STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345293	A. BUILDING: _____ B. WING _____	6/9/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION	HIGHWAY 177 S BOX 1489 HAMLET, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 507	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS

(a) Laboratory Services

(2) The facility must-

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to have copies of completed laboratory blood work available in the medical record for 1 of 6 residents reviewed for unnecessary medications (Resident #135). 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 4/18/17 revealed an order for CBC (complete blood count - this involves obtaining a blood sample which is then tested and can indicate signs of infection and other health concerns) and CMP (comprehensive metabolic panel - this involves obtaining a blood sample which is then tested and can be used to monitor kidney function and electrolyte balance as well as other health concerns) in the morning.

Review of resident ' s electronic and hard copy medical records from 4/3/17 through her discharge on 5/13/17 revealed the CBC and CMP laboratory reports that were ordered to be completed on 4/19/17 were not present in Resident #135 ' s medical record.

On 6/8/17 at 3:15 PM the Director of Nursing (DON) was interviewed and indicated she would attempt to locate a copy of the 4/19/17 CBC and CMP laboratory reports.

On 6/8/17 at 5:46 PM the DON stated that she had been able to print a copy of the completed 4/19/17 laboratory reports for Resident #135.

On 6/8/17 at 6:00 PM the DON provided a copy of the 4/19/17 laboratory reports for Resident #135. The DON added that when the results were received, abnormal results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 laboratory reports for Resident #135 were not in her medical record.

On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 507

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worked on first shift (7:00 AM - 3:00 PM) on Resident #135 ' s hall and did recall the resident but did not recall if she was one of the Nurses who handled the resident ' s laboratory reports. She stated that laboratory reports were faxed to the facility and the hall nurse on duty would get them from the fax machine and put them in the doctor ' s box for review. She added that if there were abnormal results the nurse would call the physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician came to the facility twice a week and after the laboratory report was reviewed and signed by him, it was placed in a box for filing, then was filed in the medical record. Nurse #6 stated that it was her practice to file the physician reviewed laboratory reports in the medical record herself but added that there used to be a Unit Manager that would take care of having the reviewed laboratory reports filed. She stated they had not had a Unit Manager in about 6 weeks.

F 513

483.50(b)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED

(b) Radiology and other diagnostic services.

(2) The facility must-

(iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to have copies of a completed chest x-ray available in the medical record for 1 of 6 residents reviewed for unnecessary medications (Resident #135). 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 4/18/17 revealed an order for repeat chest x-ray.
Review of resident ' s electronic and hard copy medical records from 4/3/17 through her discharge on 5/13/17 revealed the report of the chest x-ray ordered on 4/18/17 was not present in Resident #135 ' s medical record.

On 6/8/17 at 3:15 PM the Director of Nursing (DON) was interviewed and indicated she would attempt to locate a copy of the x-ray report.

On 6/8/17 at 5:46 PM the DON stated that she had not been able to print a copy of the completed chest x-ray report for Resident #135 but that x-ray had been completed. She added that she was in contact with the x-ray services provider company to find a way to print the report and put it on the resident ' s medical record.

On 6/8/17 at 5:55 PM interview with the x-ray services provider Supervisor revealed that the chest x-ray was completed on 4/19/17 and the report was faxed to the facility at 10:59 AM that day. The DON attempted to print of the results of the chest x-ray at this time according to the service provider Supervisors instructions but was unable to do so. The chest x-ray report was then refaxed by the service provider Supervisor.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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On 6/8/17 the DON was interviewed and stated that when x-ray results were received at the facility, abnormal results were called to the physician for orders as needed and that all the reports were reviewed by the Physician when he came to the facility. The DON said that when the Physician reviewed the reports he would sign that he reviewed them and possibly write a note or order on it. She stated that after review by the physician the reports were again reviewed by the nurse for implementation of new orders and then scanned into the electronic medical record by the Medical Records staff person. She did not know why the 4/19/17 chest x-ray for Resident #135 was not in her medical record.

On 6/9/17 at 5:35 PM a telephone interview was conducted with Nurse #6. She indicated that she had worked on first shift (7:00 AM - 3:00 PM) on Resident #135 ' s hall and did recall the resident but did not recall if she was one of the Nurses who handled the resident ' s 4/19/17 chest x-ray report. She stated that x-ray reports were faxed to the facility and the hall nurse on duty would get them from the fax machine and put them in the doctor ' s box for review. She added that if there were abnormal results the nurse would call the physician to report them and to receive any new orders as determined by the Physician. Nurse #6 said that the Physician came to the facility twice a week and after the x-ray report was reviewed and signed by him, it was placed in a box for filing, then was filed in the medical record. Nurse #6 stated that it was her practice to file the physician reviewed x-ray reports in the medical record herself but added that there used to be a Unit Manager that would take care of having the reviewed x-ray reports filed. She stated they had not had a Unit Manager in about 6 weeks.