STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 and complaint investigation survey was conducted on 2/6/23 through 2/9/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7IU511.	E 000		
F 000	INITIAL COMMENTS An on-site recertification and complaint investigation survey was conducted from 2/6/23 through 2/9/23. Event ID # 7IU511. The following intakes were investigated: NC00195807, NC00195368, NC00197395 and NC00196949. One of the 7 allegations resulted in deficiency (F693).	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding	F 693		2/24/23

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

Electronically Signed | 03/01/2023

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F 693	Continued From page 1 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to store a tube feeding syringe with the plunger separated from the plunger for 1 of 2 residents (Resident #60) reviewed for enteral feeding management, which created a potential for bacterial growth. Findings included: Resident #60 was admitted to the facility on 4/2/2020 with diagnoses of seizure disorder and heart disease. A Significant Change Minimum Data Set (MDS) assessment dated 1/6/2023 indicated Resident #60 was severely cognitively impaired and she received enteral feedings for nutrition. During an observation of Resident #60 on 2/7/2023 at 4:43 pm she was in bed with enteral feeding being administered by an enteral feeding pump. The enteral feeding pump stand had an enteral feeding syringe hanging in a plastic bag. The enteral feeding syringe was stored with the plunger in the syringe and there was clear fluid in the tip of the plunger. During an observation and interview with Nurse #1 at 2/7/2023 at 6:01 pm Resident #60 continued to have an enteral feeding syringe with clear fluid in the tip of the plunger and the syringe continued to be in a clear plastic bag hanging from the enteral feed pump. Nurse #1 stated she gave Resident #60 her medication through her	F 693	Regarding the alleged deficient practice of failure to prevent possible complications of enteral feedings, including storage of equipment, as evidenced by: a)Failure to store a tube feeding syringe separated from the plunger. On 02/07/2023, tube feeding syringe for Resident #60 was discarded. All other tube feeding syringes were audited on 02/07/2023 by the Director of Nursing with no additional findings. Beginning on 02/07/2023, the Director of Nursing (DON) provided in-service education to the unit coordinators, and nursing staff regarding requirements for labeling, storing, and discarding of tube feeding syringe, with education to continue upon return to work for all licensed nurses with completion by 02/24/2023. Education will be provided to newly hired or contracted nursing staff upon hire prior to receiving an assignment. Beginning on 02/23/2023 Director of Nursing or Unit Coordinator will audit tube feeding syringes in use to ensure appropriate storage. The DON and/or unit Coordinators will audit all syringes in use three times	

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F 693	Continued From page 2 gastrostomy tube at 5:30 pm and the plunger was in the syringe when she gave the medication, and she left the plunger in the syringe after giving the medication. Nurse #1 stated she was not aware she should allow the syringe to dry and store the plunger out of the syringe so that liquid would not be trapped and cause a risk for bacteria growth. Nurse #1 stated she was an agency nurse and had not received education from the facility regarding how to store the syringe. An interview was conducted with the Assistant Director of Nursing (ADON) on 2/7/2023 at 6:04 pm and she stated the plunger and syringe for enteral feedings should be allowed to air dry and then stored separately in the storage bag. On 2/8/2023 at 4:14 pm an interview was conducted with the Director of Nursing (DON) and she stated the staff are trained to rinse the enteral feeding syringe after use and place it on a barrier to dry and when the syringe and plunger are dry they should store syringe with the plunger separate. The DON stated the agency nurses are given the same education as the nurses that work for the facility and Nurse #1 received the education. The DON stated Nurse #1 should have followed the facility's procedure.	F 693	weekly for four weeks, then once weekly for 2 months to assure and validate substantial compliance. DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. The Administrator is responsible for implementing this plan of correction.	
F 761 SS=E	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.	F 761		2/24/23

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F 761	Continued From page 3 §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, record review and staff interviews, the facility failed to keep nutritional supplements cold that required refrigeration in accordance with the manufacturer's instructions for 2 of 2 supplements on 1 of 2 medication carts (300 hall). The facility also failed to date a multiple use medication bottle when opened or check the medication expiration date for 1 of 10 medication bottles on 1 of 2 medication carts (400 hall). In addition, the facility failed to date insulin pens when opened for 5 of 8 insulin pens on 2 of 2 medication carts (300 and 400 hall). Findings included: The medication cart for the 400 hall was checked with Nurse #2 on 02/08/23 at 3:05 PM. The following opened and undated medications were noted on the medication cart:	F 761	Regarding the alleged deficient practice of failure to store all drugs labeled in accordance with currently accepted professional principles, including expiration date and temperature control when applicable, as evidenced by: a)Failure to keep nutritional supplements cold that require refrigeration in accordance with manufacturer□s instructions on 300 hall medication cart. b)Failure to date a multiple use medication bottle when opened on 400 hall medication cart. c)Failure to date insulin pens when opened on 300 and 400 hall medication carts.	

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F 761	Continued From page 4 -A 30-ounce bottle of a multiple patient use protein supplement used to promote wound healing was noted to be opened, without an open date and to have expired 09/14/22. Manufacturer instructions were to date the bottle when opened and discard 3 months after opening. The bottle was verified with Nurse #2 as being half empty. -Glargine insulin pen100units (u)/milliliter (ml) with no opened date -Glargine insulin pen100u/ml with no opened date -Lispro insulin pen100u/ml with no opened date -Humalog insulin pen100u/ml with no opened date. 2. The Medication Cart for the 300 hall was checked with the Unit Manager (UM) on 02/08/23 at 2:55 PM. The following was identified: a. A cooler on top of the cart was noted to have a thawed ice pack that was warm, and contained 2 room temperature supplements. The temperature was verified by the UM. She noted the supplements were used for medications for residents. The supplements included: -an opened half empty 8-ounce bottle of chocolate nutritional shake with tape on top that indicated the bottle was opened on 02/07/23. Manufacturer instructions on the bottle noted the medication was to be refrigerated and used within 48 hours after opened. -an unopened thawed sugar free vanilla 4-ounce. Manufacturer recommendations were to thaw under refrigeration at 40 degrees or below, then keep refrigerated and use within 14 days of thawing. No date was on the	F 761	On 02/08/2023, undated insulin pen and improperly stored nutritional supplements on 300 hall medication cart were discarded, as well as, insulin pens and expired medication on 400 hall medication carts were discarded. All other medication carts were audited on 02/09/2023 by the Director of Nursing with no additional findings. Beginning on 02/08/2023, the Director of Nursing (DON) provided in-service education to the unit coordinators, and nursing staff regarding requirements for labeling, storing, and discarding of medication, with education to continue upon return to work for all licensed nurses with completion by 02/24/2023. Education will be provided to newly hired or contracted nursing staff upon hire prior to receiving an assignment. Beginning on 02/22/2023, licensed nurses will audit the med carts at least three times weekly for unlabeled, expired or opened and/or opened and undated medications. The DON and/or Unit Coordinators will audit medication carts weekly for 4 weeks, then twice a month for 2 months to assure and validate substantial compliance. DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and	

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F 761	Continued From page 5 carton when the supplement was thawed. b. An opened Levemir Insulin pen 100 unit/ml with no opened date. c. Assure blood glucose test strip bottle- 50 count with approximately 30 strips left as verified by the UM that was undated when opened. The manufacturer instructions noted glucose test strips would expire 90 days from when the bottle was opened. Review of the manufacturer guidelines for Glargine, Lispro and Humalog insulin revealed the medication should only be used for 28 days upon opening. An interview was done with the UM on 02/08/23 at 2:58 PM. The Unit Manager said the nutritional supplement cartons were to be kept frozen and refrigerated when thawed. She noted the nurses were supposed to obtain fresh coolers and ice packs each shift, to keep the supplements cold. The Unit Manager stated the bottle of blood glucose test strips should have been dated when opened and the strips were used with all resident meters. An interview with Nurse #2 was conducted on 02/09/23 at 3:05 PM. She stated the multi-dose medication bottle and insulin pens should have been dated when opened. The nurse noted the multi-dose medication bottle was facility stock and should have been checked for the expiration date when administering medications and not used if expired. An interview was conducted on 02/08/23 at 4:14 PM with the Director of Nursing (DON). She was	F 761	continue audits at the discretion of the committee. The Administrator is responsible for implementing this plan of correction.	

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F 761	Continued From page 6 informed of the findings regarding medication storage which included opened insulin pens that were not dated on two medication carts, expired medication on a cart and nutritional supplements in coolers on top of medication cart that were at room temperature. The DON stated the staff should have checked the medication carts. She noted multi-dose medication including the insulin pens should be dated when opened, and medication expiration dates should be checked prior to being administered. The DON said night shift checked the medication carts and the pharmacy liaison. The Administrator was interviewed on 02/09/23 at 2:05 PM regarding medication storage. She stated the staff should ensure supplements were kept within the appropriate temperature range per manufacturer guidelines. The Administrator noted she would expect the staff to follow the policy regarding expiration date checks and manufacturer recommendations. The expired medication was to be discarded and the medication should be dated when opened.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input	F 867		2/24/23

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F 867	Continued From page 7	F 867		

from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

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F 867	Continued From page 8 (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or	F 867		

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F 867	Continued From page 9 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews and observations, the facility's Quality Assurance and Performance committee (QAPI) failed to maintain implemented procedures and monitor the interventions put into place during a recertification survey dated 5/13/2021 (F693) and on the current recertification/ complaint survey on 2/9/2023. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. Findings included: This tag is cross referenced to:	F 867	Regarding the alleged deficient practice of failure to prevent possible complications of enteral feedings, including storage of equipment, as evidenced by: a)Failure to store a tube feeding syringe separated from the plunger. On 02/07/2023, tube feeding syringe for Resident #60 was discarded. All other tube feeding syringes were audited on 02/07/2023 by the Director of Nursing with no additional findings. Beginning on 02/07/2023, the Director of Nursing (DON) provided in-service	

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F 867	Continued From page 10 F693 - Based on observation, record review and staff interview the facility failed to store a tube feeding syringe with the plunger separated from the barrel for 1 of 2 residents (Resident #60) reviewed for enteral feeding management, which created a potential for bacterial growth. During the recertification survey of 5/13/2021,the facility failed to store a tube feeding syringe barrel and syringe plunger separately after use and rinsing which created the potential for bacterial growth. An interview was conducted with the Administrator on 2/9/2023 at 2:45 PM. The Administrator stated she had not been aware that syringes used for tube feeding medication administration were stored incorrectly. The Administrator stated she believed the audit process for the storage of tube feeding syringes after use and storage had been resolved by the previous Administrator.	F 867	education to the unit coordinators, and nursing staff regarding requirements for labeling, storing, and discarding of tube feeding syringe, with education to continue upon return to work for all licensed nurses. with completion by 02/24/2023. Education will be provided to newly hired or contracted nursing staff upon hire prior to receiving an assignment. The Regional Director of Clinical Services provided in service education for the Management team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set coordinators, Social Worker, Activities Director and Unit Coordinators regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance on 02/27/2023. Beginning on 02/23/2023 Director of Nursing or Unit Coordinator will audit tube feeding syringes in use to ensure appropriate storage. The DON and/or unit Coordinators will audit all syringes in use three times weekly for four weeks, then once weekly for 2 months to assure and validate substantial compliance. The DON will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan during the monthly QAPI meeting for 6 months or until compliance is maintained.	

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F 867	Continued From page 11	F 867	The Administrator is responsible for implementing this plan of correction.	