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 _____	03/03/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 02/28/22 through 03/03/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness, Event ID# N1ZI11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 02/28/22 through 03/03/22. Event ID# N1ZI11	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow a physician ' s order to only administer a medication which increased red blood cell production if the lab value of a hemoglobin (a test that measures the level of a protein responsible for transporting oxygen in the blood) result was less than 10 grams per deciliter (g/dL) 3 out 4 times during the month of February for 1 of 1 resident (Resident #4) observed. Findings included: Resident #4 was admitted to the facility on	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	3/14/22

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

Electronically Signed | 03/24/2022

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F 684	Continued From page 1 11/21/17. Diagnoses included, in part, anemia, renal disease and congestive heart failure (a weakness of the heart that leads to an accumulation of fluid in the lungs). The Minimum Data Set annual assessment dated 12/06/21 revealed Resident #4 was cognitively impaired. A physician ' s order written on 12/31/21 revealed an ordered for Retacrit (a medication to increase red blood cell production) solution inject 10000 units subcutaneous (under the skin) in the evening every Friday for anemia (lack of red blood cells). Administer for a hemoglobin (a protein responsible for transporting oxygen in the blood) reading (lab result) less than 10 g/dL. The lab result recordings revealed the hemoglobin range was 12.0 - 16.0 g/dL. The hemoglobin result on 02/07/22 was 10.0 g/dL, on 02/14/22 the hemoglobin result was 11.0 g/dL, and on 02/21/22 the hemoglobin result was 10.2 g/dL. A review of the Medication Administration Record (MAR) for February 2022 revealed on 02/07/22, 02/14/22, and 02/21/22 the Retacrit was administered to Resident #4 by Nurse #2 as evidenced by the nursing initials and checkmark on the MAR. An interview with Nurse #1 on 03/02/22 at 10:35 AM revealed Resident #4 was receiving the Retacrit due to her low red blood cell production. Nurse #1 explained on Monday of each week labs were ordered to obtain Resident #4 ' s hemoglobin levels to determine if the medication should be given or held based on the parameters	F 684	F684 Corrective Action for Failing to follow a Physician's Order for Retacrit if the Hemoglobin lab value result is less than 10 grams per deciliter (g/dl). For resident #4, the DON notified the MD of the medication error on 1/28/2022. MD promptly reviewed chart and orders were received for the resident. Corrective action for the residents with the potential to be affected by the alleged deficient practice. All residents receiving Retacrit have the potential to be affected. Beginning on 3/2/2022, all residents with an order for Retacrit were audited to ensure the medication order for holding the medication if the Hemoglobin level was 10gms / dl or greater was clear and had supplemental documentation prompts in the order to alert the nurse to enter the actual hemoglobin value. This was completed by 3/2/2022 by the QA Nurse Consultant. Systemic Changes: On 3/3/2022, the Nurse Management Team began in-servicing all current full-time, part-time and PRN nurses and agency nurses. This in-service included the following topics: following physicians orders for holding Retacrit, if the Hemoglobin value was 10gms/dl or greater. The importance of checking the	

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F 684	Continued From page 2 written in the physician order. Nurse #1 further added that the labs were done on Monday to ensure we had the result before Friday (the day of administration). She stated that if the hemoglobin was less than 10 g/dl nursing was to administer the medication as ordered. An interview with the Physician on 03/03/22 at 9:30 AM revealed she expected nursing staff to follow the physician ' s order as written because those were the guidelines of the medication. She stated receiving the medication when the hemoglobin was above 10 g/dL would not necessarily harm the resident but it would put the resident at increased risk for congestive heart failure. An interview with the Director of Nursing (DON) on 03/02/22 at 11:45 AM revealed she was made aware the Retacrit was being administered without regard to the parameters (give if hemoglobin less than 10 g/dL) previously when it was brought to her attention while reviewing the January pharmacy recommendation report. The DON stated she did not in service all staff with this incident and only in serviced the two nurses involved in January. She stated she did not know why Nurse #2 did not follow the order as written and administered the medication when the order indicated to give only if the hemoglobin was less than 10 g/dL. An interview with Nurse #2 on 03/03/22 at 3:00 PM revealed she was aware of the parameters within the written physician ' s order to give if the hemoglobin result was less than 10 g/dL. Nurse #2 stated she just got busy and distracted and did not follow the physicians order as she should have.	F 684	Hemoglobin lab value result prior to administering the medication. Quality Assurance: The Director of Nursing or designee will monitor tag F684 using the Medication Follow Up QA tool for auditing to ensure Hemoglobin level was checked prior to administering Retacrit and the physician order was followed. Audits will be completed weekly x 2 weeks then monthly x 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored by the Administrator and ongoing auditing program reviewed at the weekly Quality Assurance meeting. See attached QA Assurance Tool - Attachment #1 See attached Employee Education - Attachment #1A The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapist, Health Information Manager and the Dietary Manager.	

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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 §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 observations, manufacturer's instructions and staff interviews the facility failed to remove an expired insulin pen belonging to Resident #57 from 1 of 3 medication carts reviewed for medication storage. Findings included: Resident #57 was admitted to the facility on 12/02/20 with a diagnosis of Type 2 Diabetes	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	3/14/22

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F 761	Continued From page 4 Mellitus. Review of March 2022 physician orders for Resident #57 revealed the following order: Lantus Insulin Solostar Pen-inject 13 units subcutaneously every morning and 10 units at bedtime. Review of blood sugar readings for Resident #57 revealed between 02/25/22 and 03/03/22 blood sugar readings documented were within his normal range with no elevated readings. During an observation with Nurse #1 on 03/03/22 at 11:25 AM a Lantus insulin injectable pen for Resident #57 was observed opened on the 400 hall medication cart. The insulin pen had a handwritten opened date of 1/27/22. The manufacturers label on the insulin pen directed to discard the insulin pen 28 days after opening. In an interview with Nurse #1 on 03/03/22 at 11:25 AM she stated she had not noticed the Lantus insulin pen had expired. She reported she had used the expired insulin pen that morning to administer insulin to Resident #57. In an interview with the Director of Nursing on 03/03/22 at 11:15 AM she stated all nurses had been instructed on Monday, 02/28/22, to check all the medication carts to ensure no medications had expired. She assumed the nurses had checked all the medication carts and had discarded any expired medications. She herself had not inspected the carts. She calculated the insulin had expired on 02/24/22 but remained in use until 03/03/22. She stated the insulin pen should have been discarded 28 days after opening. She discarded the expired insulin pen.	F 761	compliance such that all alleged deficiencies cited have been or will be corrected by the dates. F761 Corrective Acton for Failing to remove an expired insulin pen belonging to Resident #57 from 1 of 3 medication carts reviewed for medication storage. For Resident #57, the hall nurse removed the expired insulin pen from the medication cart and discarded it on 3/3/2022. A new insulin pen was ordered from pharmacy on 3/3/2022 by the hall nurse. Corrective action for the residents with the potential to be affected by the alleged deficient practice. All residents who utilize insulin have the potential to be affected by the alleged deficient practice. On 3/3/2022, the nurse management team completed an audit of all current medication carts for the following: audited to ensure all insulin pens and vials was dated with date opened and were not expired. This was completed on 3/3/2022. Systemic Changes: In-service education began on 3/3/2022 and was provided to all full-time, part-time, PRN and agency nurses. Topics included:	

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F 761	Continued From page 5 In an interview with the attending physician on 03/03/22 at 12:00 noon she stated it was possible for an expired insulin to lose it's potency resulting in elevated blood sugar readings. She recommended expired insulin be discarded on the appropriate date to avoid any potential complications.	F 761	Dating insulin pens and insulin vials when opened and using the pens by the expiration date. Dating insulin vials when opened and discarding after 90 days of opening the vial. This information has been integrated into the standard orientation training and in the required in-service refresher course for all nurses and agency nurses and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Staff that have not received the education 3/14/2022 will not be allowed to work until to has be completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor tag F761 using the Med Cart QA tool for auditing the medication cart. This tool will audit for insulin pens and vials to be dated when opened and discarded by expiration dates. Audits will be completed weekly x 2 weeks then monthly x 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting.	

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F 761	Continued From page 6	F 761	The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Rehab Director, Health Information Manager and Dietary Manager. See attached QA Tool - Attachment #2 See attached Education Tool - Attachment #1A	