STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor the location of a resident who was unaccounted for after his scheduled appointment and did not return to the facility for 1 of 4 residents (Resident #2) reviewed for accidents. The findings included: Resident #2 was admitted to the facility on 12/5/2017 with diagnoses to include acute kidney failure, congestive heart failure, peripheral vascular disease, and cirrhosis of liver. Resident #2's quarterly Minimum Data Set (MDS) assessment dated 3/13/2019 revealed his cognition to be moderately impaired and he required supervision from staff for activities of daily living (ADL). A review of a nurse's note dated 3/26/2019 at 12:02 AM revealed the resident had not returned from a scheduled appointment. The nurse called the hospital at approximate 9:20 PM to inquire and was told by the Emergency Department (ED) nurse that Resident #2 was not a patient in the hospital. The nurse called another hospital and	F 689	1. Resident #2 discharged from the facility on 4/15/19. 2. All residents have the potential to be affected. 3. Nurses will initiate a follow-up phone call to the designated appointment within 4 hours after sign-out time and/or the close of business to ensure resident's location. Results of the follow-up phone call if needed will be documented in the progress notes. Nurses will notify the physician and responsible party if there is a delay in the resident's return to the facility from the appointment. Transportation books to assist with monitoring time out of the facility developed and placed at each nursing station. Transportation books to include: a. Resident name. b. Sign-out time. c. Destination/type of appointment. d. Transporter. e. Follow-up phone call when necessary. f. Sign-in time. Nurses will be educated on the procedure	5/17/19

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

Electronically Signed | 05/09/2019

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F 689	Continued From page 1 was told the same. Resident #2's family members were called and did not know where Resident #2 was. The Director of Nursing (DON) was called at 9:38 PM. The nurse called the appointment office and transport company, both of which were closed. The DON instructed the nurse to call the police department and the police arrived at the facility at 10:50 PM. The Administrator was called by the DON and arrived at the facility at 11:00 PM. At 11:45 PM, the 1st hospital called and notified facility that Resident #2 had been admitted to the hospital. On 4/24/2019 at 8:20 AM, an interview was conducted with nursing assistant (NA) #1. The NA stated Resident #2 was alert and oriented and could take care of himself and did not like staff assistance. The NA stated Resident #2 left the facility on the morning of 3/25/2019 for an appointment and had appeared and acted like he normally had. NA #1 stated when she left the facility at the end of her shift that day at 3:00 PM, Resident #2 had not returned to the facility. On 4/24/2019 at 8:04 AM, an interview was conducted with Nurse #1 who stated Resident #2 was alert and oriented and was very independent with ADLs. The Nurse stated she sent Resident #2 for his out-of-town scheduled appointment at approximately 7:30 AM on 3/25/2019, and he appeared to be his normal self. The Nurse further stated Resident #2 had not returned to the facility at the end of her shift at 3:00 PM and she had reported this to the oncoming nurse. On 4/23/2019 at 3:54 PM, an interview was conducted with the 3:00 to 11:00 PM NA #2. The NA stated Resident #2 was not at the facility	F 689	of: a. Completion of the transportation book. b. Documentation of follow-up phone call to ensure resident location. c. Documentation of physician and responsible party notification. DON, SDC 4. Completion of the transportation book including follow-up phone calls, and physician and responsible party notification will be audited daily x3 months starting on 5/9/19, and a random audit monthly x3 months. DON, UM 5. Audit results will be reviewed at the QAPI meetings for the next 3 months.	

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F 689	Continued From page 2	F 689		

when she started work on 3/25/2019 and she had been told he had gone out to an appointment. The NA stated she had told Nurse #2 that Resident #2 was still not in the facility at about 8:00 PM after supper.

On 4/23/2019 at 4:06 PM, an interview was conducted with NA #3. The NA stated she had asked Nurse #2 if she should put Resident #2's supper tray in his room as he wasn't back from his appointment. NA #3 stated she also told Nurse #2 that Resident #2 was still not back when she picked up the supper trays at about 7:30 or 8:00 PM that evening.

On 4/24/2019 at 2:08 PM, an interview was conducted with nurse #2 who stated she had been told by Nurse #1 that Resident #2 had gone out to an appointment on 3/25/2019 and had not returned by change of shift. Nurse #2 stated she had been keeping an eye out for him to return. Nurse #2 stated she did not remember the NAs telling her Resident #2 was not in his room at suppertime. Nurse #2 stated she decided to call about Resident #2 at about 9:30 PM because he was not in the facility. The Nurse stated she called 2 hospitals and was told he was not at either one. Nurse #2 stated she then called Resident #2 Responsible Party (RP), and then called the DON. Nurse #2 stated she called another family member of Resident #2 who also had not heard from him. The Nurse stated she tried calling the office where the appointment was and the transport company, but she did not receive an answer at either place. Nurse #2 stated the DON had called the police and the police arrived at the facility and took a report from her and then left. Nurse #2 stated shortly after the police left, the Administrator arrived at the

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F 689	Continued From page 3 facility. Nurse #2 stated the DON later reported to her that Resident #2 had been admitted to the hospital. On 4/24/2019 at 1:24 PM, an interview was conducted with the transport person who accompanied Resident #2 to his appointment on 3/25/2019. The transport person stated he was told by the appointment desk to take Resident #2 to the ED and he sat with Resident #2 most of the day at the ED. The transport person stated when the ED decided to admit Resident #2 to the hospital he tried to call the facility, but no one answered the phone. On 4/25/2019 at 8:37 AM, an interview was conducted with the previous DON who stated she was called at home the evening of 3/25/2019 and informed that staff did not know where Resident #2 was, as he had not returned from a morning appointment. The DON stated she went to the facility after being notified by Nurse #2 and called the hospital on her way to the facility. The DON stated the hospital told her Resident #2 had been admitted. The DON stated she had expected staff to communicate with her sooner when Resident #2 did not return from his appointment. On 4/25/2019 at 9:08 AM, an interview was conducted with the current DON who stated when a resident went out to an appointment, she expected staff to follow up with the resident within 2 to 4 hours following the appointment.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		5/17/19

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F 759	Continued From page 4 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to maintain a med error rate of less than 5 percent as evidenced by 4 out of 25 opportunities resulting in a medication error rate of 16 percent for 2 of 3 residents (resident #7 and #8) observed during a medication pass. The findings included: 1. Resident #7 was re-admitted to the facility on 10/31/2018 with diagnoses to include neuromuscular dysfunction of the bladder, urine retention and urinary tract infection (UTI). A Physician order dated 4/17/2019 read Cefepime Hydrochloride (an antibiotic), use 1 Gram intravenously (IV) every 12 hours for UTI for 7 days. A Physician order dated 4/17/2019 read normal saline (NS) flush solution, use 10 milliliters (ML) 2 times per day for flushes for 7 days before and after IV medication administration. During a medication administration observation on 4/24/2019 at 8:39 AM, nurse #1 was observed passing medications to Resident #7. Nurse #1 removed Seroquel 25milligrams (MG), Paxil 40 MG, Lyrica 75 MG, vitamin C 500 MG, zinc 220 MG, a multivitamin tablet, a NovoLog flex pen insulin 5 Units, and a protein powered drink from the medication cart in preparation for administration to Resident #7. Nurse #1 provided	F 759	1. Residents #1 and #2 assessed for negative medication outcomes on 5/9/19. 2. All residents have the potential to be affected. 3. Nurse #1 and Nurse #2 will complete medication competencies education including medication test and observation by 5/10/19. All nurses will be in-serviced on administering medications and will have a medication pass observation by 5/17/19. Medication administration audit for all 3 shifts 1 time per week for 1 month, then all 3 shifts 1 time per month for 2 months. Identified errors will be immediately addressed as appropriate for the resident and with the nurse. DON, SDC, UM 4. DON, SDC, UM will conduct a random observations of medication administration, will be conducted on each shift at least monthly to ensure corrections are sustained. 5. Audit results will be reviewed at the QAPI meetings for the next 3 months.	

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F 759	Continued From page 5	F 759		

the medications to Resident #7 with the medications taken without refusal. Resident #7 consented to drink only half of her protein powered drink, and no other refusal were voiced at that time.
On 4/24/2019 at 8:53 AM, immediately following the medication pass, the nurse stated she had given all the medication that were due at the 9:00 AM time frame.

During a medication reconciliation (medications given are compared to what was ordered) on 4/24/2019 at approximately 4:45 PM, it was discovered that Cefepime Hydrochloride (an antibiotic) 1 Gram (GM) and Normal Saline (NS) flush 10 milliliters (ML) were due to be given at 9:00 AM for UTI. The medication was administered at 2:29 PM.

On 4/24/2019 at 5:34 PM an interview was conducted with nurse #1 who stated resident #7 did not want her medication at that time. The nurse stated Resident #7 went out of the building for an appointment at 10:20 AM and when she returned she was cleaned up and then given lunch and then refused the medication until after lunch. The nurse stated she did not make a note of the late medication reason in the medical record, but she would write a note the next time she worked.

On 4/24/2019 at 5:14 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected medications to be given within the time frame of one hour before or after medications were ordered, or a note to be entered into the medical record for delays outside the timeframe.

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#2. Resident #8 was re-admitted to the facility on 9/15/2017 with diagnoses to include hypertension (HTN) and congestive heart failure (CHF).

A Physician order dated 3/27/2018 read Lasix 40 MG give one tablet daily for HTN.

A Physician order dated 3/16/2018 read metoprolol tartrate tablet 25 MG give 1 tablet 2 times per day for HTN.

During a medication (med) administration observation on 4/24/2019 at 9:05 AM, nurse #2 was observed passing medications to Resident #8. Nurse #2 removed Aspirin 81 MG, Colace 1 tablet, multivitamin 1 tablet, Magnesium Oxide 400 MG, Aldactazide Hydrochlorothiazide 25 MG-25 MG, Zanaflex 2 MG, Potassium Chloride 20 milliequivalents (MEQ), Gabapentin 400 MG, and Venlafaxine 150 MG from the medication cart in preparation for administration for Resident #8. Nurse #2 verified she had 9 medications to administer to the resident. Nurse #2 provided the medications to Resident #8 without incident.

During a medication reconciliation on 4/24/2019 at approximately 4:20 PM, it was discovered that Lasix 40 MG and Metoprolol Tartrate 25 MG were documented as given at the 9:00 AM medication pass.

On 4/24/2019 at 4:46 PM, an interview was conducted with Nurse #2 who stated the Lasix and metoprolol were not available on the medication cart and she had to pull them from another location after the medication pass. The nurse stated she checked the medications as given because she was going to give them later.

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F 759	Continued From page 7 On 4/24/2019 at 5:14 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected medications to be given within the time frame of one hour before or after medications were due, or a note to be entered into the medical record for delays outside the timeframe.	F 759		