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 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO REHABILITATION AND HEALTHCARE CENTER	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 4/23/23 through 4/26/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MN2311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/23/23 through 4/26/23. Event ID# MN2311. The following intakes were investigated NC00200025 and NC00199690, NC00198679, NC00198159, NC00198302, and NC00192065. 27 of the 27 complaint allegations did not result in deficiencies.	F 000		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		5/10/23

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

Electronically Signed | 05/10/2023

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F 732	Continued From page 1 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations record review and staff interviews, the facility failed to post the accurate census on the daily nurse staffing sheets for 2 of 4 days (4/23/23 and 4/24/23) of the recertification survey. The findings included: During the initial tour of the facility on 4/23/23 at 10:00 AM the daily nurse staffing sheet was observed posted on a wall by the nurse's station with a date of 4/23/23 and a census of 117. The Administrator confirmed the correct census was 120. On 4/24/23 at 11:15 AM the staff posting was observed with a date of 4/24/23 and a census of 117. The Administrator confirmed the correct census was 120. An interview was completed on 4/25/23 at 11:56	F 732	Per the 2567, based on observation, record review and staff interview, the facility failed to post the accurate census on the daily nurse staffing sheets for 2 of 4 days (4/23/23 & 4/24/23) of the recertification survey. Administrator has provided 1:1 education with the Staffing scheduler and nursing supervisors on 4/26/2023. No Adverse outcomes were identified. All residents and staff have the potential to be affected by the deficient practice. The Administrator has provided 1:1 verbal and written education with the Staffing coordinator and nursing supervisors on 4/26/2023. In-service education via verbal and written format was started by the Administrator on 4/27/2023 to all staff that	

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F 732	Continued From page 2 AM with the Staffing Manager. She indicated weekend daily nurse staffing sheets were posted prior to the end of her shift on Friday. The Staffing Manager stated the weekend unit manager was responsible for updating the census on Saturday and Sunday. Multiple attempts to contact the weekend unit manager were unsuccessful. An interview was completed on 4/26/23 at 2:05 PM with the Administrator. She stated the current census was discussed during the facility's daily morning meeting and was updated on the staffing sheets when needed. The Administrator indicated the facility failed to have the morning meeting on 4/24/23, therefore the Staffing Manager was not aware the correct census for 4/23/23 and 4/24/23 was 120. She stated she expected that the staff posting would be up to date and reflect the current census of the building.	F 732	are responsible for this task, and will be completed by 5/12/2023 on proper policies and procedures related to posting the accurate census on the daily nurse staffing sheets. An audit of the daily nurse staffing sheets was completed to ensure the census is accurate and any abnormalities were corrected immediately. This was conducted by the Administrator to ensure all Goldsboro Rehabilitation and Healthcare Center designated staff are appropriately posting the accurate nursing census sheet daily per our policies and procedures. Mandatory verbal and written all staff/contract agency staff assigned to this task will receive education related to Policy and Procedures for Posted Nurse staffing information, which includes all Departments and will be completed on 05/12/2023. Immediate education/interventions were provided to the Administrator and Staffing Manager, and included nursing supervisors 4/26/2023. All new hires and all contracted agency staff that are responsible for this will have this mandatory education prior to working with written and verbal educational format. Daily ongoing observation and education will be provided also to maintain compliance. To ensure ongoing compliance, the Administrator or designee will perform daily audits, 5x a week to ensure compliance with Daily posted nurse staffing information.	

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F 732	Continued From page 3	F 732	The results of these audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 05/12/2023	
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 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:	F 761		5/10/23

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F 761	Continued From page 4 Based on observation, record review and staff interview the facility failed to monitor temperatures for 1 of 1 medication refrigerators (300 Hall medication room refrigerator) and failed to discard expired medication for 2 of 3 medications carts (400 Hall medication cart, 500 Hall medication cart). The findings included: 1. An observation was conducted of the 300 Hall medication storage room on 4/25/23 at 9:02 AM with Nurse Supervisor #2. The refrigerator temperature registered at 28 degrees Fahrenheit and there was a large block of ice formed around the freezer section of the refrigerator. The 300 Hall refrigerator contained the following medications 1 Humalog Insulin KwikPen Prefilled syringe, 2 Novolog Insulin FlexPen Prefilled syringes, 3 Mini Bag Intravenous Ertapenem (an antibiotic) and 2 boxes of Tuberculin Purified Protein Derivative. A review of the refrigerator temperature log for the month of April 2023 revealed the refrigerator temp log needed to be at 36 to 46 degrees Fahrenheit (40 degrees Fahrenheit is the ideal temperature for the medication refrigerator was indicated on the refrigerator and freezer temperature log). A review of the temperature log revealed the refrigerator temperatures were out of range on the following dates: 4/5/23 @ 0800- 34 degrees Fahrenheit (Adjusted)The temperature was adjusted but there was no rechecked temperature to see if the temperature was maintained. 4/8/23 @ 1800 32 degrees Fahrenheit (Adjusted)	F 761	Per the 2567, based on observation, record review and staff interview, the facility failed to monitor temperatures of 1 of 1 medication refrigerators and failed to discard expired medication for 2 of 3 medication carts. the facility failed to ensure staff followed the facility's Medication Label/Store Drugs and biologicals. Items within this citation were corrected immediately. The District Director of Clinical Operations and designated pharmacy nurse consultant has provided 1:1 education with the Director of Nursing on 4/26/2023. No Adverse outcomes were identified. All residents receiving medications have the potential to be affected by the deficient practice. The District Director of Operations has provided 1:1 education with the Director of Nursing on 4/26/2023. In-service education via verbal and written format was provided by the Director of Nursing, SDC/Infection Preventionist beginning on 4/27/2023 to all licensed nursing and contract staff, and will be completed by 05/12/2023 on proper policies and procedures related to medication storage/labeling and drug storage A full house audit of all medication refrigerators and medication carts was performed to ensure temperatures were in normal range and no expired medications in the medication carts, and any abnormalities were corrected immediately. This was conducted by the Director of Nursing, and Infection Preventionist/designee to ensure all Goldsboro Rehabilitation and	

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F 761	Continued From page 5 4/9/23 @ 0810 34 degrees Fahrenheit (Adjusted) 4/9/23 @ 2200 32 degrees Fahrenheit (Adjusted) 4/13/23 @ 1530 30 degrees Fahrenheit (Adjusted) 4/18/23 @ 1600 30 degrees Fahrenheit (Adjusted) 4/19/23 @ 0800 30 degrees Fahrenheit (Adjusted) 4/19/23 @ 1600 20 degrees Fahrenheit (Adjusted) 4/20/23 @ 1500 28 degrees Fahrenheit (Adjusted) An interview was conducted with Nurse Supervisor #2 at 9:38 AM. NS #2 stated the medication refrigerator was checked twice daily and the temperature was adjusted either up or down to maintain the refrigerator within the desired range. NS #2 stated she would remove the medications and place them in another refrigerator. NS#2 stated she would have maintenance look at the refrigerator. An interview was conducted with the Maintenance Director on 4/25/23 at 12:52 PM. The Maintenance Director stated he was made aware of the issue with the refrigerator this morning. He stated that most of the time when the medication refrigerator stopped maintaining its temperature it was due to their being a large block of ice in it. The Maintenance Director stated the medication refrigerator should maintain its	F 761	Healthcare Center staff are appropriately following our medication label/storage and drug storage policies and procedures. Mandatory verbal and written all licensed nursing staff/contract agency staff education on policies and procedures related to Medication storage/labeling and drug storage, which includes all LPN/RN will be completed on 05/12/2023. Immediate education/interventions were provided to the Nurse Supervisor #2, Nurse #10, and Nurse #9 on 4/25/2023. Full house Education initiated on 4/25/2023 and completed 05/12/2023. All new hires and all contracted agency licensed nursing staff will have this mandatory education prior to working on the unit with written and verbal educational format. Daily ongoing observation and education will be provided also to maintain compliance. To ensure ongoing compliance, the Director of nursing or designee will perform daily audits, 5x a week to ensure compliance with Medication storage/labeling and drug storage. The results of the Medication labeling, and drug storage audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 05/12/2023	

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F 761	Continued From page 6	F 761		

ideal temperature with the door closed. He further stated that nursing notified maintenance when the medication refrigerators needed defrosting.

An interview was conducted with the Administrator and Regional Vice President of Clinical Services on 4/26/23 at 3:09 AM. The Administrator stated the refrigerator temperatures were checked twice daily. She stated if the refrigerator was consistently out of range, then the medications should have been removed, and maintenance should look at the refrigerator. The Administrator stated a work order was placed in the TELS electronic system (a computer system that allows staff to put in work orders for the facility) to notify maintenance personnel.

2 a. During the observation on 4/25/23 at 9:02 AM with Nurse Supervisor #2 the 300 Hall refrigerator contained the following medications 1 Humalog Insulin KwikPen Prefilled syringe, 2 Novolog Insulin FlexPen Prefilled syringes, 3 Mini Bag Intravenous Ertapenem (an antibiotic) and 2 boxes of Tuberculin Purified Protein Derivative.

b. An observation of the 400 Hall medication cart on 4/25/23 at 9:45 AM revealed an opened Timolol Maleate Ophthalmic Solution 0.5% dated 3/24/23.

An interview was conducted with Nurse #10 on 4/25/23 at 9:58 AM. Nurse #9 stated she did not realize the expired medication was on the cart. Nurse #10 stated the nurse assigned to the cart was responsible for checking for expired medications each shift.

c. An observation of the 500 Hall medication cart

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F 761	Continued From page 7 on 4/25/23 at 10:01 AM revealed an opened bottle of Dorzolamide Opthalmic Solution 0.2% dated 3/24/23. An interview was conducted with Nurse #9 on 4/25/23 at 10:05 AM. Nurse #9 stated she did not realize the expired medication was on the cart. Nurse #9 stated the nurse assigned to the cart was responsible for checking for expired medications. An interview was conducted with the Administrator and Regional Vice President of Clinical Services on 4/26/23 at 3:09 AM. The Administrator stated expired medications should be removed prior to their expiration date.	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 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	F 867		5/10/23

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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:
(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

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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 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

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F 867	Continued From page 10 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, observation, and staff interview, the facility ' s Quality Assurance and Assessment (QAA) Committee failed to maintain implemented procedures and monitor interventions put in place following the recertification and complaint investigation survey of 12/16/21. This was for a deficiency in the area of Label/Store Drugs and Biologicals (F761) originally cited on 12/16/21, recited on a recertification follow up survey on 2/2/22, and subsequently recited on the current recertification survey of 4/26/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: F761: Based on observation, record review and staff interview the facility failed to monitor temperatures for 1 of 1 medication refrigerators (300 Hall medication room refrigerator) and failed to discard expired medication for 2 of 3	F 867	Per the 2567, based on staff interview and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 12/16/2021 recertification survey. This was for a deficiency in the area of Label/Store Drugs and Biologicals (F761), recited on a recertification follow up survey on 2/2/22, and subsequently recited on the current recertification survey of 4/26/23. The continued failure during two surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. This tag is cross referenced to: F761 Based on record review, observation and staff interviews, the facility failed to ensure staff followed the facility's Medication Label/Store Drugs and biologicals by not staff not monitoring temperatures of 1 of 1 medication refrigerator (300 Hall medication room refrigerator and failed to discard expired medication for 2 of 3	

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F 867	Continued From page 11 medications carts (400 Hall medication cart, 500 Hall medication cart). During the previous recertification survey of 12/16/21, the facility failed to discard a vial of expired influenza vaccine and to date an opened vial of Tuberculin purified protein for 1 of 2 medication rooms reviewed for medication storage. During the recertification follow up survey of 2/2/22 the facility failed to dispose of 3 insulin pens that were labeled with an opened date of over 28 days and to label three insulin pens with an opened date on one of one medication carts reviewed (the 100 Hall Medication Cart). During an interview with the Administrator and Regional Vice President of Clinical Services on 4/26/23 at 3:09 PM the Administrator stated the Quality Assurance Performance Improvement meeting was held monthly to discuss various concerns in the facility. The Administrator stated the staff were constantly being educated through in-services and all staff meetings about the performance improvement plans. The Administrator stated the facility had faced a lot of administrative turnovers and she felt this change had directly affected the facility ' s ongoing performance improvement plan.	F 867	medication carts (400 Hall medication cart, 500 Hall medication cart.) The District Director of Clinical Operations has provided 1:1 education with the Director of Nursing on 4/26/2023. No Adverse outcomes were identified. All residents receiving medications have the potential to be affected by the deficient practice. The District Director of Operations has provided 1:1 education with the Director of Nursing on 4/26/2023. In-service education via verbal and written format was provided by the Director of Nursing, SDC/Infection Preventionist beginning on 4/27/2023 and will be completed by 05/12/2023 on proper policies and procedures related to medication storage/labeling and drug storage. A full house audit of all medication refrigerators and medication carts was performed to ensure temperatures were in normal range and no expired medications in the medication carts. Any abnormalities found were immediately corrected. This was conducted by the Director of Nursing, and Infection Preventionist to ensure all Goldsboro Rehabilitation and Healthcare Center staff are appropriately following our medication label/storage and drug storage policies and procedures. Mandatory all staff education via verbal and written format on policies and procedures related to Medication storage/labeling and drug storage, which includes all licensed nurses will be completed on 05/12/2023. Immediate	

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 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12	F 867	education/intervention was provided to the Nurse Supervisor #2, Nurse #10, and Nurse #9 on 4/25/2023. All new hires and all contracted agency licensed nursing staff will have this mandatory education prior to working on the units with written and verbal educational format. Daily ongoing observation and education will be provided also to maintain compliance. The District Director of Operations and/or Designee will attend the facilities QAPI monthly meetings to ensure Medication storage/labeling and drug storage compliance. To ensure ongoing compliance, the District Director of Operations and/or designee will attend the facilities monthly QAPI meeting and monitor the results from the audit for the Medication labeling and drug storages. The District Director of Clinical Operations and/or designee will provide additional education on any areas of concern. The results of the Medication labeling and drug storage audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 05/12/2023	