ELIZABETHTOWN HEALTHCARE & REHAB CENTER 229 MERCER ROAD ELIZABETHTOWN NC 28337 (M) D (PHERK) ROO SUMMARY STATEMENT OF DEFICIENCIES (EAC) EDERCENT AND TO DEFICIENCY MERCENT AND TO DEFICIENCY MUST REPRECEDD BY YULL ROO production and concentry to the conc		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SUPPLIER ELIZABETTHTOWN HEALTHCARE & REHAB CENTER SUPPLIER IVAID TAG SUMMARY STATEMENT OF DEPICENCIES (EACH DEPICIENT WIS 198 PERCEENEDED BY FULL (EACH DEPICIENT WIS 198 PERCEENEDED BY FULL (EACH DEPICIENT WIS 198 PERCEENEDED BY FULL (EACH DEPICIENT WIS 198 PERCEENED BY FULL (EACH DEPICIENT BY FUELD BY FULL (EACH DEPICIENT			345210	B. WING		-
ELIZABETHTOWN HEALTHCARE & REHAB CENTER ELIZABETHTOWN, NC 28337 (M1)0 MREFIX TAS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ER PRECEDED BY FULL (EACH DEFICIENCY) E 000 Initial Comments E 000 An unannounced Recertification survey was conducted on 10/07/19 through 10/10/19. The facility was found in compliant investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. F 000 An unannounced recertification and complaint investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. F 658 F 658 Services Provided Meet Professional Standards SS=0 CFR(s): 483.21(b)(3)(Comprehensive Care Plans The services provided or arranged by the facility, ras envices provided for an angle by the facility, ras envices provided for an addiction ordered by the PNPK for 10 8 residents (Resident #19) whose medications were reviewed. Findings included: 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 oraceton. This plan of correction. This plan of correction. This plan of correction is submitted as the facility's credible allegation of complance.	NAME OF F	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	
Preprint TAG CEACH DEFICIENCY MUST BE PRECEDED BY TULL REDULTION OR LISC IDENTIFYING INFORMATION) PREFIX TAG CRACH CORRECT ACTION SHOLD BE DEFICENCY COMPLETE DEFICENCY E 000 Initial Comments E 000 E 000 Initial Comments E 000 An unannounced Recertification survey was conducted on 1007/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and complaint investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. F 658 F 11/7/19 Ss=D CFR(s): 483.21(b)(3) Comprehensive Care Plans The Services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (1) Meet professional standards of quality. This RECOUREMENT 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 00/07/19 and had diagnoses of bipolar disorder, chronic pain, and diabetes. 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 ormer, This plan of correction. This plan of correction. This plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. IMMEDIATE ACTION T	ELIZABE	THTOWN HEALTHCARE	& REHAB CENTER			
An unannounced Recertification survey was conducted on 10/07/19 through 10/10/19. The facility was found in compliance with the requirement CFR 493.73, Emergency Preparedness. F 000 An unannounced recertification and complaint investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. F 000 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 Services Provided Meet Professional Standards SS=D CFR(s): 483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (1) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 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 tresponse and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 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. 1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETI
conducted on 10/07/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and complaint investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. F 658 F 658 Services Provided Meet Professional Standards Services Provided Meet Professional Standards () 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: 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. 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:	E 000	Initial Comments		E 000		
investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. Investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. Investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. Investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. Investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. Investigation survey was conducted from 10/07/19 through 10/10/19. The three allegations were unsubstantiated. Investigation survey was conducted from 10/07/19 and had diagnoses of bipolar disorder, chronic pain, and diabetes. Investigation survey was conducted from 10/07/19 and had diagnoses of bipolar disorder, chronic pain, and diabetes. Investigation adverse from 10/07/19 and had verbal behaviors for 1-3 days of the look back period. Resident #19 did not reject care. Investigation adverse from 10/07/19 through 10/10/19. The three allegation from 10/07/19 through 10/10/10/10/10/10/10/10/10/10/10/10/10/1	F 000	conducted on 10/07/1 facility was found in o requirement CFR 483 Preparedness.	19 through 10/10/19. The compliance with the 3.73, Emergency	F 000		
SS=D 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 1.3 days of the look back period. Resident #19 did not reject care. 1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:		investigation survey v 10/07/19 through 10/	vas conducted from 10/19. The three allegations			
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:Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.Resident #19 was readmitted to the facility on 08/07/19 and had diagnoses of bipolar disorder, chronic pain, and diabetes.Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.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.1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:				F 658		11/7/19
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: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.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.1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:		The services provided as outlined by the con- must- (i) Meet professional This REQUIREMENT	d or arranged by the facility, mprehensive care plan, standards of quality.			
08/07/19 and had diagnoses of bipolar disorder, chronic pain, and diabetes.response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.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.1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:		Based on record rev Nurse Practitioner (P failed to administer a PNP for 1 of 8 reside	NP) interviews the facility medication ordered by the nts (Resident #19) whose		do not constitute admission or agreeme by the provider that a deficiency exists. This response is also not to be constru as an admission of fault by the facility,	ent ed its
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.1. IMMEDIATE ACTION TAKEN FOR RESIDENT #19 THAT WAS FOUND TO BE AFFECTED INCLUDE:		08/07/19 and had dia	gnoses of bipolar disorder,		response and plan of correction. This plan of correction is submitted as the	ce.
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		08/14/19 revealed Re cognitively impaired a 1-3 days of the look b	esident #19 was moderately and had verbal behaviors for		RESIDENT #19 THAT WAS FOUND TO	
	BORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		& MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONTRECTION	BENTI TOATION NOMBER.	A. BUILDING	3	
			D MINO		С
		345210	B. WING		10/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ELIZABET	HTOWN HEALTHCAR	E & REHAB CENTER		208 MERCER ROAD	
				ELIZABETHTOWN, NC 28337	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	DATE
F 658	Continued From pa	ge 1	F 65	8	
	The PNP Telephone	e Order dated 09/16/19		The Divalproex DR 125mg ha	is been
		or divalproex DR (a delayed		administered as ordered daily a	
		sant also used for mood		beginning 10/12/2019. Copy of	eMAR
	stabilization) 125 mg (milligrams) every morning for Resident #19.			attached. ATTACHMENT #1.	
	Review of the PNP	progress note dated 09/16/19		2. IDENTIFICATION OF OTHER	2
		cility on 09/16/19 revealed		RESIDENTS HAVING THE PO	
		od stabilizer would be adjusted		TO BE AFFECTED BY THE SA	
		d and behaviors. The orders		ALLEGED DEFICIENT PRACT	
	-	gress note were to start		ACCOMPLISHED BY:	
		mg every morning in addition			
	-	were given at bedtime.		It was determined that all resid	
				receiving medications have the	potential
		ministration Record (MAR)		to be affected.	
		08/19 showed no record that			
	-	125 mg was listed on the MAR		3. ACTIONS TAKEN/SYSTEMS	
	or that it had been a	administered every morning.		INTO PLACE TO REDUCE THE	
				FUTURE OCCURANCE INCLU	IDE:
		view 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			On 10/10/19, the Director of N	
				provided in-service education pr	
				for all licensed staff regarding th	
		aviors that included cussing,		transcription and submission of	physician
		, and being resistant to care.		orders. ATTACHMENT #2.	
		t she ordered the divalproex			
	-	ry morning to improve		4. HOW CORRECTIVE ACTIO	
		od and behaviors. The PNP		BE MONITORED TO ENSURE	
		ad written the order on a		PRACTICE WILL NOT RECUR	•
		eet and left the chart with the		The Director of Nursing or deale	
		e nursing desk as was her PNP stated that her progress		The Director of Nursing or design monitor the provision of services	
	-	visit with Resident #19 had		and provided for residents - ten	
		the facility on 09/16/19. She		records per week for one (1) mo	
		the handwritten order and the		five (5) records every two (2) we	
		progress note that the facility		(2) months. Discrepancies will b	
		es to begin the medication.		promptly reported to the Administ	
		d that it was very important for		QAPI EXAMPLES 1 & 2 ATTAC	
	-	the medications that were			

Facility ID: 923150

If continuation sheet Page 2 of 8

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COMPL	
		345210	B. WING		1	C D/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C		
	HTOWN HEALTHCARE	& REHAB CENTER		208 MERCER ROAD		
	mown heatmoake			ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 658	Continued From page	e 2	F 658	8		
	wrote to be followed.	expected the orders she		This plan of correction will the monthly Quality Assurate until such time consistent set	nce meeting	
	verified that she was 09/16/19. She indica responsibility of the n charts for orders after practitioner had been transfer the orders in stated that it was also resident's nurse to re by the provider or fax they contained any of the order for the dival morning had been mi been administered as In an interview on 10. Director of Nursing (E	inverse to check the resident's r a physician or nurse in to see a resident and to to the electronic record. She to the responsibility of the view any progress notes left red to the facility to see if rders. Nurse #1 clarified that liproex DR 125 mg every issed twice and had not s ordered. (10/19 at 11:57 AM the DON) stated she expected be orders into the electronic		compliance has been met.		
F 761 SS=D	had to do with the res day. The DON expre	nd Biologicals	F 76	1		11/7/19
	Drugs and biologicals	y and cautionary				

Facility ID: 923150

If continuation sheet Page 3 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/12/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345210	B. WING		C 10/10/2019
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ELIZABET	HTOWN HEALTHCARE	& REHAB CENTER		208 MERCER ROAD ELIZABETHTOWN, NC 28337	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETION
F 761	Continued From page	23	F 761		
	Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min be readily detected.	Ardance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. Cality must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can			
	Based on observation facility failed to keep to secured by leaving th cart for 1 of 3 medicat medication cart) observed	n and staff interviews the unattended medications em on top of a medication tion carts (100 hall erved. Findings included: n on 10/09/19 at 8:48 AM		Preparation and/or execution of do not constitute admission or a by the provider that a deficiency This response is also not to be of as an admission of fault by the fa employees, agents or other indiv who draft or may be discussed in	greement exists. construed acility, its <i>r</i> iduals
	Nurse #1 was seen w coming from the direc the medication cart w Nurse #1 carried a bo	ralking down the 100 hallway ction of the nurse's station to hich was outside room 105. ottle of pills in her hand.		response and plan of correction. of correction is submitted as the credible allegation of compliance	This plan facility's e.
	sitting on top of the m medication cup appea	ared to have pills in it. There ck of Valsartan 40 mg		1. IMMEDIATE ACTION(S) TAK THE RESIDENT(S) FOUND TO BEEN AFFECTED INCLUDE: No resident was found to be a	HAVE
	In an interview on 10/ confirmed that she ha unattended when she	09/19 at 8:49 AM Nurse #1 ad left the medications e went to get a bottle of tion storage. She stated		Nurse #1 removed all meds fro of her medication cart. Nurse #1 received employee counseling /	y .

Facility ID: 923150

If continuation sheet Page 4 of 8

	S FOR MEDICARE &	MEDICAID SERVICES		IPLE CONSTRUCTION		IO. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		MPLETED
		345210	B. WING		1	C 0/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
ELIZABE	THTOWN HEALTHCARE	& REHAB CENTER		208 MERCER ROAD ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 761	that she had only bee cart for approximately confirmed that the cu the medications hydr losartan 25 mg. Nurs Valsartan 40 mg bub Nurse #1 stated that left on top of the med anyone could take th In an interview on 10. Director of Nursing (I medications should n top of the medication Nurse #1 could have bring her the bottle of medications would no She indicated that if n	en away from the medication y 20 seconds. Nurse #1 up with applesauce contained ochlorothiazide 12.5 mg and se #1 verified that the ble pack contained 20 pills. medications should not be lication carts because em. /10/19 at 11:57 AM the	F	 disciplinary action due to protocol. 2. IDENTIFICATION OF RESIDENTS HAVING TH TO BE AFFECTED WAS ACCOMPLISHED BY: The facility has determ our resident(s) may have be affected by this allege 3. ACTIONS TAKEN/SYS INTO PLACE TO REDUC FUTURE OCCURRENCE On 10/09/19, the Direct Services provided in-servithe licensed staff regardi Pass" with emphasis on not to be left unattended ATTACHMENT #3. 4. HOW THE CORRECT WILL BE MONITORED T PRACTICE WILL NOT R 	OTHER HE POTENTIAL ined that some of the potential to ed deficiency. STEMS PUT CE THE RISK OF E INCLUDE: for of Nursing vice education for ng "Medication medications are on the cart.	
				designee will perform rar cart checks during med p basis for 4 weeks, if no d found during the month a frequency will change to The Consultant Pharmac for discrepancies during med pass audits on a con This plan of correction wi the monthly Quality Assu	bass on a weekly liscrepancies audit, the monthly audits. cist will monitor the quarterly ntinuous basis.	

Facility ID: 923150

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/12/2 FORM APPROV OMB NO. 0938-03
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345210	B. WING		C 10/10/2019
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	
				208 MERCER ROAD	
ELIZABET	HTOWN HEALTHCARE	& REHAB CENTER		ELIZABETHTOWN, NC 28337	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 761	Continued From page	e 5	F 7	until such time consistent si compliance has been met.	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)	(i)	F 7	70	11/7/19
	 §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. 			Preparation and/or execution do not constitute admission by the provider that a deficion This response is also not to as an admission of fault by employees, agents or other who draft or may be discussed response and plan of correct plan of correction is submitted facility's credible allegation	or agreement ency exists. be construed the facility, its individuals sed in this ction. This ted as the
	laboratory result repo	evealed there were no orts for 2018 and the facility ce any laboratory reports for		1. IMMEDIATE ACTION(S) THE RESIDENT #2 FOUNI BEEN AFFECTED INCLUD	D TO HAVE
	10/11/18 revealed that moderately cognitive	ly impaired, had no		Resident #2 annual labs date for 2019.	were up to
	behaviors, and did no Review of the Novem	ot reject care. Iber 2018 Nursing Services		2. IDENTIFICATION OF O RESIDENTS HAVING THE TO BE AFFECTED WAS	

Facility ID: 923150

If continuation sheet Page 6 of 8

STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY MPLETED
			A. BUILDIN	G		С
		345210	B. WING		1	0/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
FI IZABET	HTOWN HEALTHCARE	& REHAB CENTER		208 MERCER ROAD		
				ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 770	Continued From page	e 6	F 7	70		
	Notes revealed no do	ocumentation that laboratory ne or that blood draws had		ACCOMPLISHED BY:		
	been refused by Res	ident #2.		The facility determined the have the potential to be affected by the second sec		
	06/25/19 revealed a and CMP (comprehe	ge laboratory results dated CBC (complete blood count) nsive metabolic panel) had e hospital and Resident #2's within normal limits.		3. ACTIONS TAKEN/SYST INTO PLACE TO REDUCE FUTURE OCCURRENCE I	THE RISK OF NCLUDE:	
	an order dated 11/11/ and a CMP yearly be	s for October 2019 revealed /16 for the lab to draw a CBC ginning on 11/01/17 for ypokalemia (low potassium).		On 10/10/19, the Director Services provided an in-ser for all licensed staff regardi of Physician Ordered Servi emphasizing the importanc resident orders. A facility w	vice education ng "Provision ces" e of tracking	
	Nurse #2 stated that responsible for order She expressed that s she had ordered the that if a resident refus drawn it would be do	iew on 10/10/19 at 11:32 AM in November 2018 she was ing the laboratory studies. she could not remember if studies or not. She clarified sed to have their blood cumented in the medical		was completed on 10/14/19 resident safety and facility of The Treatment RN complet each resident with lab orde reference and to ensure co physician orders. ATTACH	 to ensure compliance. ed a form for rs for quick mpliance with 	
	Director of Nursing (E residents would refus She indicated that if t expect it to be docum The DON expressed	/10/19 at 11:57 AM the DON) stated that sometimes se to have their blood drawn. that happened, she would nented in the nursing notes. that laboratory studies as ordered and were an sident's care.		4. HOW THE CORRECTIVE WILL BE MONITORED TO PRACTICE WILL NOT REC The Director of Nursing S designee will audit patient I weekly to ensure compliance (ATTACHMENTS 5&6). Qu wide lab audits will be perfor ensure compliance with phy Discrepancies will be prom the Administrator.	ENSURE THE CUR: Services or ab testing ce. arterly facility ormed to ysician orders.	
				This plan of correction will the monthly Quality Assuration until such time consistent s	nce meeting	

Event ID: X4TK11

Facility ID: 923150

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/12/2019 1 APPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345210	B. WING			10/	_ 10/2019
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
ELIZABET	HTOWN HEALTHCARE	& REHAB CENTER			08 MERCER ROAD LIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	Continued From page	97	F	770	compliance has been met.		
	7(02-99) Previous Versions Obs	olete Event ID: X4			sility ID: 923150	tinuation sh	

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