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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Pines Healthcare and Rehabilitation Cente	Highway 177 S 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Pharmacist, and Physician interviews, the pharmacy failed to provide the correct dose of Depakote (an anticonvulsant medication used to treat epilepsy) for a resident. This was for 1 of 6 residents reviewed for medications (Resident #53).The findings included:Resident #53 was admitted to the facility on [DATE] with diagnoses that included unspecified convulsions/epilepsy. Review of Resident #53's active orders revealed an order dated 03/16/25 for Depakote Sprinkle Capsule 125mg (milligram), give 2 capsules by mouth three times a day. Review of Resident 53's nursing progress notes revealed a note dated 04/02/25 at 5:30 PM written by Nurse #1 that she received a call from Pharmacist #2 revealing that pharmacy sent the wrong dose of Depakote for Resident #53. Pharmacist #2 indicated to discontinue the order for Depakote and pharmacy would send the correct Depakote dosage. Nurse #1 was unavailable for interview during the survey period.Review of a copy of the Smartpass pouch revealed Resident #52's name, Depakote 500mg DR (delayed release). tablets, pink oblong, with the RX (prescription) number and physician's name. Take 2 capsules = (equals) 250mg PO (by mouth) three times a day. A phone interview was conducted on 12/18/25 at 10:20 AM with Pharmacist #1. She stated that according to the pharmacy tracking system, Resident #53 did receive 3 separate deliveries of Depakote 500mg tablets with instructions on the pill packet to give 2 capsules three times a day to equal 250mg. These included on 03/17/25 she received a 3 day supply, on 03/20/25 a 7 day supply, and on 03/27/25 a 7 day supply.Review of a pharmacy Packing Slip dated 03/17/25 revealed 18 Depakote 500mg tablets were delivered, the Packing Slip dated 03/20/25 revealed 42 Depakote 500mg tablets were delivered, and the Packing Slip dated 03/27/25 revealed 42 Depakote 500mg tablets were delivered. A phone interview was conducted on 12/18/25 at 10:25 AM with Pharmacist #2. When asked how the Depakote 500mg tablets were mistakenly sent instead of the Depakote 125mg capsules she stated the pharmacists did not pay attention and entered the incorrect dose into the system. Pharmacist #2 further stated it was a human error. Pharmacist #2 indicated Pharmacist #3 had entered the incorrect Depakote dose into the Smartpass system. A phone interview was conducted on 12/18/25 at 12:28 PM with the Pharmacy Operations Manager and the Pharmacy Chief Clinical Officer. The Pharmacy Chief Clinical Officer stated that when the pharmacist entered the Depakote dose into the Smartpass system she entered the incorrect dose. He indicated they were unsure exactly who originally entered the incorrect dose however it was a human error. Once the medication name and dose with the instructions were entered the medication was then dispensed into the pouches and sent to the facility. The pharmacist completed a drug regimen review on 04/02/25 and caught the discrepancy. Pharmacist #2 called to notify the facility of the error and requested they remove the medication from the medication cart, and they would send the correct dose to them. Pharmacist #2 also recommended the facility to obtain a Depakote (valproic acid/sodium valproate) level. The Pharmacy Chief Clinical Officer explained they completed an incident report, reviewed and provided education to pharmacy technicians and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacists, and are reviewing the incident in their quality assurance meetings to prevent further occurrences. A phone interview was conducted on 12/18/25 at 12:43 PM with Pharmacist #3. She stated she did not recall entering the incorrect Depakote dose for Resident #53 into Smartpass system (Smartpass is an automated system where medications are pre-packaged by the pharmacy into clearly labeled, single-dose plastic pouches. Each pouch features clear, detailed labeling to help ensure the correct dosage and time for administration. Nursing staff use electronic scanners to scan each pouch, instantly matching the medication to a specific resident and verifying the dosage and time against the electronic health record) prior to filling the order on 03/17/25. An interview was conducted on 12/18/25 at 9:50 AM with the Director of Nursing (DON). She stated she was not working at the facility when the medication error occurred in March/April 2025 with Resident #53's Depakote. She explained she expected the pharmacy to send the correct medication, correct medication dose, and correct medication form; however, it was also the nurse's responsibility to check all medications with the active orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, Pharmacist, and Physician interviews, the facility failed to administer the correct dose of Depakote (an anticonvulsant medication used to treat epilepsy). This was for 1 of 6 residents reviewed for medications. The findings included: Resident #53 was admitted to the facility on [DATE] with diagnoses that included unspecified convulsions/epilepsy. Review of Resident #53's active orders revealed an order dated 03/16/25 for Depakote Sprinkle Capsule 125mg (milligram), give 2 capsules by mouth three times a day unspecified convulsions.Resident #53's significant change Minimum Data Set (MDS) dated [DATE] indicated her cognition was severely impaired. She had no behaviors and no rejection of care coded. Resident #53 received scheduled anticonvulsant medications during the MDS review period. Resident #53's March 2025 electronic Medication Administration Record (MAR) indicated she received Depakote Sprinkle Capsule 125mg, 2 capsules by mouth three times a day from 03/17/25 through 03/31/25. The MAR indicated she refused a dose on 03/28/25 at 9:00 PM. Review of Resident 53's nursing progress notes revealed a note dated 04/02/25 at 5:30 PM written by Nurse #1 that she received a call from Pharmacist #2 revealing that pharmacy sent the wrong dose of medication for Resident #53. Pharmacist #2 indicated to discontinue the order for Depakote and pharmacy would send the correct Depakote dosage. Unsuccessful attempts were made to contact Nurse #1 for interview during the survey period. Resident #53's April 2025 electronic MAR indicated she received Depakote Sprinkle Capsule 125mg, 2 capsules by mouth three times a day on 04/01/25 through 04/02/25 at 5:33 PM. The medication was put on hold from 04/02/25 at 5:33 PM through 04/05/25 at 7:51 PM. Medication Error Report dated 04/02/25, completed by the Previous Director of Nursing (DON), revealed pharmacy dispensed Depakote 500mg, 2 capsules to be given by mouth three times a day to Resident #53. Resident #53's active order read Depakote 125mg 2 capsules to be given by mouth three times a day. The Medication Error Report indicated Resident #53 received the incorrect dose for 6 days. Immediate action taken included a medication review for corrections, medication removed from Smartpass pouches. (Smartpass is an automated system where medications are pre-packaged by the pharmacy into clearly labeled, single-dose plastic pouches. Each pouch features clear, detailed labeling to help ensure the correct dosage and time for administration. Nursing staff use electronic scanners to scan each pouch, instantly matching the medication to a specific resident and verifying the dosage and time against the electronic health record). The report also indicated the pharmacy would send pill cards with the corrected dose and for the facility to obtain lab work. No change in level of consciousness and no pain was noted. Investigation Summary dated 04/02/25, completed by the Previous DON, revealed on 03/27/25 pharmacy delivered the weekly Smartpass medication rolls to the facility. On 04/02/25 pharmacy notified the facility that the wrong dosage of Depakote was dispensed to the facility for Resident #53. The Physician and Responsible Party were notified. The facility initiated education on 04/03/25 for medication scanners. Routine labs were obtained on 04/04/25 with normal results. Lastly, on 04/14/25 Depakote (valproic acid/sodium valproate) level was obtained per pharmacy recommendation. A phone interview was conducted on 12/18/25 at 10:26 AM with the Previous DON. She stated she recalled the occurrence with pharmacy sending the incorrect dose of Depakote for Resident #53. She explained that she received an email from the pharmacy consultant that the pharmacy had identified the error and the facility needed to pull the incorrect dose from the medication cart immediately. She stated that the medication had been removed from the medication cart when Nurse #1 received the phone from Pharmacist #2. The Previous DON then explained that pharmacy felt the error occurred due to nursing not utilizing the medication scanner when preparing the medications for administration. She indicated she provided education with nurses (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding using the scanner instead of clicking the medications off with the computer mouse. She further explained if staff had used the scanner during medication preparation, it would have alerted them Resident #53's Depakote dose was not matching the MAR. Lab draws were ordered to get the Depakote levels however Resident #53 had a history of refusing lab draws and taking her medications. Review of lab work obtained revealed a blood draw was attempted on 04/04/25 at 5:00 AM. Lab cancelled order due to quantity of blood was not sufficient for the test. Another blood draw was attempted on 04/04/25 at 4:21 PM however Resident #53 refused to allow the technician to obtain the blood. A blood draw was completed on 04/14/25 at 12:58 PM with the valproic acid level being 18.1 (normal range 50-100). A follow-up phone interview was conducted on 12/18/25 at 10:53 AM with the Previous DON. She stated she did not in-service nursing on reading and comparing the Smartpass medication pouches with the orders on the MAR because she did not feel that was part of the reason that caused the medication error. The Previous DON did verify that the active order for the Depakote on Resident #53's MAR and the order on the Smartpass pouch was not the same. She also explained that staff did monitor Resident #53 and she had no signs or symptoms of a change in condition or an increased valproic acid/sodium valproate level. (High valproic acid/sodium valproate levels can cause symptoms ranging from mild gastrointestinal upset and drowsiness to severe and life-threatening conditions like coma, respiratory depression, and cerebral edema). The Previous DON also verified she worked the medication cart on 03/29/25 and 03/30/25 from 7:00 PM to 7:00 AM but did not remember identifying the medication error at that time. The Previous DON indicated she administered Resident #53 the incorrect dose of Depakote and she did not use the scanner or compare the pouch to the order on the MAR.Nursing schedules from 03/17/25 through 04/02/25 indicated the following nurses and medication aide worked on the days and times the incorrect dose of Depakote was administered. An interview was conducted on 12/17/25 at 2:12 PM with Nurse #11. She verified that she did work on 03/25/25 and 04/01/25 from 7:00 AM to 7:00 PM and knew Resident #53. She indicated she recalled getting education on utilizing the scanners for scanning the medications but not the medication error. She explained when she pulled a resident's medications, she scanned each Smartpass pouch and compared it to the residents MAR. She further explained she read the orders and compared them with the MAR. If the dose was different than what the MAR had on it she would have seen that. A phone interview was conducted on 12/17/25 at 5:34 PM with Medication Aide (MA) #2. She verified that she did work on 03/24/25 and 03/25/25 from 7:00 PM to 7:00 AM and was familiar with Resident #53. MA #2 indicated she did not recall education or a medication error involving Resident #53's Depakote. A phone interview was conducted on 12/18/25 at 10:25 AM with Nurse #8. She verified that she did work on 03/22/25 and 03/23/25 from 7:00 AM to 7:00 PM and knew Resident #53. Nurse #8 indicated she did not recall education or a medication error involving Resident #53's Depakote dosage. An interview was conducted on 12/18/25 at 1:22 PM with Nurse #12. She verified that she did work on 03/24/25 from 7:00 AM-7:00 PM and on 03/28/25 from 7:00 PM to 7:00 AM. She stated she did not work with Resident #53 very often. She indicated she did not recall receiving education on the medication error related to Resident #53's Depakote. She explained and demonstrated when she pulled a resident's medications she scanned each Smartpass pouch and compared it to the residents MAR. She further explained she read the orders and compared them with the MAR and if the dose was different than what the MAR had on it, she would have noticed that. A phone interview was conducted on 12/18/25 at 4:54 PM with Nurse #2. Nurse #2 worked on 03/26/25 from 7:00 AM to 7:00 PM. She verified that she did work at the facility at the end of March 2025 and knew Resident #53. She indicated she did not recall the medication error that occurred at the end of March 2025 in reference to Resident #53's Depakote. She explained when she gathered a resident's medications she scanned (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each Smartpass pouch and compared it to the residents MAR. She could not recall if she was utilizing the scanner at that time but stated she always read the orders and compared them with the MAR and she did not know how she would have missed the incorrect dose.Unsuccessful attempts were made to contact the following nurses for interviews during the survey period: Nurse #1 worked on 03/19/25, 03/27/25, 03/28/25, 03/31/25, and 04/02/25 from 7:00 AM to 7:00 PM. Nurse #3 worked 03/29/25, 03/30/25 from 7:00 AM to 7:00 PM. Nurse #5 worked 03/20/25 and 03/21/25 from 7:00 AM to 7:00 PM. Nurse #6 worked 03/20/25 from 7:00 PM to 7:00 AM. Nurse #7 worked 03/21/25 from 7:00 PM to 7:00 AM. Nurse #9 worked 03/22/25, 03/23/25, and 03/26/25 from 7:00 PM to 7:00 AM. Nurse #10 worked 03/31/25 from 7:00 PM to 7:00 AM.An interview was conducted on 12/18/25 at 9:50 AM with the DON. She stated she was not working at the facility when the medication error occurred in March/April 2025 with Resident #53's Depakote. The DON also stated if she had a medication error occurred where the Smartpass pouch medication order did not match the active order that was on the MAR she would immediately pull the incorrect medication from the medication cart, notify pharmacy, Physician, and Responsible Party. She explained she would obtain needed blood work and educate the nursing staff on reading and comparing the medication on hand with the active medication order for accuracy. She also explained she felt if the nursing staff had read and compared the Smartpass pouch with the active order for Depakote the incorrect dose would have been identified prior to administering it. A phone interview was conducted on 12/18/25 at 4:25 PM with Physician #1. She stated she had been contacted by staff about the medication error that had occurred in March and April 2025 with Resident #53's Depakote. She indicated she believed the nursing staff that administered the Depakote should have read the order on the MAR and compared it to the medication on hand. She explained that staff were monitoring Resident #53 and she did not act any differently than prior to the medication error. Physician #1 also explained that staff did not report any signs or symptoms of Depakote toxicity such as upset stomach, drowsiness, or respiratory depression. Physician #1 continued by saying valproic levels were requested and came back as being low and she felt the levels were low due to Resident #53 refusal of medications on a regular basis. She then stated she felt that Resident #53 refused medications at times, but the nursing staff forgot to mark the MAR as the medications being refused. Physician #1 was not concerned that Resident #53 had received 1000mg of Depakote three times a day because Resident #53 did not exhibit a change in condition.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative, and staff interviews, the facility failed to administer influenza and pneumonia vaccines on admission for 1 of 5 residents reviewed for immunizations (Resident #13). The findings included: Resident #13 was admitted to the facility on [DATE] with diagnoses including heart failure and hypertension. The admission consent dated 11/5/25 and signed by Resident #13's Representative and the Admissions staff included the following: Flu vaccine authorization I acknowledge that the resident is not allergic to eggs, and I give permission for the administration of the flu vaccine which is given annually unless medically contraindicated. The checkbox yes was checked beside this statement. The space for the date of the last flu vaccine was blank. Pneumonia vaccine authorization I give permission for the administration of the pneumonia vaccine, which is given on admission unless medically contraindicated. The checkbox yes was checked beside this statement. The space for the date of the last pneumonia vaccine was blank.The admission Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #13 to be severely cognitively impaired. The MDS documented that immunizations (influenza and pneumonia) were not given because they were not offered. Review of the medical record for Resident #13 revealed no immunizations were documented as administered and no documentation that indicated the consent for immunizations had been withdrawn. There was no documentation indicating Resident #13 had received the flu and pneumonia vaccine in the recent year. The Resident Representative was interviewed by phone on 12/17/25 at 9:34 AM. The Representative reported Resident #13 had not received his flu or pneumonia vaccines on admission to the facility. The Representative reported she had signed the consents on admission and expected Resident #13 to receive the vaccines from the facility, but no one from the facility had communicated Resident #13 had received the flu or pneumonia vaccines to her. The former Infection Control nurse (IC nurse) was interviewed by phone on 12/17/25 at 12:37 PM. The IC nurse explained that prior to her leaving her position in November 2025, she had not provided a flu or pneumonia vaccine to Resident #13. The IC nurse explained that new admissions were discussed during the morning meeting and she was aware Resident #13 requested a flu and pneumonia vaccine, but she did not administer the vaccines. When questioned, the IC nurse reported she had no reason for not administering the flu or pneumonia vaccines to Resident #13.The Administrator was interviewed on 12/18/25 at 12:50 PM. The Administrator reported that new admissions were discussed during the daily morning meeting and residents who requested immunizations were communicated to the team. The Administrator explained that Resident #13's Representative was not certain if he received the vaccines prior to admission to the facility and she was going to get that information for the facility. Administrator reported she expected residents to receive vaccines when they or the Representative requested.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Resident Representative, and staff interviews, the facility failed to administer COVID-19 vaccine on admission for 1 of 5 residents reviewed for immunizations (Resident #13).The findings included: Resident #13 was admitted to the facility on [DATE] with diagnoses including heart failure and hypertension. The admission consent dated 11/5/25 and signed by Resident #13's Representative and the Admissions staff included the following: COVID-19 vaccine authorization, I give permission for the administration of the COVID-19 vaccine, which is given annually unless medically contraindicated. The checkbox yes was checked beside this statement. The space for the last date COVID-19 vaccine received was blank. The admission Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #13 to be severely cognitively impaired. The MDS documented that immunization (COVID-19) was not given because the vaccine was not offered. Review of the medical record for Resident #13 revealed no COVID-19 immunization was documented as administered. Review of the medical record revealed no documentation that indicated the consent for immunizations had been withdrawn. There was no documentation indicating Resident #13 had received the COVID-19 vaccine in the recent year. The Resident Representative was interviewed by phone on 12/17/25 at 9:34 AM. The Representative reported Resident #13 had not received his COVID-19 vaccines on admission to the facility. The Representative reported no one from the facility had communicated Resident #13 had received the COVID-19 vaccine to her. The former Infection Control nurse (IC nurse) was interviewed by phone on 12/17/25 at 12:37 PM. The IC nurse explained that prior to her leaving her position in November 2025, she had not provided a COVID-19 vaccine to Resident #13. The IC nurse explained that new admissions were discussed during the morning meeting and she was aware Resident #13 requested a COVID-19 vaccine, but she did not administer the vaccine. When questioned, the IC nurse reported she had no reason for not administering the COVID-19 vaccine to Resident #13. The Administrator was interviewed on 12/18/25 at 12:50 PM. The Administrator reported that new admissions were discussed during the daily morning meeting and residents who requested immunizations were communicated to the team. The Administrator explained that Resident #13's Representative was not certain if he received the vaccines prior to admission to the facility and she was going to get that information for the facility. Administrator reported she expected residents to receive vaccines as they or their Representative request.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident, and staff interviews, the facility failed to provide a privacy curtain for 1 of 3 residents reviewed for privacy (Resident #86).The findings included: Resident #86 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #86 was cognitively intact and provided personal care for herself with set-up and supervision. An observation of Resident #86's room on 12/16/25 at 2:40 PM, revealed no privacy curtains. Another observation of Resident #86's room occurred on 12/17/25 at 9:55 AM and revealed no privacy curtains were present.On 12/17/25 at 10:50 AM, an interview occurred with Resident #86. She stated the privacy curtains in the room had been missing for about 7 to 8 months but couldn't recall if she had told any staff member about it. She further stated that she provided her personal care in the bathroom of her room but that when she had a privacy curtain, she liked to utilize it for privacy from her roommate when there were visitors in the room or when she was resting in bed. Nurse Aide (NA) #1 was interviewed on 12/17/25 at 1:03 PM, who indicated she routinely provided care to Resident #86. She reported that she had not noticed Resident #86 did not have a privacy curtain. An interview with Resident #86's Medication Aide (MA) #1 on 12/17/25 at 2:50 PM, stated that she normally provided medications and some supervision with personal care tasks but had not noticed that the privacy curtains were missing from Resident #86's room. A review of Resident #86's medical record revealed an order dated 4/3/25 to wash all clothes, bed linens, coats and blankets with hot water for a skin infection. The Environmental Services Manager (ESM) was interviewed on 12/17/25 at 1:32 PM and stated that when privacy curtains were removed for laundering, a fresh set would be put back up the same day. He recalled that Resident #86's privacy curtains were removed for laundering a while back due to a skin infection and that he forgot to have a new set of privacy curtains put back up. The Administrator was interviewed on 12/18/25 at 4:10 PM. She stated that she had been at the facility for five weeks but would have expected privacy curtains to be replaced the same day if they were taken down to be laundered. She further stated that room rounds were completed daily by multiple members of the management team and couldn't explain why the missing privacy curtains had not been identified previously.