STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 02/15/2024

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GOLDSBORO REHABILITATION AND HEALTHCARE CENTER	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 02/13/24 through 02/15/24. Event ID# UW3C11. The following inake was investigated: NC00212807. 5 of the 5 complaint allegations did not result in deficiency.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		2/26/24

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

Electronically Signed | 02/23/2024

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F 842	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 842	F 842 = Resident Records - Identifiable	

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F 842	Continued From page 2 facility failed to accurately document on the electronic Medication Administration Record (eMAR) when cardiac medications were withheld according to parameters defined by the physician's orders for 3 of 3 residents reviewed for medication administration (Resident's #1, #2, and #3). 1. Resident #1 was admitted to the facility on 12/08/23 and discharged on 01/10/24 with diagnosis that included atrial fibrillation, nonrheumatic mitral valve insufficiency, atherosclerotic heart disease of the coronary artery, the presence of an automatic implantable cardiac defibrillator, and stroke. Review of the physician orders for Resident #1 revealed the following order : Metoprolol Tartrate Oral tablet 25 MG (Milligram), give 0.25 tablet via peg tube two times a day for hypertension-hold for systolic blood pressure < 93 mmHg (units of Millimeters of mercury) or a heart rate < 60 beats per minute, order date 12/09/23. On 12/10/23 at 8:02 PM the resident had a recorded systolic blood pressure of 90 mmHg, on 12/12/23 at 11:08 AM the resident had a recorded systolic blood pressure of 88 mmHg, and on 12/14/23 at 9:27 AM the resident had a recorded systolic blood pressure of 91 mmHg. On all three occasions the medication was documented as administered. In an interview with Nurse #1 on 02/13/24 at 4:11 PM she stated she had documented in error that the Metoprolol on 12/10/23 at 8:02 PM was administered. She reported that she always took blood pressures before administering any blood pressure medications. She was sure she had not	F 842	Information What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Element #1 Per the 2567, based on observation, record review, staff, and resident interviews the facility failed to accurately document on the Electronic Medication Administration Record (eMAR) when cardiac medications were withheld according to parameters defined by the physician's orders for 3 of 3 residents reviewed for medication administration (Resident's #1, #2, and #3). No Adverse outcomes were identified. All residents on cardiac medication with a Vital Sign parameter in the physician order have the potential to be affected by the deficient practice. Element #2 A 100% audit on residents was completed on 2/15/2024 to ensure all residents with cardiac medications were withheld according to parameters defined by the physician's orders. Any adverse events noted in this audit were corrected immediately. No further discrepancies were noted. In addition, supplemental data within the MD order was used to further verify that the MD ordered VS parameters were within the body of the Md order and eMAR for nursing to visualize. The nurse must obtain vital signs at the time a medication is due and accurately document when a medication was held.	

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F 842	Continued From page 3 given the medication because she always checked the parameters before administering. She thought she may have been busy and accidentally documented that the medication had been administered when it had not been given. She noted the hall the resident resided on was the rehab hall, it was very busy everyday with admissions, bells ringing and other distractions. In an interview with Certified Medication Aide (CMA) #1 on 02/13/24 at 4:25 PM she stated the Metoprolol on 12/12/23 at 11:08 AM and on 12/14/23 at 9:27 AM for Resident #1 was given as documented but the recorded blood pressures were not the blood pressures she had obtained prior to giving the medications. She stated she had been in a hurry on both days and instead of typing in the blood pressures she had taken, she clicked on the option to document the last recorded vital sign in the system and had not noticed they were out of range. She knew she had taken the blood pressures and the systolic blood pressures had been above the required 93 mmHg because the family was always present and insisted the blood pressure was taken before medications were administered. She noted she should have typed in the blood pressures she had taken instead of using the last recorded values. 2. Resident #2 was admitted to the facility on 02/07/24 and discharged on 02/15/24. He had diagnoses that included essential hypertension, atherosclerotic heart disease of the native coronary artery, and atrial fibrillation. Review of the physician orders for Resident #2 revealed the following order: Metoprolol Tartrate Tablet, give 12.5 MG by mouth two times a day, hold for a systolic blood pressure < 96 mmHg or	F 842	What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 On 2/16/2024 current licensed nursing staff were educated by the Director of Nursing via lecture and written format for ensuring all residents with cardiac medications were withheld according to parameters defined by the physician's orders. In addition, supplemental data within the MD order was used to further verify that the MD ordered VS parameters were within the body of the Md order and eMAR for nursing to visualize. Licensed Agency staff and New Licensed Nursing Hires will be educated with this prior to working in the facility and will be part of their new hire orientation by the Director of Nursing or Designee. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing and/or designee will conduct compliance audits 5x/wk. x 12 weeks to all residents with cardiac medications to ensure they were withheld according to parameters defined by the physician's orders. In addition, supplemental data entry within the MD order will be used to further verify that the	

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F 842	Continued From page 4 a heart rate < 60 beats per minute related to unspecified atrial fibrillation, order date 02/07/24. Nurse #4 documented Resident #2 was administered Metoprolol 12.5 MG on 02/10/24 at 9:00 PM with a recorded systolic blood pressure of 94 mmHg. In an interview with Nurse #4 on 02/13/24 at 3:15 PM she stated on 02/10/24 she had taken Resident #2 ' s blood pressure and wrote the result of a systolic blood pressure of 105 mmHg on the 24 hour nurse report but did not enter the result in the computer. Instead, she stated she had clicked on the choice to record the last value recorded in the system and did not realize that value was below the parameter. She noted she was a new nurse and still in orientation. She stated she was not completely familiar with the computer system yet. 3. Resident #3 was admitted to the facility on 04/06/23 with diagnoses that included: atherosclerotic heart disease of the native coronary artery, essential hypertension, and heart failure. Review of the physician orders for Resident #3 revealed the following order: Losartan Potassium Oral Tablet 50 MG, give 1 tablet by mouth one time a day related to essential (primary) hypertension, hold for a systolic blood pressure < 120 mmHg or a heart rate <60 beats per minute, order date 08/22/23. Nurse #3 documented Resident #3 was administered Losartan 50 MG on 09/10/23 at 9:43 AM with a recorded heart rate of 53.	F 842	MD ordered VS parameters were within the body of the MD order and eMAR for nursing to visualize and follow. The facility will provide education on any areas of concern noted. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 2/26/2024	

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F 842	Continued From page 5	F 842		

In an interview with Nurse #3 on 02/14/24 at 3:10 PM she stated she did not remember administering the medication back in September but was sure it was not given if the resident had a heart rate of 53. She stated it was a documentation error. She knew not to give the medication if the heart rate was low because she was familiar with the resident and the parameters. She stated she had been busy and accidentally clicked in the computer that the medication had been given when it had been held.

CMA #2 documented Resident #3 was administered Losartan 50 MG by CMA #2 on 09/14/23 at 10:45 AM with a recorded heart rate of 54 and on 09/24/23 at 12:51 PM with a recorded heart rate of 57.

In an interview with CMA #2 on 02/14/24 at 3:30 PM she stated she knew she would not have given Resident #3 Losartan 50 MG if her heart rate was below 60 beats per minute. She noted she always checked Resident #3 ' s vital signs before she poured her medications because she was familiar with the resident and knew she had parameters on her Losartan medication. She stated she could not remember that far back, but knew she always held this resident ' s cardiac medications according to the vital signs she took herself. She concluded that she had probably been busy and clicked that the medication had been given when it had actually been held. She stated she was 100% sure she had held the medication both times on 09/14/23 and 09/24/23.

Nurse #2 documented she had administered Losartan 50 MG to Resident #3 on the following dates with the corresponding heart rate values:

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F 842	Continued From page 6	F 842		

-10/04/23 at 11:00 AM with a recorded heart rate of 57 beats per minute
-11/10/23 at 11:40 AM with a recorded heart rate of 59 beats per minute
-11/13/23 at 8:45 AM with a recorded heart rate of 57 beats per minute
-11/23/23 at 10:40 AM with a recorded heart rate of 55 beats per minute
-12/27/23 at 14:40 PM with a recorded heart rate of 56 beats per minute
-01/02/24 at 11:36 PM with a recorded heart rate of 58 beats per minute

In an interview with Nurse #2 on 02/14/24 at 3:45 PM she stated she was familiar with the resident and knew which medications not to give Resident # 3 if her blood pressure or heart rate were below a certain range. She said she held any medications that were outside of the parameters set. She noted she had a habit of passing out all the medications than going back at the end of the medication pass and clicking that all the medications had been administered for each resident. She stated the reason she documented incorrectly was because she did not record each medication as she either held it or gave it. She did not specifically recall any of the dates she documented she gave the medication that she had actually held but was sure she had not given the resident a medication that was to be held if her heart rate was low because she always took the time to take her vital signs before she gave the medications. She concluded she had a "teachable moment" with the Director of Nursing and now she documents in the computer at the time she either gives or holds a medication.

In an interview with the Administrator and the Vice President of Clinical Services North Carolina

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F 842	Continued From page 7 Region on 02/15/24 at 1:15 PM, the Administrator stated she expected the nurses to obtain vital signs at the time a medication was due and accurately document when a medication was held. She noted the eMARs had been changed the previous evening for every physician order that had parameters so that a medication could not be documented as either given or withheld without first typing the vital signs into the medical record.	F 842		