STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HEALTH & REHAB CENTER	**54 RED MULBERRY WAY LILLINGTON, NC 27546**

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E 000	Initial Comments An unannounced recertification and complaintint investigation survey was conducted on 1/3/2023 through 1/6/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 6EV711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 1/3/2023 through 1/6/2023. The following intakes were investigated NC00188881, NC00190264, NC00191136, NC00194794 and NC00195980. 2 of the 13 compliant allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		1/27/23

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

Electronically Signed | 02/01/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to ensure staff spoke to a resident in a respectful and dignified manner for 1 of 1 resident (Resident #44) reviewed for dignity. Findings included: Resident #44 was admitted to the facility on 12/15/2022 and discharged on 1/4/2023. The admission Minimum Data Set (MDS) assessment dated 12/21/2022 indicated the resident was cognitively intact. In an initial pool interview with Resident #44 on 1/3/2023 at 3:45 p.m., she stated on 12/24/2022	F 550	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents F550 Resident Rights/Exercise Rights CFR(s)483.10(a)(1)(2)(b)(1)(2)	

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F 550	Continued From page 2 at 8:00 p.m. when she went up to the nursing station and asked the nurse (name unknown) who was head of housekeeping because her room had been nasty for two days. She stated the nurse and her got into a shouting match with each other and stated the nurse asked her, "Why you up here at 8:00 p.m. to ask about housekeeping and you had all day. Ain't no nurse going to clean the room tonight." Resident #44 stated she had spoken to Nurse #4 about the incident and was unable to recall exactly when. On 1/6/2023 at 2:00 p.m. in a phone interview with Resident #44, she stated after the incident with Nurse #5 on 12/24/2022, Nurse #5 would get another nurse to administer her medications. She stated the incident was emotionally unnecessary and she felt intimidated, and a sense of trust was lost. She stated the tone Nurse #5 used with her was horrible, and she isolated herself to her room after the incident. Nursing documentation dated 1/4/2023 by Nurse #4 revealed Resident #44 reported verbal aggression from a staff member (Nurse #5). There was no date or time indicate in the nursing documentation when the incident of verbal aggression occurred. Nursing documentation revealed Resident #5 stated the staff member (Nurse #5) was rude and both Resident #44 and the staff member (Nurse #5) raised their voices and engaged in a hollering match. Nurse #4 recorded Resident #44 denied anyone making any physical contact during the time of the incident, but it made the situation awkward when she had to later engage with the staff member (Nurse #5). On 1/6/2023 at 7:39 a.m. in a phone interview	F 550	1) How corrective action will be accomplished for residents(s) found to have been affected. A. Resident #44 discharged from the facility on 01/04/2023 2) How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: A. The Administrator re-educated all staff on 1/27/2023 regarding Resident Rights and treating residents with Dignity B. The Administrator/ designee conducted interviews on 1/5/2023 with all like residents to ensure they are being treated with dignity and respect. 3) What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? A. The Administrator or designee will conduct random interviews with 5 residents weekly for 4 weeks, then 3 residents weekly for 2 months to ensure they are being treated with dignity. 4) Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: A. The Administrator or designee will collect data from the audits, and it will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) committee meeting. The Administrator will discuss the audit results with the IDT	

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F 550	Continued From page 3	F 550		

with Nurse #5, she stated Resident #44 approached the nursing station on 12/24/2022 at 8:00 p.m. wanting to speak with the housekeeping manager about her room not being cleaned. She stated she informed Resident #44 there was no one there at that time to speak with her and concerns would be addressed the next morning with housekeeping. She stated Resident #44 repetitively continued to ask the same questions about her room being cleaned and started shouting and yelling. Nurse #5 stated she responded to her questions firmly and did not raise her voice.

On 1/6/2023 at 12:19 p.m. in an interview with Nurse #6, she stated she witnessed the conversation between Nurse #5 and Resident #44 on 12/24/2022. She stated Resident #44 was at the nursing station asking Nurse #5 who she could talk to about her room not being clean. She stated Nurse #5 was using a normal tone when informing Resident #44 that housekeeping had left for the evening, and there was nothing she could do. She stated Nurse #5 asked Resident #44 why she had not reported it earlier. Nurse #6 stated as the conversation continued, the volumes of both Nurse #5 and Resident #44 voices got higher. She stated the volume of the conversation between Nurse #5 and Resident #44 was high enough, she came out of a room to see what was going on. She stated Nurse #5 was professional in trying to explain herself to Resident #44, and Resident #44 kept interrupting her until both Nurse #5 and Resident #44 were trying to be heard over each other. Nurse #6 stated Resident #44 left the nursing station and returned to her room, and when she administered Resident #44 her medications that night, Resident #44 did not mention the incident with

during the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.

The facility alleges compliance on 1/27/2023.

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F 550	Continued From page 4	F 550		

Nurse #5 to her and did not appear in any distress.

On 1/6/2023 at 12:49 p.m. in an interview with Nurse #4, she stated when she spoke with Resident #44 sometime the week after Christmas about her concerns with housekeeping and medication administration, Resident #44 stated she and Nurse #5 got into a "hollering match" over her room not being clean. Nurse #4 stated Resident #44 just wanted someone to know what had happened and never stated she felt verbally abused when speaking with her. She stated she spoke with the nursing staff and Nurse #5 about not raising their voices when talking with residents. She stated hollering was not acceptable behavior, and staff must be respectfully and professional when talking to residents. Nurse #4 stated she did not record Resident #44 concerns or have any documentation of the education provided to the staff.

In a follow up interview with Nurse #4 on 1/6/2023 at 1:03p.m., she stated she could not recall what day she spoke with Resident #44 and stated Resident #44 verbalized she was not afraid to reside in the facility.

On 1/6/2023 at 1:24 p.m. in an interview with the Administrator, she stated she spoke with Resident #44 on 1/3/2023 evening after learning from the state surveyor on 1/3/2023 at 4;50 p.m. Resident #44 had alleged verbal abuse. The Administrator stated she was aware Resident #44 had been upset about her room not being clean and did not recall Nurse #4 using the verbiage, "hollering match" when discussing Resident #44 concerns with Administration. She stated when

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F 550	Continued From page 5 speaking with Resident #44 on the evening of 1/3/2023 about the incident on 12/24/2022 with Nurse #5, Resident #44 did not say she was afraid or fearful of being in the facility and what she gathered was Resident #44 was disrespected by Nurse #5 on 12/24/2022. On 1/6/2023 at 4:22 p.m.in an interview with the Director of Nursing, she stated nursing staff were to provide resident care respectfully and professionally and use a respectful tone when in conversations with Resident #44.	F 550		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		1/27/23

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F 655	Continued From page 6 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an individualized person centered baseline care plan for 1 of 9 residents reviewed for pharmacy services. (Resident #196) Findings included: Resident #196 was admitted to the facility on 4/22/2022. Resident #196 was discharged from the facility on 5/3/2022. The discharged summary dated 4/22/2022 from the hospital revealed Resident #196 was receiving two seizure medications, Lamictal XR 100 milligrams (mg) and Keppra 1000 mg twice a day.	F 655	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents F655 Baseline Care plans CFR(s)483.21(a)(1)-(3)	

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F 655	Continued From page 7 Physician orders dated 4/22/2022 revealed Lamictal 100mg twice a day and Keppra XR 1000mg twice a day were ordered for Resident #196 for seizures. A review of the April 2022 Medication Administration Record revealed Resident #196 started receiving Lamictal and Keppra on 4/23/2022 and continued to receive twice a day while in the facility. The baseline care plan dated 4/23/2022 for Resident #196 included no plan of care for seizures or receiving anti-seizure medication. The care plan was documented as having been most recently reviewed by the facility on 04/30/2022. The admission Minimum Data Set (MDS) assessment dated 4/29/2022 indicated Resident #196 was cognitively intact, and diagnoses included a seizure disorder. On 1/5/2022 at 8:38 a.m. in an interview with MDS Nurse #1, she stated MDS nurses were responsible for development of residents' baseline care plans, and care plans were developed based on the following information: diagnoses, discharge summaries, history and physicals, and physician orders. She stated Resident #196's diagnoses included seizures and was receiving anti-seizure medications, and there was no primary focus for seizures on Resident #196's baseline care plan. She stated she was not taught to include seizures as a separate plan of care and noted seizures with other primary focuses in the care plan like falls related to seizures.	F 655	1) How corrective action will be accomplished for residents(s) found to have been affected. A. Resident #196 was discharged from the facility on 5/03/2022 2) How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: A. A baseline care plan audit on all residents was completed on 1/27/2023. B. The interdisciplinary team including MDS, Director of Nursing, Social Services, and Dietary was in serviced by the Regional Director of Clinical Services on Baseline Care Plans implementation on 1/24/2023. 3) What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? A. The Administrator will complete audits of new admissions verifying Baseline Care Plans are initiated within 48 hours. Audits will be completed 3 times a week for 4 weeks and monthly for 2 months. 4) Indicate how facility plan to monitor it performance to make sure that solution are achieved and sustained: A. The Administrator or designee will collect data from the audits, and it will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) committee meeting. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance	

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F 655	Continued From page 8 On 1/6/2022 at 4:17 p.m. in an interview with the Director of Nursing, she stated Resident #196 had a history of seizures and was receiving medications for seizures. She stated MDS nurses were responsible for developing baseline care plans, and Resident #196 should have had a plan of care for seizures. On 1/5/2022 at 1:58 p.m. in an interview with the Administrator, she stated Resident #196's baseline care plan should be comprehensive and individualized based on diagnoses and the resident's needs.	F 655	Performance Improvement (QAPI) meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification. The facility alleges compliance on 1/27/2023.	
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	F 761		1/20/23

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F 761	Continued From page 9 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 and staff interviews, the facility failed to discard an expired medication and store Gabapentin liquid, a seizure medication, in the refrigerator as indicated on the pharmacy label and bottle of medication for 1 of 2 medications carts observed (Front 300-Hall Medication Cart). Findings included: a. An observation of the Front 300-Hall Medication Cart was conducted on 1/4/2023 at 5:36 a.m. in the presence of Nurse #1. A four ounce opened bottle of Guaiasorb DM (dextromethorphan) liquid, an expectorant cough suppressant, was observed in the facility stock medication drawer for liquids dated opened on 12/20/2022, and the expiration date on the bottle of Guaiasorb DM was 6/2022. The medication was not prescribed to one particular resident. Nurse #1 stated she checked medication expiration dates when administering medications and had not administered the medication to any residents. She stated she had not checked all medications on the cart for expiration dates and was unsure who was responsible for checking the medication cart for expired medications. Nurse #1 disposed of the medication bottle in the medication room. On 1/6/2023 at 9:10 a.m. in an interview with the Director of Nursing (DON) she stated Guaiasorb was a facility stocked medication and there were no residents ordered the medication, Guaiasorb.	F 761	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents F761 Label/Store Drugs and Biologicals A. How corrective action will be accomplished for residents(s) found to have been affected. 1. The expired bottle of cough medicine and the gabapentin not refrigerated have been disposed of B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: 1. On 1/09/2023 an audit was completed by the DON/Unit Manager of all medication carts to ensure no expired medications or medications needing refrigeration are on the carts. 2. The Director of Nursing initiated reeducation to all licensed nurses beginning 1/09/23 regarding medication	

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F 761	Continued From page 10 In a follow up interview with the Director of Nursing on 1/6/2023 at 11:10 a.m., she stated seven residents had received cough suppressants in the month of December 2022. Two of the seven residents received medications from the front 300-hall medication cart. The DON stated she was unaware of any negative outcomes with the identified residents that could have received the medication. On 1/6/2023 at 4:46 p.m. in an interview with the unit manager, she stated the unit manager was responsible for checking medication carts weekly for expired medications. She stated she had not checked the front 300-hall medication cart this week due to conducting other duties. On 1/6/2023 at 4:10 p.m. in an interview with the Director of Nursing, she stated medication carts were checked for expired medications by the pharmacy (The DON could not remember how often pharmacy checked the medication carts), by the unit manager weekly and by the nurses daily when administering medications to residents. She stated the bottle of Guaiasorb DM should have not been used when opened on 12/20/2022 and should had been removed from the front 300-hall medication cart. b. A medication pass observation for Resident #194 was conducted on 1/5/2022 at 2:46 p.m. with Nurse #2. Nurse #2 was observed obtaining a bottle of Gabapentin liquid, a seizure medication, from the front 300-hall medication cart. The Gabapentin bottle label and the pharmacy label was observed with instructions to refrigerate the medication for Resident #194. Nurse #2 stated she was unable to administer Gabapentin to Resident #194 because the	F 761	storage focusing on identification of expiration dates and appropriate temperature storage. 100% of licensed nurses re-education will be completed by 1/20/23. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? 1. -The Director of Nursing or designee will complete medication cart audits three (3) times a week for four weeks, then two (2) times a week for eight weeks to ensure there are no expired or refrigerated medications on cart. D. Indicate how facility plans to monitor its performance to make sure that solution are achieved and sustained: 1. The Director of Nursing or designee will collect data from the audits, and it will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) committee meeting. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification. The facility alleges compliance on 01/20/2023	

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	345173	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HEALTH & REHAB CENTER	54 RED MULBERRY WAY LILLINGTON, NC 27546

(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
F 761	Continued From page 11 pharmacy label and the bottle label stated to refrigerate the medication, and the medication was at room temperature on the front 300-hall medication cart. Nurse #2 stated she did not know how long the Gabapentin liquid bottle had been on the front 300-hall medication cart. The Gabapentin liquid bottle was removed from the front 300-hall medication cart by Nurse #2 and a new bottle of Gabapentin liquid was ordered for Resident #194. On 1/6/2023 at 4:10 p.m. in an interview with the Director of Nursing, she stated Gabapentin liquid was to be stored correctly based on the guidelines in the refrigerator.	F 761		