility unsupervised and was found by Nurse #1 few feet away from a road. Immediate jeopardy began on 5/1/17 when Resident #80 was found in bed with his head entrapped between the mattress and the foot board resulting in a bruise to the back of his neck. The immediate Jeopardy is present and ongoing. This tag is cross referenced to: 1. F323 - Based on record review, observation and staff interview, the facility failed to prevent a cognitively impaired resident from exiting the facility unsupervised (Resident #3) and also failed to prevent a cognitively impaired resident from bed entrapment between the mattress and the foot board (Resident #80.) These were evident for 2 (Resident #3 and Resident #80) of 3 sampled residents reviewed for accidents. Immediate jeopardy began on 3/4/17 when Resident #3 exited the building unsupervised. Immediate jeopardy began on 5/1/17 when Resident #80's head was found caught between the foot board and the mattress causing a bruise to the back of neck.	F 520	recommendation and immediate protection of residents. On 6/10/17, the RVP in-serviced the department heads (director of nursing, minimum data set nurses, treatment nurse, quality improvement/infection control nurse, maintenance director, dietary manager, social worker, medical records, dietary manager and contract housekeeping manager) related to the appropriate functioning of the Quality Assurance Assessment Committee (QAA) and the purpose of the committee to include identifying issues related to quality assessment and assurance activities and in the development and implementation of plans of action for identified facility concerns. On 6/12/17, the Quality Improvement (QI) Committee members (administrator, director of nursing, quality improvement nurse, minimum data set nurses, social worker, maintenance assistants) met and discussed what went wrong, why, and performed a 5 Whys root cause analysis (RCA). Using the RCA process, the QI Committee identified communication as a root cause in the deficient practice areas of: 1) resident neglect, 2) revising care plans, 3) preventing entrapment, 4) preventing elopement, 5) supervision, 6) administration, and 7) Quality Assurance and Assessment Committee. The Committee further implemented immediate in-services, observations, and monitoring tools for the protection and safety of the residents.	

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F 520	Continued From page 208 Immediate jeopardy is present and ongoing. 2. F224 - Based on record review, observation and staff interview, the facility neglected to supervise a cognitively impaired resident who was identified as a wanderer which resulted in an unsupervised exit from the facility for 1 of 3 sampled residents reviewed for accidents (Resident #3). Resident #3 was found a few feet to the road heading towards a busy highway. Resident #3 had to go through a parking lot to get to the road. Immediate jeopardy began on 3/4/17 when Resident #3 exited the building unsupervised. Immediate jeopardy is present and ongoing. 3. F221 - Based on record review, observation and staff interview, the facility utilized a device (foot board) in bed without considering it to be a restraint and without a medical symptom. Resident #80's head was caught between the bed's mattress and the foot board causing a bruise to the back of the resident's neck. This was evident for 1 of 3 sampled residents reviewed for accidents. (Resident #80). Immediate jeopardy began on 5/1/17 when Resident #80 was found with his head entrapped between the mattress and the foot board causing a bruise to the back of the resident's neck. The immediate Jeopardy is present and ongoing. Interview with the Quality Assurance (QA) Nurse was conducted on 6/8/17 at 2:40 PM. She stated that she started as a QA Nurse in March 2017. She stated that she had no guidance or training regarding QA but she was learning. She stated that she had not identified the use of the foot	F 520	Findings and results of the QI tools will be reviewed during the monthly QI Committee and the quarterly QAA Committee meeting for 6 months. The QI and QAA Committees will focus on improving resident care through development and implementation of communication processes. As identified through root cause analysis and the utilization of the cause and effect process, the committee will assist the facility management in uncovering the real causes for resident care process failures. These failures include: 1) resident neglect, 2) revising care plans, 3) preventing entrapment, 4) preventing elopement, 5) supervision, 6) administration, and 7) QAA. The monthly QI committee will review the results of the bed audit tools, Federal Drug Administration Entrapment measurement tools, care plan updates and implementation, restraint audits, accident reports, and exit door audits. These audits will be reviewed monthly for 6 months for the identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring. The QI committee will make recommendations to the administrator and DON to ensure sustained compliance. The administrator and/or DON will present the committee findings and recommendations of the monthly QI committee to the quarterly Quality Assurance Assessment (QAA) committee for further recommendations and	

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F 520	Continued From page 209 board as a restraint or accident hazard. She added she didn't have any monitoring tools to monitor falls or elopement. She further indicated that they discussed incident report during the morning meeting but she didn't remember what happened after that. The administrator and the DON were notified of immediate jeopardy on 6/7/17 at 1:23 PM for Resident #3 and on 6/8/17 at 12:06 PM for Resident #80. 3. The facility failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey 6/2/16 in the area of resident Assessment at F278. In the area of Quality of Care, F312 was recited and in the area of Nursing Services, F353 pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. Findings included: This tag is cross referenced to: 1. F278-D: Based on record review, observations, and staff interview and resident interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of dental and diagnoses for 2 (Resident #71 and Resident #100) 22 MDS ' s reviewed for accuracy. During the recertification survey of June 2016 the facility was cited for F278 for failing to accurately code catheter use, bed mobility, toilet use, eating status, and restraint use for sampled residents. On the current survey the facility was recited for	F 520	oversight. The QAA committee meeting agenda, resulting plans of corrections, and audit results will be documented in the meeting minutes. The administrator will be responsible for ensuring QAA committee concerns are addressed and recommendations followed. The administrator or DON will report back to the QAA committee at the next scheduled quarterly meeting. On 6/18/17, the RVP contacted the Quality Improvement Organization (QIO), Raleigh, NC office to request a consultation to provide guidance and help with the QI/QAA process and assist in the identification of further areas in quality improvement systematic failures. On 7/13/17, the administrator, director of nursing, and corporate consultant met at the facility with the QIO and received a consultation, reference materials, and discussed additional quality improvement measures. The administrator will present the QIO consultation information at the next QI and QAA Committee meetings. On 6/10/17, the regional vice president (RVP), corporate clinical director, and corporate consultants (Corporate), began providing oversight to the facility and monitoring to ensure the facility has systems in place for quality assessment and assurance (QAA) that will develop and implement appropriate plans of action to correct identified quality deficiencies. On 6/14/17, the QAA Committee met. The	

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F 520	Continued From page 210 failure to accurately code areas of dental care and diagnoses on MDS ' s. 2. F312-D: Based on observations, staff and resident interviews and record review, the facility failed to provide resident showers as scheduled for 1 (Resident #37) of 5 residents who required staff assistance with bathing and reviewed for activities of daily living (ADLs.) During the recertification survey of June 2016 the facility was cited for failure to provide nail care to a resident. On the current survey the facility was recited for failure to provide showers to a dependent resident. 3. F353-D: Based on observations, resident interview, staff interviews and record review, the facility failed to provide sufficient staff to provide showers as scheduled for residents who required staff assistance with bathing for 1 (Resident #37) of 5 residents reviewed for activities of daily living (ADLs.) During the recertification survey of June 2016 the facility was cited for failure to provide sufficient nursing staff to meet the needs of resident in the area of restorative nursing. On the current survey the facility was recited for failure to provide sufficient staff to complete showers for a dependent resident. In an interview on 6/8/17 at 3:05 PM, the Administrator stated her expectation was for the Quality Assurance Nurse to have focused on the areas identified on the last survey of record, monitored for effectiveness if the implemented interventions, and notified her if there was evidence on continued noncompliance in those areas.	F 520	medical director, administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, hall nurse, nursing assistant, maintenance director, social worker, medical records, activities, dietary manager, therapy manager, and environmental services supervisor will attend quarterly QAA Committee meetings on an ongoing basis and will assign additional team members as appropriate. Using the 5 Whys root cause analysis process, the QAA Committee was able to determine communication is a key factor in the deficient practice areas of 1) physician and resident representative notification, 2) unnecessary restraints/entrapment, 3) resident neglect/unsupervised exits, 4) participation in care planning, 5) accidents/falls, 6) administration, 7) QAA purpose, process, and failure. On 6/19/17, the regional vice president and administrator contacted the Quality Improvement Organization (QIO) to request assistance with the QAA process. On 7/13/17 the administrator, DON, QI nurse, and Corporate are scheduled to meet with the QIO for consultation. On 6/23/17, the administrator, DON, QI nurse, MDS registered nurse, and/or corporate facility consultants continued monitoring the facility in-services, questionnaires, wandering boards and books, resident beds, facility exit doors, work orders, and audit tools to validate completion/updates/proper functioning. The administrator and DON also continue	

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F 520	Continued From page 211 In an interview on 6/9/17 at 12:30 PM, the Quality Assurance Nurse stated the committee met based on needed actions and they had no tool to identify and problems. She stated she was new to her position and she was not aware of any focus on the previously cited tags at F278, F312 and F353.	F 520	to verbally quiz staff (nurses, nursing assistants, dietary, environmental services, therapy, maintenance, social services, bookkeeping, receptionist) to confirm understanding of expectations related to: resident safety, prevention of accidents, code orange for unsupervised exit, reporting of incidents to DON/administrator, notification of physicians and resident representatives, and documentation. The monitoring revealed the facility wander guard system required additional maintenance which was completed on 7/13/17, Hand-In-Hand training needs completion by current staff and is being provided to new hires by the QI nurse, and quizzing of staff confirms understanding of expectations. On 6/26/17, the corporate regional vice president, corporate consultant, and/or corporate clinical director (Corporate) will begin attending the facility department head meetings, QI meetings, and QAA meetings. The purpose of meeting attendance is to provide additional oversight and guidance. The regional vice president or corporate clinical director will aide in facilitating the QI and QAA Committees root cause analysis process. Corporate attendance at the facility meetings will occur five times weekly for two weeks, three times weekly for two weeks, twice weekly for four weeks, and at least once weekly for 16 weeks. On 6/26/17, the regional vice president in-serviced the Quality Improvement (QI)	

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F 520	Continued From page 212	F 520	Committee (administrator, DON, QI nurse, MDS nurses, treatment nurse, maintenance assistants, social worker, activities, medical records, dietary manager, therapy manager, environmental services supervisor) related to the appropriate functioning of the QI and QAA Committees and the purpose of the committees to include identifying issues related to quality improvement, quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. As of 6/26/17, the DON, QI nurse, MDS nurse, social worker, and/or the maintenance assistant will present the findings of the audit tools (Accident Hazards/Supervision Audit Tool, Progress Note Audit Tool, Unsupervised Exit Audit Tool, Planning Participation and Revision Audit Tool) at the monthly Quality Improvement Committee meeting. The Quality Improvement Committee will review the results of the audits monthly x 6 months, identify trends, use 5 Whys root cause analysis, and make recommendation for follow-up as needed. As of 6/26/17, the monthly QI Committee began identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern log.	

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F 520	Continued From page 213	F 520	The quarterly Executive QAA Committee, to include the medical director, will meet at a minimum of quarterly. The quarterly Executive QAA Committee, including the medical director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The DON, QI nurse, MDS nurse, social worker, and/or maintenance will present the findings of the audit tools (Accident Hazards/Supervision Audit Tool, Progress Note Audit Tool, Unsupervised Exit Audit Tool, Planning Participation and Revision Audit Tool) at the quarterly Quality Assessment and Assurance (QAA) Committee meeting. Findings and results of the QI tools will be reviewed by the monthly QI committee and the quarterly QAA committee meeting for 6 months. The QI and QAA committees will focus on improving resident care through developing communication processes. As recommended by QIO, utilization of the cause and effect (fishbone) diagram and 5 Whys Root Cause Analysis (RCA) will help the facility uncover the real causes for systemic breakdown including: 1) physician and resident representative notification, 2) unnecessary restraints/entrapment, 3) resident neglect/unsupervised exits, 4) participation in care planning, 5) accidents/falls, 6) administration, 7) QAA purpose, process, and failure.	

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F 520	Continued From page 214	F 520	The QAA Committee will review the QI Committee recommendations and facility□'s follow-up to the QI Committee'□s recommendations. The QAA Committee will validate the facility□'s progress in correction of deficient practices or identify concerns. The QAA Committee will perform additional root cause analysis as needed, make additional recommendations, and provide oversight. The quarterly Executive QAA Committee meeting agenda, resulting plans of corrections, and audit results will be documented in the meeting minutes. The administrator will be responsible for ensuring QAA Committee concerns and recommendations are addressed through further training or other interventions so that newly implemented process are sustained to maintain regulatory compliance in the area of effective administration/resident well-being. The administrator will report back to the Executive QAA Committee at the next scheduled quarterly meeting.	