STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER ROAD ELIZABETHTOWN, NC 28337

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E 000	Initial Comments An unannounced Recertification survey was conducted on 10/07/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Psychiatric Nurse Practitioner (PNP) interviews the facility failed to administer a medication ordered by the PNP for 1 of 8 residents (Resident #19) whose medications were reviewed. Findings included: Resident #19 was readmitted to the facility on 08/07/19 and had diagnoses of bipolar disorder, chronic pain, and diabetes. The quarterly Minimum Data Set (MDS) dated 08/14/19 revealed Resident #19 was moderately cognitively impaired and had verbal behaviors for 1-3 days of the look back period. Resident #19 did not reject care.	F 658	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:	11/7/19

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

Electronically Signed | 10/25/2019

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F 658	Continued From page 1 The PNP Telephone Order dated 09/16/19 revealed an order for divalproex DR (a delayed release anti-convulsant also used for mood stabilization) 125 mg (milligrams) every morning for Resident #19. Review of the PNP progress note dated 09/16/19 and faxed to the facility on 09/16/19 revealed Resident #19's mood stabilizer would be adjusted to improve his mood and behaviors. The orders included in the progress note were to start divalproex DR 125 mg every morning in addition to the 250 mg that were given at bedtime. The Medication Administration Record (MAR) dated 09/16/19-10/08/19 showed no record that the divalproex DR 125 mg was listed on the MAR or that it had been administered every morning. In a telephone interview on 10/09/19 at 4:14 PM the PNP stated that when she came in to the facility to see Resident #19 on 09/16/19 she had been told by the nursing staff that he was having an increase in behaviors that included cussing, being mean to staff, and being resistant to care. She expressed that she ordered the divalproex DR to be given every morning to improve Resident #19's mood and behaviors. The PNP indicated that she had written the order on a telephone order sheet and left the chart with the order flagged on the nursing desk as was her usual practice. The PNP stated that her progress note regarding her visit with Resident #19 had also been faxed to the facility on 09/16/19. She indicated that with the handwritten order and the order written on the progress note that the facility had two opportunities to begin the medication. The PNP expressed that it was very important for residents to receive the medications that were	F 658	The Divalproex DR 125mg has been administered as ordered daily at 8am beginning 10/12/2019. Copy of eMAR attached. ATTACHMENT #1. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WAS ACCOMPLISHED BY: It was determined that all residents receiving medications have the potential to be affected. 3. ACTIONS TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURANCE INCLUDE: On 10/10/19, the Director of Nursing provided in-service education programs for all licensed staff regarding the transcription and submission of physician orders. ATTACHMENT #2. 4. HOW CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR: The Director of Nursing or designee will monitor the provision of services ordered and provided for residents - ten (10) records per week for one (1) month then five (5) records every two (2) weeks for (2) months. Discrepancies will be promptly reported to the Administrator. QAPI EXAMPLES 1 & 2 ATTACHED.	

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F 658	Continued From page 2 ordered and that she expected the orders she wrote to be followed. In an interview on 10/10/19 at 11:45 AM Nurse #1 verified that she was Resident #19's nurse on 09/16/19. She indicated that it was the responsibility of the nurse to check the resident's charts for orders after a physician or nurse practitioner had been in to see a resident and to transfer the orders into the electronic record. She stated that it was also the responsibility of the resident's nurse to review any progress notes left by the provider or faxed to the facility to see if they contained any orders. Nurse #1 clarified that the order for the divalproex DR 125 mg every morning had been missed twice and had not been administered as ordered. In an interview on 10/10/19 at 11:57 AM the Director of Nursing (DON) stated she expected the nurses to transcribe orders into the electronic record and to review any faxes that came in that had to do with the residents they cared for that day. The DON expressed that she expected residents to receive the medications that were ordered by the providers.	F 658	This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		11/7/19

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F 761	Continued From page 3 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications secured by leaving them on top of a medication cart for 1 of 3 medication carts (100 hall medication cart) observed. Findings included: During an observation on 10/09/19 at 8:48 AM Nurse #1 was seen walking down the 100 hallway coming from the direction of the nurse's station to the medication cart which was outside room 105. Nurse #1 carried a bottle of pills in her hand. There was a medication cup with applesauce sitting on top of the medication cart. The medication cup appeared to have pills in it. There was also a bubble pack of Valsartan 40 mg (milligrams) on top of the cart. In an interview on 10/09/19 at 8:49 AM Nurse #1 confirmed that she had left the medications unattended when she went to get a bottle of vitamins from medication storage. She stated	F 761	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT(S) FOUND TO HAVE BEEN AFFECTED INCLUDE: No resident was found to be affected at the time of the alleged deficiency. Nurse #1 removed all meds from the top of her medication cart. Nurse #1 received employee counseling /	

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F 761	Continued From page 4 that she had only been away from the medication cart for approximately 20 seconds. Nurse #1 confirmed that the cup with applesauce contained the medications hydrochlorothiazide 12.5 mg and losartan 25 mg. Nurse #1 verified that the Valsartan 40 mg bubble pack contained 20 pills. Nurse #1 stated that medications should not be left on top of the medication carts because anyone could take them. In an interview on 10/10/19 at 11:57 AM the Director of Nursing (DON) stated that medications should never be left unattended on top of the medication carts. She expressed that Nurse #1 could have asked someone else to bring her the bottle of vitamins and then the medications would not have been left unattended. She indicated that if medications were left on top of the medication carts anyone could remove them.	F 761	disciplinary action due to violating facility protocol. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WAS ACCOMPLISHED BY: The facility has determined that some of our resident(s) may have the potential to be affected by this alleged deficiency. 3. ACTIONS TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURRENCE INCLUDE: On 10/09/19, the Director of Nursing Services provided in-service education for the licensed staff regarding "Medication Pass" with emphasis on medications are not to be left unattended on the cart. ATTACHMENT #3. 4. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR: The Director of Nursing Services or designee will perform random medication cart checks during med pass on a weekly basis for 4 weeks, if no discrepancies found during the month audit, the frequency will change to monthly audits. The Consultant Pharmacist will monitor for discrepancies during the quarterly med pass audits on a continuous basis. This plan of correction will be monitored at the monthly Quality Assurance meeting	

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F 761	Continued From page 5	F 761	until such time consistent substantial compliance has been met.	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide laboratory services as ordered by the physician for 1 of 5 residents (Resident #2) whose laboratory orders were reviewed. Findings included: Resident #2 was admitted to the facility on 11/17/15 and had diagnoses of dementia with behaviors, anxiety disorders, and major depressive disorder. The medical record revealed there were no laboratory result reports for 2018 and the facility was unable to produce any laboratory reports for 2018 for Resident #2. The annual Minimum Data Set (MDS) dated 10/11/18 revealed that Resident #2 was moderately cognitively impaired, had no behaviors, and did not reject care. Review of the November 2018 Nursing Services	F 770	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT #2 FOUND TO HAVE BEEN AFFECTED INCLUDE: Resident #2 annual labs were up to date for 2019. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WAS	11/7/19

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F 770	Continued From page 6 Notes revealed no documentation that laboratory studies had been done or that blood draws had been refused by Resident #2. The hospital discharge laboratory results dated 06/25/19 revealed a CBC (complete blood count) and CMP (comprehensive metabolic panel) had been performed at the hospital and Resident #2's potassium level was within normal limits. The Physician Orders for October 2019 revealed an order dated 11/11/16 for the lab to draw a CBC and a CMP yearly beginning on 11/01/17 for Resident #2 due to hypokalemia (low potassium). In a telephone interview on 10/10/19 at 11:32 AM Nurse #2 stated that in November 2018 she was responsible for ordering the laboratory studies. She expressed that she could not remember if she had ordered the studies or not. She clarified that if a resident refused to have their blood drawn it would be documented in the medical record. In an interview on 10/10/19 at 11:57 AM the Director of Nursing (DON) stated that sometimes residents would refuse to have their blood drawn. She indicated that if that happened, she would expect it to be documented in the nursing notes. The DON expressed that laboratory studies should be performed as ordered and were an important part of a resident's care.	F 770	ACCOMPLISHED BY: The facility determined that all residents have the potential to be affected. 3. ACTIONS TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURRENCE INCLUDE: On 10/10/19, the Director of Nursing Services provided an in-service education for all licensed staff regarding "Provision of Physician Ordered Services" emphasizing the importance of tracking resident orders. A facility wide lab audit was completed on 10/14/19 to ensure resident safety and facility compliance. The Treatment RN completed a form for each resident with lab orders for quick reference and to ensure compliance with physician orders. ATTACHMENT 4. 4. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR: The Director of Nursing Services or designee will audit patient lab testing weekly to ensure compliance. (ATTACHMENTS 5&6). Quarterly facility wide lab audits will be performed to ensure compliance with physician orders. Discrepancies will be promptly brought to the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial	

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F 770	Continued From page 7	F 770	compliance has been met.	