STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of [DIAGNOSES REDACTED].# 42 & # 66), falls (Resident # 11), Nutrition (Resident # 20 & #19), hospice (Resident #76) and PASRR level II (Resident #59) for 7 of 25 sampled residents reviewed. Findings included: 1a. Resident # 59 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The doctor's progress note dated 3/25/19 revealed Resident #59 had a past medical history of [REDACTED]. The quarterly MDS assessment dated [DATE] indicated that Resident #59's cognition was intact, and she had an active [DIAGNOSES REDACTED]. She stated that Resident #59 had Chronic [MEDICAL CONDITIONS] was not currently getting treatment for [REDACTED]. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the MDS Nurse had been working at the facility as MDS Nurse for 1 and years. She indicated that the MDS Nurse was still learning MDS, but she expected the MDS assessments to be coded accurately. b. Resident # 59 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident #59 was evaluated on 2/5/18 for Preadmission Screening and Resident Review (PASRR) level II and was reevaluated on 2/11/19 due to mental illness. The annual MDS assessment dated [DATE] indicated that Resident #59 was a PASRR level II and was not related to mental illness. On 7/13/20 at 2:45 PM, the Social Worker was interviewed. She stated that Resident #59 was a PASRR level II due to mental illness. On 7/15/20 at 1:12 PM, the MDS Nurse was interviewed. She verified that Resident #59 was a PASRR level II due to mental illness. The MDS Nurse stated that she coded the 3/27/20 annual MDS inaccurately. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the MDS Nurse had been working at the facility as MDS Nurse for 1 and years. She indicated that the MDS Nurse was still learning MDS, but she expected the MDS assessments to be coded accurately. 2. Resident #11 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].#11 had severe cognitive impairment and had 2 or more falls with no injury since admission /reentry or prior assessment. The incident report and nurse's note dated 3/6/20 at 7:50 PM indicated that Resident #11 had told the nurse aide that she had a fall in the bathroom. She was found to have a small hematoma to her left eye and had a goose egg above left eye. The doctor and the responsible party (RP) were notified. an order for [REDACTED].#11 sustained hematoma on her left eye and the MDS dated [DATE] should have been coded as fall with injury but it was not. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the MDS Nurse had been working at the facility as MDS Nurse for 1 and years. She indicated that the MDS Nurse was still learning MDS, but she expected the MDS assessments to be coded accurately. 3. Resident #66 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #66 had severe cognitive impairment and had received an antibiotic drug for 5 days during the assessment period. The assessment further indicated that Resident #66 did not have a [DIAGNOSES REDACTED].#66 had an active [DIAGNOSES REDACTED].) twice a day for 5 days for UTI. The Medication Administration Record [REDACTED]. On 7/15/20 at 1:13 PM, the MDS Nurse was interviewed. She verified that Resident #66 was admitted from the hospital on [DATE]. The resident was admitted with an order for [REDACTED]. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the MDS Nurse had been working at the facility as MDS Nurse for 1 and years. She indicated that the MDS Nurse was still learning MDS, but she expected the MDS assessments to be coded accurately. The DON further indicated that since Resident #66 had received an antibiotic for UTI during the assessment period, the MDS dated [DATE] should have been coded for UTI under active diagnosis. 4. Resident #20 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident # 20 had moderate cognitive impairment and had received [MEDICATION NAME]/intravenous (IV) feeding during the last 7 days while a resident at the facility. The Medication Administration Records (MARs) for 4/2020 were reviewed. The MARs revealed that Resident #20 had received tube feeding but not [MEDICATION NAME]/IV feeding. On 7/15/20 at 1:13 PM, the MDS Nurse was interviewed. She verified that Resident #20 was receiving tube feeding. The MDS Nurse stated that the 4/28/20 quarterly MDS assessment under nutritional status, the [MEDICATION NAME]/IV feeding was coded incorrectly. She indicated that the resident did not receive [MEDICATION NAME]/IV feeding during the assessment period. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the MDS Nurse had been working at the facility as MDS Nurse for 1 and years. She indicated that the MDS Nurse was still learning MDS, but she expected the MDS assessments to be coded accurately. 5. Resident # 42 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The hospital discharge summary dated 9/18/18 indicated that Resident #42 had [DIAGNOSES REDACTED].# 42 had moderate cognitive impairment and had active [DIAGNOSES REDACTED]. She stated that Resident #42 had Chronic [MEDICAL CONDITIONS] was not currently getting treatment for [REDACTED]. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the MDS Nurse had been working at the facility as MDS Nurse for 1 and years. She indicated that the MDS Nurse was still learning MDS but she expected the MDS assessments to be coded accurately. 6) Resident #76 was originally admitted to the facility on [DATE] and was discharged from the facility on 2/13/2020. His [DIAGNOSES REDACTED]. A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was marked with an active [DIAGNOSES REDACTED]. A review of the resident's care plan indicated on 2/17/2020 a revision was made to include resident #76 received Hospice care for [MEDICAL CONDITION]. During an interview with the MDS Nurse on 7/16/2020 at 9:50 AM, she confirmed she was aware the resident had received Hospice care and Hospice was not marked on the MDS assessment dated [DATE]. She stated it was an oversight. An interview was conducted with the Director of Nursing on 7/16/2020 at 11:30 AM, and stated it was her expectation for the MDS to be coded accurately. 7a) Resident #19 was originally admitted to the facility 10/12/18 with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was coded for weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. Resident #19's weight data revealed the following weights during the MDS assessment look back period of November 2019 to April 2020, which showed a 3.52% weight loss in a month and a 0.52% weight loss in 6 months: 4/16/2020 192 lbs. 3/10/2020 199 lbs. 11/4/19 193 lbs. On 7/16/2020 at 9:50 AM, an interview was conducted with the MDS Nurse who stated the Dietary Manager coded the nutrition section of the MDS assessment. An interview occurred with the Dietary Manager on 7/16/2020 at 10:15 AM. She reviewed the nutrition area on the 4/23/20 MDS and weight data, indicated it was coded incorrectly and should not have been coded as a weight loss. During an interview with the Director of Nursing on 7/16/2020 at 11:30 AM, she indicated it was her expectation for the MDS to be coded accurately. 7b) Resident #19 was originally admitted to the facility 10/12/18 with [DIAGNOSES REDACTED]. Review of Resident #19's active care plan dated 4/22/2020 revealed a care plan in place for nutrition and fluids via the PEG tube due to dysphagia and nothing by mouth (NPO) status. Appropriate goals and interventions were present. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had severe cognitive impairment and required total assistance from staff for fluid intake through the PEG tube (Percutaneous Endoscopic Gastrostomy- a way of receiving nutrition and fluids) She was coded as receiving 500 milliliters (ml) or less of fluid intake per day by the PEG tube. A review of the April 2020 physician orders [REDACTED]. On 7/16/2020

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

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) at 9:50 AM, an interview was conducted with the MDS Nurse who stated the Dietary Manager coded the nutrition section of the MDS. An interview occurred with the Dietary Manager on 7/16/2020 at 10:15 AM. She reviewed the nutrition area on the 4/23/20 MDS and stated the 500 ml or less of fluids through the PEG tube was marked in error and should have been 501 ml or more per day. During an interview with the Director of Nursing on 7/16/2020 at 11:30 AM, she indicated it was her expectation for the MDS to be coded accurately.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a comprehensive care plan in area of hospice for 1 of 4 residents (Resident #15) reviewed for hospice care. The findings included: Resident #15 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's order [REDACTED].#15 indicated a hospice consultation was to be conducted. An admission form for hospice care indicated Resident #15 was admitted on [DATE]. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 ' s cognition was severely impaired. He was noted with a prognosis of less then 6 months and was on hospice. Resident #15 ' s active care plan was reviewed on 7/16/20 at 8:00 AM. There was no care plan in place related to hospice care. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 10:13 AM. The ADON confirmed Resident #15 was on hospice care since 4/16/20. The active care plan for Resident #15 was reviewed with the ADON. The ADON provided a newly initiated care plan for Resident #15, dated 7/16/20, with the focus area of hospice care due to a terminal illness. She verified there was no care plan in place related to hospice care for Resident #15 prior to 7/16/20. She reported that care plans were able to be developed by herself, the Director of Nursing (DON), the MDS Nurse, as well as the Unit Managers. The ADON was unable to explain why a care plan related to hospice care had not been developed for Resident #15 prior to 7/16/20. An interview was conducted with the MDS Nurse on 7/16/20 at 11:20 AM. The MDS Nurse confirmed Resident #15 was on hospice care since 4/16/20. She verified the ADON ' s interview that indicated there was no care plan in place related to hospice care for Resident #15 prior to 7/16/20. She reported that normally, she initiated a hospice care plan when she completed the significant change MDS assessment related to the hospice admission. The MDS Nurse was unable to explain why she had not developed a hospice care plan for Resident #15 when the 4/21/20 significant change MDS assessment was completed. During an interview with the DON on 7/16/20 at 11:30 AM she indicated that a care plan was expected to be developed for any resident who was on hospice care.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to revise the care plan in the area of range of motion for 1 (Resident # 42) of 3 sampled residents reviewed for limitation in range of motion (ROM). Findings included: Resident #42 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS assessment dated [DATE] indicated that Residents #42 had moderate cognitive impairment and had limitation in range of motion on both sides of upper and lower extremities. On 5/28/20, Resident #42 had a doctor's order for Occupational Therapy (OT) to evaluate and treat as indicated. The OT note dated 5/28/20 revealed that Resident #42 was referred due to decline in ROM and high risk of worsening contractures, exhibits decreased shoulder flexion, shoulder abduction, elbow extension and hand extension. He had increased tone in his bilateral wrist and may benefit from change of splints or splint adjustment for greater wrist extension and improved positioning. Review of Resident #42's care plan dated 6/3/20 was conducted. One of the care plan problems was resident at risk for limitation in range of motion in lower extremities. The goal was to have no further limitation in ROM in lower extremities by the next review. The approaches included splint to left elbow and bilateral hands as resident tolerates by restorative aide/nursing aide. On 7/13/20 at 2:08 PM, Resident #42 was observed lying in bed. He was not wearing a splint on his left elbow and on his bilateral hands. On 7/13/20 at 2:10 PM, the Restorative Nursing Aide (RNA) was interviewed. The RNA stated that Resident #42 was not on her case load for splinting. She stated that the resident was picked up by the Occupational Therapist (OT) sometime in May 2020 and restorative nursing was no longer responsible for the application of the splints. On 7/15/20 at 1:13 PM, the MDS Nurse was interviewed. She verified that OT had picked up Resident #42 in May 2020 and when the OT was working with the resident, restorative nursing was not responsible for the splint application. The MDS Nurse stated that she should have removed the splint application from the care plan. On 7/16/20 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that Resident #42 was picked up by OT in May 2020 and the MDS assessment was completed on 6/3/20, she expected the care plan to have been reviewed and revised by removing the splint application by restorative aide/nursing aide from the care plan
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff and physician interviews, the facility failed to transcribe admission orders [REDACTED]. The findings included: Resident #22 was originally admitted to the facility on [DATE] with the most recent readmission date of [DATE]. His [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #22 had severe cognitive impairment and required total assistance from staff for toileting. An indwelling catheter was present. The hospital discharge summary dated 7/7/2020 was reviewed and indicated in the Details of Inpatient Stay section to change the suprapubic urinary catheter in one month. The admission orders [REDACTED]. Resident #22's current MAR and Treatment Administration Records (TAR) dated 7/7/20 to 7/31/20 were reviewed and no entry was noted to change the suprapubic catheter in one month. On 7/16/2020 at 9:10 AM, an interview occurred with the Assistant Director of Nursing (ADON) who signed the admission orders [REDACTED]. The ADON explained when she reviewed the discharge orders, she looked at the diagnoses, discharge medication list and outpatient follow-ups, and normally didn't read the whole summary for any other instructions. She verbalized it was an oversight and should have been transcribed to the current MAR or TAR. The ADON further stated normally she or the Staff Development Coordinator reviewed the transcribed admission orders [REDACTED]. Nurse #1 further stated she overlooked it as it was in the details of the hospital stay section and she should have reviewed the entire summary for other instructions that may have been present. On 7/16/2020 at 11:00 AM, the Medical Director was interviewed and stated when he assessed new admissions or readmissions, he reviewed the entire hospital discharge summary as he would often find other instructions throughout the summary. The Medical Director added he would expect the nursing staff to review the entire hospital discharge summary for orders/instructions. The Director of Nursing was interviewed on 7/16/2020 at 11:30 AM and reported she expected the admission orders [REDACTED]
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and resident and staff interview, the facility failed to assess the resident prior to the use of the side rails and then quarterly for 1 of 2 sampled residents reviewed for side rail use (Resident #11). Findings included: Resident #11 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].#11 had severe cognitive impairment and had 2 or more falls with no injury since admission /reentry or prior assessment. Review of the nurse's notes and incident reports revealed that Resident #11 had a fall on 3/6/20 and 3/19/20. The care plan was reviewed. Resident #11 had a care plan initiated on 3/20/20 for the use of the side rails. The problem was use of bed rails for increasing or maintaining current bed mobility or transfer ability, safety in transfers-bilateral quarter rails. The approaches included to assess resident for risk of entrapment from bed rails periodically and as necessary and to evaluate

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) use of the device periodically for continued effectiveness and appropriateness. On 7/13/20 at 2:03 PM, Resident #11 was observed lying in bed with bilateral quarter rails in the up position. The resident stated that she used it for turning from side to side. On 7/15/20 at 1:13 PM, the MDS Nurse was interviewed. The MDS Nurse stated that she didn't remember why the side rails were used for Resident #11 on 3/20/20. On 7/16/20 at 8:50 AM, the Administrator was interviewed. She stated that Resident #11 had a fall on 3/19/20 and the care plan for the side rails was initiated on 3/20/20. She reported that the Nurse should have evaluated/assessed the resident prior to the use of the side rails. On 7/16/20 at 8:52 AM, the Director of Nursing (DON) was interviewed. She stated that Resident #11 was assessed for the need of the side rails on 7/15/20, and she did not need them, so they were removed from her bed. The DON further stated that the nurse on 3/20/20 should have completed a side rail assessment for the resident prior to use. On 7/16/20 at 8:55 AM, Nurse # 1, assigned to Resident #11 on 3/20/20, was interviewed. She stated that a Physical Device assessment should be completed prior to the use of side rails. Nurse #1 indicated that she didn't know why the Physical Device assessment was not completed for Resident #11 prior to the use of the side rails. On 7/16/20 at 11:05 AM, a follow interview with the DON was conducted. The DON stated that she expected the nurses to complete the side rails assessment prior to use and then quarterly.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff, hospice staff, Consultant Pharmacist, Medical Director (MD) and Hospice Medical Director interviews and record review, the Consultant Pharmacist failed to identify and address as needed (PRN) [MEDICATION NAME] orders that were not time limited in duration (Residents #40, #32, #60, #15) for 4 of 4 residents reviewed for hospice. The facility also failed to act upon Pharmacy Consultant recommendations to complete an Abnormal Involuntary Movement Scale (AIMS) for 1 of (Resident #59) 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #40 was admitted on [DATE] with cumulative [DIAGNOSES REDACTED]. Resident #40's revised care plan dated 2/20/20 read he was on hospice care due to a terminal illness. Resident #40's March 2020 Physician orders [REDACTED]. Resident #40's Medication Administration Records (MAR) from March 2020 to July 16, 2020 reveal he last received an [MEDICATION NAME] dose on 3/10/20. A monthly Pharmacist Consultant Progress Note dated 3/24/20 read a medication regimen review was completed with no recommendations. A monthly Pharmacist Consultant Progress Note dated 4/18/20 read a medication regimen review was completed with no recommendations. A monthly Pharmacist Consultant Progress Note dated 5/16/20 read a medication regimen review was completed with no recommendations. A monthly Pharmacist Consultant Progress Note dated 6/20/20 read a medication regimen review was completed with a recommendation to nursing. The Consultant Pharmacist's Medications Regimen Review note for nursing dated 6/20/20 read for nursing to consider discontinuation PRN orders per the automatic stop order policy. This recommendation included [MEDICATION NAME]. It further read that discontinuing PRNs that have not been used may prevent medications from going out of date, free up medication cart storage and save the payor money. The follow through response read that the [MEDICATION NAME] was a hospice order for comfort care. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. She stated the Consultant Pharmacist Physician Recommendations were given to the MD every month and she followed up with the MD to make sure they were addressed. She stated she reviewed the Medication Regimen Review notes and addressed any nursing concerns identified. She stated she wrote the follow through response on the Consultant Pharmacist's Medications Regimen Review note dated 6/20/20. The ADON stated Resident #40's PRN [MEDICATION NAME] was prescribed by hospice and she was not aware that PRN [MEDICATION NAME] had to be time limited in duration and reassessed by the Physician. A telephone interview was conducted with Consultant Pharmacist #1 on 7/16/20 at 8:54 AM. She stated she was new to the facility and that she had discussed at length the PRN antianxiety medications time limited duration with the facility. Consultant Pharmacist #1 confirmed she did not complete a Physician Recommendation on 3/24/20, 4/18/20 and 5/18/20. She stated she noted Resident #40's PRN [MEDICATION NAME] orders in her Medication Regimen Review notes to be addressed by nursing by using the automatic stop policy to streamline the process in an effort not to bother the prescribing Physician. The facility's automatic stop order policy revised on 4/15/11 did not include [MEDICAL CONDITION] medications. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He stated he was aware that [MEDICATION NAME] had to be time limited in duration then re-evaluated for the continued use. He stated he not received any Physician Recommendations regarding Resident #40's PRN [MEDICATION NAME]. He stated he received Physician Recommendations from his other facilities but not from this facility. He stated the Physician Recommendations were triggered by the Consultant Pharmacist during a monthly medication review and it was his expectation that any medication irregularities be address by the Consultant Pharmacist. Another interview was conducted with the ADON on 7/16/20 at 9:20 AM. She stated she did not contact the prescribing Physician when reviewing the Medication Regimen Review notes because it was her understand that a Physician Recommendation was completed by the Consultant Pharmacist and given to the Physician to address. The ADON stated the Medication Regimen Review notes are not given to the prescribing Physician but rather addressed by nursing. An interview was conducted the Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated since the PRN [MEDICATION NAME] was part of the hospice comfort package, it was not re-evaluated. She stated she was not aware of the time limited use of PRN [MEDICATION NAME] so all the hospice resident's Physician orders [REDACTED]. An interview was conducted with the MD on 7/16/20 at 10:55 AM. He stated normally the Consultant Pharmacist generated a Physician Recommendation for him to address. He stated he had not received a Physician Recommendation regarding Resident #40's PRN [MEDICATION NAME]. The MD stated it was his expectation that the Consultant Pharmacist complete a Physician Recommendation as required during the monthly pharmacy medication review regarding any medication irregularities. Another telephone interview was conducted with Consultant Pharmacist #1 on 7/16/20 at 11:09 AM. She stated she documented her recommendations about the PRN [MEDICAL CONDITION] in the Executive Summary of the Consultant Pharmacist's Medication Regimen Review report given to the facility monthly. She stated she only comes to the facility on e day a month and that she doesn't always access to the MAR's. She stated she was aware of the time limited duration for PRN [MEDICAL CONDITION] but was unable to explain why she did not complete Physician Recommendations. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:25 AM. She stated it was her expectation the that the Consultant Pharmacist complete a Physician Recommendation regarding Resident #40's PRN [MEDICATION NAME]. 2. Resident #15 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 ' s cognition was severely impaired. He was noted with a prognosis of less than 6 months and was on hospice. A physician's order [REDACTED]. This PRN [MEDICATION NAME] physician's order [REDACTED]. The most recent monthly pharmacy consultant medication regimen review for Resident #15 was completed on 6/12/20 by Pharmacy Consultant #2. There were no recommendations made related to Resident #15 ' s PRN [MEDICATION NAME] (initiated on 6/1/20) that was prescribed with no stop date. A review of the 6/1/20 through 7/15/20 hard copy Medication Administration Records (MARs) for Resident #15 indicated no PRN [MEDICATION NAME] had been administered. The July 2020 active physician's order [REDACTED]. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. The ADON stated Resident #15 ' s PRN [MEDICATION NAME] was prescribed by the hospice physician. She revealed she was aware of the regulation that required all physician's order [REDACTED]. An interview was conducted Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated PRN [MEDICATION NAME] was part of the hospice comfort package and it was prescribed without a stop date. She indicated she was not aware of the regulation applicable to all facility residents that indicated physician's order [REDACTED]. Hospice Nurse #1 revealed that all of their hospice residents at the facility had a physician's order [REDACTED]. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He confirmed that the hospice comfort package normally included a physician's order [REDACTED]. He stated he was aware of the regulation applicable to all facility residents that indicated physician's order [REDACTED]. He reported that normally, if PRN [MEDICATION NAME] with no stop date was ordered for a facility resident, he was alerted by a pharmacy recommendation from the facility ' s Pharmacy Consultant and/or by facility nursing staff and a stop date was implemented. He revealed he received no notification related to Resident #15 ' s physician's order [REDACTED]. A phone interview was conducted with Pharmacy Consultant #2 on 7/16/20 at 12:00 PM. She stated that she was aware that PRN [MEDICAL CONDITION] medications were required to be time limited in duration. The PRN [MEDICATION NAME] physician's order [REDACTED].#15 was reviewed with Pharmacy Consultant #2. She reported that she had no notes in her June 2020 review that indicated Resident #15 had a physician's order [REDACTED]. She explained that there were times when telephone orders slipped out of the hard copy charts

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) and/or were missed. Pharmacy Consultant #2 revealed that PRN [MEDICAL CONDITION] medication orders with no stop date had been on an ongoing issue at the facility going back as far as February 2020. She explained that every month she and/or Pharmacy Consultant #1 completed an Executive Summary of Consultant Pharmacist ' s Medication Regimen Review that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. Pharmacy Consultant #2 requested that the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review for June 2020 be reviewed for additional information. As requested by Pharmacy Consultant #2 during her phone interview, the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review dated 6/20/20 for the time period of 6/1/20 through 6/20/20, read, in part: All PRNs (psychoactive medications) require stop dates per (Centers for Medicare and Medicaid Services). May wish to make all prescribers and nursing staff aware of this regulation. An interview was conducted with the Medical Director on 7/16/20 at 10:55 AM. The Medical Director stated he was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. He additionally stated that he was aware this regulation applied to hospice residents. He indicated that it was an error if a stop date was not included in the physician's order [REDACTED]. The Medical Director reported that he depended on the Pharmacy Consultant to identify and address PRN [MEDICAL CONDITION] medication orders that had no stop date during the monthly medication regimen review. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. She additionally stated that she was aware this regulation applied to hospice residents. The DON was unable to explain why Resident #15 had an active order for PRN [MEDICATION NAME] (initiated on 6/1/20) that had no stop date. She indicated that it was possible that the hospice staff audited the comfort packages for their facility residents on 6/1/20 and reinitiated physician's order [REDACTED]. She reported that she depended on the Pharmacy Consultant to identify and address PRN [MEDICAL CONDITION] medication orders that had no stop date during the monthly medication regimen review. 3. Resident #60 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's order [REDACTED]. This PRN [MEDICATION NAME] physician's order [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 ' s cognition was moderately impaired. He was noted with a prognosis of less than 6 months and was on hospice. The most recent monthly pharmacy consultant medication regimen review for Resident #60 was completed on 6/12/20 by Pharmacy Consultant #2. There were no recommendations made related to Resident #60 ' s PRN [MEDICATION NAME] (initiated on 6/1/20) that was prescribed with no stop date. A review of the 6/1/20 through 7/15/20 hard copy Medication Administration Records (MARs) for Resident #60 indicated no PRN [MEDICATION NAME] had been administered. The July 2020 active physician's order [REDACTED]. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. The ADON stated Resident #60 ' s PRN [MEDICATION NAME] was prescribed by the hospice physician. She revealed she was aware of the regulation that required all physician's order [REDACTED]. An interview was conducted Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated PRN [MEDICATION NAME] was part of the hospice comfort package and it was prescribed without a stop date. She indicated she was not aware of the regulation applicable to all facility residents that indicated physician's order [REDACTED]. Hospice Nurse #1 revealed that all of their hospice residents at the facility had a physician's order [REDACTED]. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He confirmed that the hospice comfort package normally included a physician's order [REDACTED]. He stated he was aware of the regulation applicable to all facility residents that indicated physician's order [REDACTED]. He reported that normally, if PRN [MEDICATION NAME] with no stop date was ordered for a facility resident, he was alerted by a pharmacy recommendation from the facility ' s Pharmacy Consultant and/or by facility nursing staff and a stop date was implemented. He revealed he received no notification related to Resident #60 ' s physician's order [REDACTED]. A phone interview was conducted with Pharmacy Consultant #2 on 7/16/20 at 12:00 PM. She stated that she was aware that PRN [MEDICAL CONDITION] medications were required to be time limited in duration. The PRN [MEDICATION NAME] physician's order [REDACTED].#60 was reviewed with Pharmacy Consultant #2. She reported that she had no notes in her June 2020 review that indicated Resident #60 had a physician's order [REDACTED]. She explained that there were times when telephone orders slipped out of the hard copy charts and/or were missed. Pharmacy Consultant #2 revealed that PRN [MEDICAL CONDITION] medication orders with no stop date had been on an ongoing issue at the facility going back as far as February 2020. She explained that every month she and/or Pharmacy Consultant #1 completed an Executive Summary of Consultant Pharmacist ' s Medication Regimen Review that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. Pharmacy Consultant #2 requested that the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review for June 2020 be reviewed for additional information. As requested by Pharmacy Consultant #2 during her phone interview, the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review dated 6/20/20 for the time period of 6/1/20 through 6/20/20, read, in part: All PRNs (psychoactive medications) require stop dates per (Centers for Medicare and Medicaid Services). May wish to make all prescribers and nursing staff aware of this regulation. An interview was conducted with the Medical Director on 7/16/20 at 10:55 AM. The Medical Director stated he was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. He additionally stated that he was aware this regulation applied to hospice residents. He indicated that it was an error if a stop date was not included in the physician's order [REDACTED]. The Medical Director reported that he depended on the Pharmacy Consultant to identify and address PRN [MEDICAL CONDITION] medication orders that had no stop date during the monthly medication regimen review. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. She additionally stated that she was aware this regulation applied to hospice residents. The DON was unable to explain why Resident #60 had an active order for PRN [MEDICATION NAME] (initiated on 6/1/20) that had no stop date. She indicated that it was possible that the hospice staff audited the comfort packages for their facility residents on 6/1/20 and reinitiated physician's order [REDACTED]. She reported that she depended on the Pharmacy Consultant to identify and address PRN [MEDICAL CONDITION] medication orders that had no stop date during the monthly medication regimen review. 4. Resident #32 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 ' s cognition was severely impaired. She was noted with a prognosis of less than 6 months and was on hospice. A physician's order [REDACTED]. This PRN [MEDICATION NAME] physician's order [REDACTED]. The most recent monthly pharmacy consultant medication regimen review for Resident #32 was completed on 6/20/20. There were no recommendations made related to Resident #32 ' s PRN [MEDICATION NAME] (initiated on 6/1/20) that was prescribed with no stop date. A review of the 6/1/20 through 7/15/20 hard copy Medication Administration Records (MARs) for Resident #32 indicated no PRN [MEDICATION NAME] had been administered. The July 2020 active physician's order [REDACTED]. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. The ADON stated Resident #32 ' s PRN [MEDICATION NAME] was prescribed by the hospice physician. She revealed she was aware of the regulation that required all physician's order [REDACTED]. An interview was conducted Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated PRN [MEDICATION NAME] was part of the hospice comfort package and it was prescribed without a stop date. She indicated she was not aware of the regulation applicable to all facility residents that indicated physician's order [REDACTED]. Hospice Nurse #1 revealed that all of their hospice residents at the facility had a physician's order [REDACTED]. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He confirmed that the hospice comfort package normally included a physician's order [REDACTED]. He stated he was aware of the regulation applicable to all facility residents that indicated physician's order [REDACTED]. He reported that normally, if PRN [MEDICATION NAME] with no stop date was ordered for a facility resident, he was alerted by a pharmacy recommendation from the facility ' s Pharmacy Consultant and/or by facility nursing staff and a stop date was implemented. He revealed he received no notification related to Resident #32 ' s physician's order [REDACTED]. A phone interview was conducted with Pharmacy Consultant #1 on 7/16/20 at 8:54 AM. She indicated that she was new to the facility and she worked with Pharmacy Consultant #2. She stated that she was aware that PRN [MEDICAL CONDITION] medications were required to be time limited in duration. The PRN [MEDICATION NAME] physician's order [REDACTED].#32 was reviewed with Pharmacy Consultant #1. She confirmed she had not completed a pharmacy recommendation that addressed the 6/1/20 PRN [MEDICATION NAME] physician's order [REDACTED].#32. Pharmacy Consultant #1 revealed that PRN [MEDICAL CONDITION] medication orders with no stop date had been an ongoing issue at the facility. She explained that instead of writing a pharmacy recommendation specific to Resident #32, the overall issue of PRN [MEDICAL CONDITION] medication orders with no stop date was addressed in the summary of monthly regimen reviews that was provided to the facility. She indicated that Pharmacy Consultant #2 would be able to explain the monthly summary. A phone interview was conducted with Pharmacy Consultant #2 on 7/16/20 at 12:00 PM. Pharmacy Consultant #2

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	345293	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) reiterated Pharmacy Consultant #1 ' s statement that PRN [MEDICAL CONDITION] medication orders with no stop date had been on an ongoing issue at the facility going back as far as February 2020. She explained that every month she and/or Pharmacy Consultant #1 completed an Executive Summary of Consultant Pharmacist ' s Medication Regimen Review that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. Pharmacy Consultant #2 requested that the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review for June 2020 be reviewed for additional information. As requested by Pharmacy Consultant #2 during her phone interview, the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review dated 6/20/20 for the time period of 6/1/20 through 6/20/20, read, in part, All PRNs ([MEDICAL CONDITION] medications) require stop dates per (Centers for Medicare and Medicaid Services). May wish to make all prescribers and nursing staff aware of this regulation. An interview was conducted with the Medical Director on 7/16/20 at 10:55 AM. The Medical Director stated he was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. He additionally stated that he was aware this regulation applied to hospice residents. He indicated that it was an error if a stop date was not included in the physician's order [REDACTED]. The Medical Director reported that he depended on the Pharmacy Consultant to identify and address PRN [MEDICAL CONDITION] medication orders that had no stop date during the monthly medication regimen review. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. She additionally stated that she was aware this regulation applied to hospice residents. The DON was unable to explain why Resident #32 had an active order for PRN [MEDICATION NAME] (initiated on 6/1/20) that had no stop date. She indicated that it was possible that the hospice staff audited the comfort packages for their facility residents on 6/1/20 and reinitiated physician's order [REDACTED]. She reported that she depended on the Pharmacy Consultant to identify and address PRN [MEDICAL CONDITION] medication orders that had no stop date during the monthly medication regimen review. 3. Resident # 59 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] indicated that Resident #59's cognition was intact, and she had exhibited other behavioral symptoms. Resident # 59 was being followed by the psychiatric services monthly for medication management. During the 3/12/20 visit, the psychiatric service had recommended to discontinue the [MEDICATION NAME] (an antipsychotic drug) for Resident #59. On 3/23/20, the Consultant Pharmacist had conducted the drug regimen review (DRR) for Resident #59 and had recommended to nursing for need Dyskinesia Identification System Condensed User Scale (DISCUS) due to discontinuation of [MEDICATION NAME]. The electronic records for Resident #59 were reviewed. The last DISCUS completed was on 2/27/20. There was no DISCUS completed after 3/23/20. On 7/15/20 at 1:45 PM, the Director of Nursing (DON) was interviewed. The DON stated that the Assistant Director of Nursing (ADON) was responsible for making sure the recommendations from the Pharmacy Consultant were acted upon. On 7/15/20 at 5:05 PM, the ADON was interviewed. She stated that she was responsible for responding to the Pharmacist recommendations. She reported that she had received the recommendation for the need of DISCUS in March 2020 for Resident #59 and she thought she had completed a DISCUS for the resident, but she did not. On 7/16/20 at 11:05 AM, a follow up interview was conducted with the DON. The DON stated that she expected the Pharmacist recommendation to be acted upon timely. She reported that the recommendation for the need of DISCUS for Resident #59 was an oversight on the part of the ADON.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff, hospice staff, Consultant Pharmacist, Medical Director (MD) and Hospice Medical Director interviews and record review, the facility failed to ensure physician's orders for as needed (PRN) [MEDICATION NAME] were time limited in duration (Residents #40, #32, #60, #15) for 4 of 4 residents reviewed for hospice. The findings included: 1. Resident #40 was admitted on [DATE] with cumulative [DIAGNOSES REDACTED]. Resident #40's quarterly Minimum Data Set ((MDS) dated [DATE] indicated severe cognitive impairment and he was coded for physical behaviors. The MDS indicated he had not received any antianxiety medications. He was also coded for hospice. Resident #40's revised care plan dated 2/20/20 read he was on hospice care due to a terminal illness. Resident #40's March 2020 Physician orders included an order dated 3/11/20 for [MEDICATION NAME] (antianxiety) one milligram (mg) by mouth three times a day as needed (hold for sedation). Resident #40's Medication Administration Records (MAR) from March 11, 2020 to July 16, 2020 revealed, the PRN [MEDICATION NAME] order remained in effect during this time period. The MAR indicated [REDACTED]. The Executive Summary of Consultant's Pharmacist's Medication Regimen Review dated 3/24/20 read the facility was still having issues with the Centers of Medicare and Medicaid Services (CMS) regulation regarding as needed (PRN) time limited duration of [MEDICAL CONDITION]. The Executive Summary of Consultant's Pharmacist's Medication Regimen Review dated 5/16/20 read all PRN [MEDICAL CONDITION] must have a stop date per CMS regulation. The Executive Summary of Consultant's Pharmacist's Medication Regimen Review dated 6/20/20 read all PRN [MEDICAL CONDITION] must have a stop date per CMS regulation. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. She stated she reviewed the Executive Summary of Consultant's Pharmacist's Medication Regimen Review summary monthly. The ADON stated Resident #40's PRN [MEDICATION NAME] was prescribed by hospice and she was not aware that PRN [MEDICATION NAME] had to be time limited in duration and reassessed by the Physician. A telephone interview was conducted with Consultant Pharmacist #1 on 7/16/20 at 8:54 AM. She stated she was new to the facility and that she had discussed at length the PRN antianxiety medications time limited duration with the facility and documented her recommendations in the Executive Summary of Consultant's Pharmacist's Medication Regimen Review summary. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He stated he was aware that [MEDICATION NAME] had to be time limited in duration then re-evaluated for the continued use. He stated he not received any recommendations regarding Resident #40's PRN [MEDICATION NAME] and it was his expectation that any medication irregularities be address by the facility. An interview was conducted the Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated since the PRN [MEDICATION NAME] was part of the hospice comfort package, it was not re-evaluated. She stated she was not aware of the time limited use of PRN [MEDICATION NAME] so all the hospice resident's Physician orders were incorrect. An interview was conducted with the MD on 7/16/20 at 10:55 AM. He stated he had not received any recommendations regarding Resident #40's PRN [MEDICATION NAME]. The MD stated it was his expectation that the facility follow-up on any pharmacy recommendations regarding any medication irregularities. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:25 AM. She stated it was her expectation the that the facility follow-up on any Executive Summary of Consultant's Pharmacist's Medication Regimen Review summary recommendations regarding the time limited use of PRN [MEDICAL CONDITION]. 2. Resident #15 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 ' s cognition was severely impaired. He was noted with a prognosis of less than 6 months and was on hospice. A physician ' s order for Resident #15 dated 6/1/20 indicated [MEDICATION NAME] (antianxiety medication) 1 milligram (mg) every 8 hours as needed (PRN). This PRN [MEDICATION NAME] physician ' s order had no stop date. A review of the 6/1/20 through 7/15/20 hard copy Medication Administration Records (MARs) for Resident #15 indicated no PRN [MEDICATION NAME] had been administered. The July 2020 active physician ' s orders for Resident #15 were reviewed on 7/15/20 and revealed the 6/1/20 PRN [MEDICATION NAME] physician ' s order continued to be active. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. The ADON stated Resident #15 ' s PRN [MEDICATION NAME] was prescribed by the hospice physician. She revealed she was aware of the regulation that required all physician ' s orders for PRN [MEDICAL CONDITION] medications to be time limited in duration, but she was not aware that the regulation applied to hospice residents. An interview was conducted Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated PRN [MEDICATION NAME] was part of the hospice comfort package and it was prescribed without a stop date. She indicated she was not aware of the regulation applicable to all facility residents that indicated

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) physician ' s orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. Hospice Nurse #1 revealed that all of their hospice residents at the facility had a physician ' s order for PRN [MEDICATION NAME] with no stop date. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He confirmed that the hospice comfort package normally included a physician ' s order for PRN [MEDICATION NAME] with no stop date. He stated he was aware of the regulation applicable to all facility residents that indicated physician ' s orders for PRN [MEDICATION NAME] were required to be time limited in duration. He reported that normally, if PRN [MEDICATION NAME] with no stop date was ordered for a facility resident, he was alerted by a pharmacy recommendation from the facility ' s Pharmacy Consultant and/or by facility nursing staff and a stop date was implemented. He revealed he received no notification related to Resident #15 ' s physician ' s order dated 6/1/20 for PRN [MEDICATION NAME] with no stop date. A phone interview was conducted with Pharmacy Consultant #1 on 7/16/20 at 8:54 AM. She indicated she was new to the facility and she worked with Pharmacy Consultant #2. She stated she was aware that all physician ' s orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. She revealed that PRN [MEDICAL CONDITION] medication orders with no stop date had been an ongoing issue at the facility. A phone interview was conducted with Pharmacy Consultant #2 on 7/16/20 at 12:00 PM. She stated she was aware that all orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. Pharmacy Consultant #2 reiterated Pharmacy Consultant #1 ' s interview that PRN [MEDICAL CONDITION] medication orders with no stop date had been on an ongoing issue at the facility going back as far as February 2020. She explained that every month she and/or Pharmacy Consultant #1 completed an Executive Summary of Consultant Pharmacist ' s Medication Regimen Review that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. Pharmacy Consultant #2 requested that the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review for June 2020 be reviewed for additional information. As requested by Pharmacy Consultant #2 during her phone interview, the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review dated 6/20/20 for the time period of 6/1/20 through 6/20/20, read, in part: All PRNs (psychoactive medications) require stop dates per (Centers for Medicare and Medicaid Services). May wish to make all prescribers and nursing staff aware of this regulation. An interview was conducted with the Medical Director on 7/16/20 at 10:55 AM. The Medical Director stated he was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. He additionally stated that he was aware this regulation applied to hospice residents. He indicated that it was an error if a stop date was not included in the physician ' s order for a PRN [MEDICAL CONDITION] medication. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. She additionally stated that she was aware this regulation applied to hospice residents. The DON was unable to explain why Resident #15 had an active order for PRN [MEDICATION NAME] (initiated on 6/1/20) that had no stop date. She indicated that it was possible that the hospice staff audited the comfort packages for their facility residents on 6/1/20 and reinitiated physician ' s orders for PRN [MEDICATION NAME] with no stop date and that this had not yet been not identified and corrected. 3. Resident #60 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician ' s order for Resident #60 dated 6/1/20 indicated [MEDICATION NAME] (antianxiety medication) 1 milligram (mg) every 8 hours as needed (PRN). This PRN [MEDICATION NAME] physician ' s order had no stop date. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 ' s cognition was moderately impaired. He was noted with a prognosis of less than 6 months and was on hospice. Resident #60 received no antianxiety medication during the 7-day MDS look back period. A review of the 6/1/20 through 7/15/20 hard copy Medication Administration Records (MARs) for Resident #60 indicated no PRN [MEDICATION NAME] had been administered. The July 2020 active physician ' s orders for Resident #60 were reviewed on 7/15/20 and revealed the 6/1/20 PRN [MEDICATION NAME] physician ' s order continued to be active. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. The ADON stated Resident #60 ' s PRN [MEDICATION NAME] was prescribed by the hospice physician. She revealed she was aware of the regulation that required all physician ' s orders for PRN [MEDICAL CONDITION] medications to be time limited in duration, but she was not aware that the regulation applied to hospice residents. An interview was conducted Hospice Nurse #1 on 7/16/20 at 9:50 AM. She stated PRN [MEDICATION NAME] was part of the hospice comfort package and it was prescribed without a stop date. She indicated she was not aware of the regulation applicable to all facility residents that indicated physician ' s orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. Hospice Nurse #1 revealed that all of their hospice residents at the facility had a physician ' s order for PRN [MEDICATION NAME] with no stop date. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He confirmed that the hospice comfort package normally included a physician ' s order for PRN [MEDICATION NAME] with no stop date. He stated he was aware of the regulation applicable to all facility residents that indicated physician ' s orders for PRN [MEDICATION NAME] were required to be time limited in duration. He reported that normally, if PRN [MEDICATION NAME] with no stop date was ordered for a facility resident, he was alerted by a pharmacy recommendation from the facility ' s Pharmacy Consultant and/or by facility nursing staff and a stop date was implemented. He revealed he received no notification related to Resident #60 ' s physician ' s order dated 6/1/20 for PRN [MEDICATION NAME] with no stop date. A phone interview was conducted with Pharmacy Consultant #1 on 7/16/20 at 8:54 AM. She indicated she was new to the facility and she worked with Pharmacy Consultant #2. She stated she was aware that all physician ' s orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. She revealed that PRN [MEDICAL CONDITION] medication orders with no stop date had been an ongoing issue at the facility. A phone interview was conducted with Pharmacy Consultant #2 on 7/16/20 at 12:00 PM. She stated she was aware that all orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. Pharmacy Consultant #2 reiterated Pharmacy Consultant #1 ' s interview that PRN [MEDICAL CONDITION] medication orders with no stop date had been on an ongoing issue at the facility going back as far as February 2020. She explained that every month she and/or Pharmacy Consultant #1 completed an Executive Summary of Consultant Pharmacist ' s Medication Regimen Review that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. 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He indicated that it was an error if a stop date was not included in the physician ' s order for a PRN [MEDICAL CONDITION] medication. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. She additionally stated that she was aware this regulation applied to hospice residents. The DON was unable to explain why Resident #60 had an active order for PRN [MEDICATION NAME] (initiated on 6/1/20) that had no stop date. She indicated that it was possible that the hospice staff audited the comfort packages for their facility residents on 6/1/20 and reinitiated physician ' s orders for PRN [MEDICATION NAME] with no stop date and that this had not yet been not identified and corrected. 4. Resident #32 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 ' s cognition was severely impaired. She was noted with a prognosis of less than 6 months and was on hospice. Resident #32 received no antianxiety medication during the 7-day MDS look back period. A physician ' s order for Resident #32 dated 6/1/20 indicated [MEDICATION NAME] (antianxiety medication) 1 milligram (mg) every 8 hours as needed (PRN). This PRN [MEDICATION NAME] physician ' s order had no stop date. A review of the 6/1/20 through 7/15/20 hard copy Medication Administration Records (MARs) for Resident #32 indicated no PRN [MEDICATION NAME] had been administered. The July 2020 active physician ' s orders for Resident #32 were reviewed on 7/15/20 and revealed the 6/1/20 PRN [MEDICATION NAME] physician ' s order continued to be active. An interview was conducted with the Assistant Director of Nursing (ADON) on 7/16/20 at 8:27 AM. 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	345293	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) applicable to all facility residents that indicated physician ' s orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. Hospice Nurse #1 revealed that all of their hospice residents at the facility had a physician ' s order for PRN [MEDICATION NAME] with no stop date. A telephone interview was conducted with the Hospice Medical Director on 7/16/20 at 9:05 AM. He confirmed that the hospice comfort package normally included a physician ' s order for PRN [MEDICATION NAME] with no stop date. He stated he was aware of the regulation applicable to all facility residents that indicated physician ' s orders for PRN [MEDICATION NAME] were required to be time limited in duration. He reported that normally, if PRN [MEDICATION NAME] with no stop date was ordered for a facility resident, he was alerted by a pharmacy recommendation from the facility ' s Pharmacy Consultant and/or by facility nursing staff and a stop date was implemented. He revealed he received no notification related to Resident #32 ' s physician ' s order dated 6/1/20 for PRN [MEDICATION NAME] with no stop date. A phone interview was conducted with Pharmacy Consultant #1 on 7/16/20 at 8:54 AM. She indicated she was new to the facility and she worked with Pharmacy Consultant #2. She stated she was aware that all physician ' s orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. She revealed that PRN [MEDICAL CONDITION] medication orders with no stop date had been an ongoing issue at the facility. A phone interview was conducted with Pharmacy Consultant #2 on 7/16/20 at 12:00 PM. She stated she was aware that all orders for PRN [MEDICAL CONDITION] medications were required to be time limited in duration. Pharmacy Consultant #2 reiterated Pharmacy Consultant #1 ' s interview that PRN [MEDICAL CONDITION] medication orders with no stop date had been on an ongoing issue at the facility going back as far as February 2020. She explained that every month she and/or Pharmacy Consultant #1 completed an Executive Summary of Consultant Pharmacist ' s Medication Regimen Review that provided the facility a summary of the medication regimen review results for that month. She further explained that this summary was not part of the medical record for each resident. Pharmacy Consultant #2 requested that the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review for June 2020 be reviewed for additional information. As requested by Pharmacy Consultant #2 during her phone interview, the Executive Summary of Consultant Pharmacist ' s Medication Regimen Review dated 6/20/20 for the time period of 6/1/20 through 6/20/20, read, in part: All PRNs (psychoactive medications) require stop dates per (Centers for Medicare and Medicaid Services). May wish to make all prescribers and nursing staff aware of this regulation. An interview was conducted with the Medical Director on 7/16/20 at 10:55 AM. The Medical Director stated he was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. He additionally stated that he was aware this regulation applied to hospice residents. He indicated that it was an error if a stop date was not included in the physician ' s order for a PRN [MEDICAL CONDITION] medication. An interview was conducted with the Director of Nursing (DON) on 7/16/20 at 11:30 AM. The DON stated she was aware of the regulation that required all PRN [MEDICAL CONDITION] medications to be time limited in duration. She additionally stated that she was aware this regulation applied to hospice residents. The DON was unable to explain why Resident #32 had an active order for PRN [MEDICATION NAME] (initiated on 6/1/20) that had no stop date. She indicated that it was possible that the hospice staff audited the comfort packages for their facility residents on 6/1/20 and reinitiated physician ' s orders for PRN [MEDICATION NAME] with no stop date and that this had not yet been not identified and corrected.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to discard expired Purified Protein Derivatives (used in the [DIAGNOSES REDACTED]. Findings included: 1. On [DATE] at 12:42 PM, the main medication room was observed. In the refrigerator, there was 1 used bottle of Purified Protein Derivatives (PPD) with an open date of [DATE]. The instruction on the PPD box read discard 30 days after opening. On [DATE] at 12:43 PM, Nurse #1 was interviewed. The Nurse stated that she was not sure how long PPD was good once opened. She also indicated that she didn't know who was responsible for checking the medication cart and the medication room for expired and undated medication because she had to float on different halls. Nurse #1 was observed to read the instruction on the PPD box and stated that the PPD was good for 30 days after opening. The nurse verified that the PPD was already expired and she was observed to discard the used PPD bottle. On [DATE] at 2:05 PM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the facility policy on medications discard dates and the manufacturer's instruction to be followed. She reported that the facility policy and the manufacturer's instruction was to date the PPD when opened and to discard 30 days after opening. She also indicated that she expected the nurses to check the medication cart and the medication room daily for expired and undated medications. 2. On [DATE] at 1:55 PM, the medication cart on the upper 400 hall was observed. There was a used bottle of Prostat about ,[DATE] full observed with no date of opening. The instruction on the bottle of the Prostat read discard 3 months after opening. On [DATE] at 3:01 PM, the Medication Aide (Med Aide) assigned on the upper 400 hall was interviewed. She looked at the used bottled of Prostat and verified that it was not dated when opened. She stated that it was not required to date the bottle of Prostat when opened. On [DATE] at 2:05 PM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the facility policy on medications discard dates and the manufacturer's instruction to be followed. She reported that the facility policy and the manufacturer's instruction was to date the Prostat when opened and to discard 3 months after opening. She also indicated that she expected the nurses/Med Aides to check the medication cart and the medication room daily for expired and undated medications.