STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345397	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472

(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 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		12/24/18

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

Electronically Signed | 12/19/2018

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F 623	Continued From page 1	F 623		

(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to send a written letter to the resident and/or the responsible party (RP) for the reason of the resident ' s transfer to the hospital for 2 of 2 residents reviewed for transfers (Resident #47,and #17). The findings included: 1. Resident #47 was originally admitted to the facility on 1/7/14 and had a diagnosis of cerebrovascular accident (stroke) and Alzheimer ' s disease. Review of the clinical record revealed Resident #47 was discharged to the hospital on 10/21//18. On 12/5/18 at 10:15 AM the Social Worker stated in an interview she did not send a letter to the resident or the RP when a resident was transferred to the hospital or another facility.	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 1. Corrective action for affected residents. For resident #47, the resident returned to the facility on 10/26/2018 and resided there until her death on 12/11/2018. For resident #17, the resident returned to the facility on 10/06/2018 and remains in the	

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F 623	Continued From page 3 On 12/5/18 at 10:23 AM the Administrator stated in an interview she sent a list of transfers to the ombudsman at the end of each month. The Administrator further stated the facility notified the RP by phone but she was not aware a letter needed to be sent to the resident/RP to notify them of the reason for the transfer. 2. Resident # 17 was admitted to the facility on 12/4/18 with diagnoses of Spinal Stenosis, Cerebral Palsy, Diabetes Mellitus and Cervical Disc. Disorder. A review her clinical record revealed Resident # 17 was discharged to the hospital on 10/2/18. On 12/5/18 at 10:15 AM the Social Worker stated in an interview she did not send a letter to the resident or the RP when a resident was transferred to the hospital or another facility. On 12/5/18 at 10:23 AM the Administrator stated in an interview she sent a list of transfers to the ombudsman at the end of each month. The Administrator further stated the facility notified the RP by phone but she was not aware a letter needed to be sent to the resident/RP to notify them of the reason for the transfer.	F 623	facility at this time. For resident #17 she was given a late notice of transfer. She is her own RP. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with a facility initiated transfer or discharge have the potential to be affected by the alleged deficient practice. On, December 14th the Social Worker audited all discharges for the past 30 days to identify facility initiated transfers or discharges. For those residents identified with a facility initiated transfer or discharge, the transfer/discharge notice was given in writing to the resident or resident representative if those residents were no longer currently at the facility. This was completed on December 19th . 3. Systemic changes In-service education was provided by the Staff Development Coordinator to all full time, part time, and as needed Nurses, Social Worker, Business Office Manager, and Administration. In-service will be completed on or before 12/24/18. started on Topics included: " The new Transfer/Discharge notice form. " When to initiate the Transfer/Discharge notice form " Follow up to be completed by the Social Worker within 72 hours post transfer of a resident to the hospital for	

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F 623	Continued From page 4	F 623	acute care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all identified staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Business office manager will monitor compliance with transfer/discharge notice weekly x 2 weeks then monthly x 3 months using the Transfer/Discharge Quality Assurance monitor. Monitoring will include auditing all facility initiated transfer/discharge to ensure the transfer/discharge notice form was provided in writing to the resident or resident representative. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 658 SS=D	Services Provided Meet Professional Standards 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,	F 658		12/24/18

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F 658	Continued From page 5 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow physician orders resulting in missed medication doses for 1 of 6 residents reviewed for medications (Resident #38). Findings included: Resident #38 had been admitted on 6/18/14. Her diagnoses included anxiety disorder, major depressive disorder, psychosis, insomnia, diabetes, hypertensive heart disease, heart failure, chronic obstructive pulmonary disease and dementia. A physician order dated 5/24/18 for Alprazolam 0.5 mg, give one tablet by mouth two times a day and give two tablets at bedtime for anxiety. Resident #38 ' s most recent Minimum Data Set dated 9/14/18 revealed she had mild cognitive impairment. She had received antianxiety medications daily. Noted to be on Hospice care. A prescription written by a Nurse Practitioner (NP) dated 9/12/18 for Alprazolam 0.5 mg; give one tablet twice a day, dispense 60 tablets, with 5 refills. Resident #38 ' s care plan, most recently updated on 10/3/18, indicated use of anti-anxiety medications and a diagnosis of anxiety. Interventions included to give antianxiety medications ordered by the physician. A review of Resident #38 ' s October 2018	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. For resident #38, The corrective action is as follows: On October 4th prescription was received by provider, pharmacy filled medication and resident started receiving medication on 10/4/18 at 9PM. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents receiving narcotic medications have the potential to be affected by the alleged deficient practice. Beginning on December 12, 2018, the Nursing Department Mangers completed an audit of all current residents□ physician orders to identify which residents have orders for narcotic medications. Once residents were identified, the Nursing Department	

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F 658	Continued From page 6 medication administration record (MAR) revealed Alprazolam 0.5 mg, one tablet to be given at 9 AM, one tablet to be given at 5 PM and two tablets at 9 PM for a total of four tablets daily. Review of the October 2018 MAR also revealed Resident #38 had not received any doses of Alprazolam on 10/2/18 at 9 PM, 10/3/18 at 9 AM, 5 PM or 9 PM and 10/4/18 at 9 AM or 5 PM. On 12/04/18 at 9:13 AM an interview with Nurse #1 was conducted. She stated she had cared for Resident #38 during the time Resident #38 had been out of alprazolam. The nurse stated she had been unsure why there had been a delay in receiving the Alprazolam from the pharmacy or a new prescription from the physician. On 12/04/18 at 3:34 PM an interview with the Hospice nurse was conducted. The nurse stated the facility had run short of the medication because the dose had changed, the pharmacy was sending fewer tablets and the facility nurses had been administering the medication three times a day as previously ordered. On 12/05/18 at 9:26 AM a telephone interview with the pharmacy technician (PT) who managed the narcotic prescriptions at the facility ' s pharmacy was conducted. She stated when a new prescription was presented, it canceled the previous prescriptions of the same medication. She stated a prescription had been received on 9/12/18 for Alprazolam 0.5 mg one tablet twice a day. The PT also stated Resident #38 had been under Hospice care and because of this, only 15 days of medications were dispensed at a time. So because of this new order, and only 15 days of medication dispensed at a time, 30 tablets had	F 658	Mangers audited the current supply on hand for those narcotics to ensure each identified resident had an adequate supply on hand. For those residents that did not have an adequate supply on hand, the pharmacy or MD were notified to obtain a refill or hard script to obtain the drug. In addition to this, the Nursing Department Mangers compared the physician□s order to the current narcotic drug label to ensure accuracy. This process was completed on December 14, 2018 by SDC and DON. 3. Systemic changes In-service education was provided by the Staff Development Coordinator to all full time, part time, and as needed Nurses. This in-service will be completed on or before 12/24/18. Topics included: " Auditing narcotics for refill needs every Tuesday. " How to obtain a hard script for narcotic refills and who to contact. " How to avoid residents missing doses of ordered mediations. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure.	

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F 658	Continued From page 7 been sent. The PT stated this prescription had been refilled on 9/24/18, and because the facility had been administering 4 tablets daily instead of 2, they ran out of medication before the expected refill time. On 12/05/18 at 9:41 AM an interview with Resident #38 ' s physician was conducted. The physician stated the timing of the fax requests may have why there had been a delay in receiving a new prescription. He stated Resident #38 had not suffered any withdrawal symptoms and had no adverse outcome from missing six doses of the Alprazolam. On 12/05/18 at 2:57 PM an interview with the Director of Nursing (DON) was conducted. The DON stated the Nurse Practitioner (NP) had written the prescription on 9/12/18 and had not realized Resident #38 also took a bedtime dose of the Alprazolam. The DON stated when the discrepancy had been realized, Resident #38 ' s physician had been contacted and the prescription had been corrected. On 12/06/18 at 9:15 AM an interview with the NP was conducted. She stated she did not regularly care for Resident #38 but had been helping the facility because of inclimate weather. She stated when she had received the request for a new prescription for resident #38 ' s Alprazolam, she reviewed the MAR and had only observed Alprazolam 0.5 mg to be given twice a day and had written a prescription reflecting that. She stated if staff had alerted her that this was not Resident #38 ' s complete daily dosing, she would have corrected the prescription.	F 658	The Unit Manager or Staff Development Coordinator will monitor availability of narcotics weekly x 2 weeks then monthly x 3 months using the Narcotic Availability Quality Assurance monitor. Monitoring will include auditing narcotic medications to ensure and adequate supply is on hand and that no doses are missed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	