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	345397	A. BUILDING ______ B. WING ______	03/12/2021

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SHORELAND HLTH CARE & RETIREME	**200 FLOWER-PRIDGEN DRIVE** **WHITEVILLE, NC 28472**

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E 000	Initial Comments An unannounced Recertification Survey was conducted on 03/08/21 through 03/12/21. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# DRZ011.	E 000		
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: Based on observation and staff interviews the	F 761	The statements made on this plan of	4/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/25/2021

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.

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F 761	Continued From page 1 facility failed to keep unattended treatment medications (creams and ointments) secured in a locked treatment cart for 1 of 1 treatment carts observed. Findings included: In a continuous observation on 03/10/21 from 8:31 AM-8:34 AM an unattended treatment cart was against the wall outside room 203 with the drawers facing the hallway. The lock on the treatment cart did not appear to be engaged and no staff member was seen near the cart. At 8:34 AM a staff member who identified herself as the Wound Technician (Tech) walked up to the treatment cart. In an interview on 03/10/21 at 8:34 AM the Wound Tech verified that the treatment cart was unlocked by opening the cart drawers without having to use a key to unlock the cart. There were creams and ointments that were to be used for resident treatments in the drawer. She stated that the treatment cart should not be left unlocked and unattended because a resident could get into the cart and take something. In an interview on 03/10/21 at 2:46 PM the Director of Nursing (DON) stated that medication and treatment carts needed to be locked at all times unless the cart was in a doorway with the drawers facing into the room. She indicated that unlocked medication or treatment carts needed to be within the line of sight of the responsible staff member at all times. The DON stated that the purpose of keeping the treatment cart locked was to keep residents from getting into things they should not get into.	F 761	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. F0761 How corrective action will be accomplished for residents affected by the deficient practice A. The Director of Nursing upon notification from the surveyor immediately went and educated the employee and all employees working or scheduled to work that day. No residents were affected by this. How the facility will identify other residents having the potential to be affected by the deficient practice. A. All residents have the potential to be affected by the alleged deficient practice Measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur: A. A. The Director of nursing completed education to all clinical staff who have responsibilities for locked medication and/or treatment carts.	

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F 761	Continued From page 2	F 761	B. All new hired clinical staff will be educated in the facility orientation and be checked off upon completion of orientation on their understanding of policies and regulations on locked medication and locked treatment carts. C. The Director of Nursing or designee will medication and treatment carts daily for 4 weeks and then monthly until the QA committee deems that the POC has been successful and will be sustained. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained A. The plan of correction including audits/new hire check off etc. will be addressed in QA at each meeting until the committee deems that the POC has been successful and will be sustained.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 849		4/9/21

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F 849	Continued From page 3 §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the	F 849		

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F 849	Continued From page 4 determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide	F 849		

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F 849	Continued From page 5 bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of	F 849		

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F 849	Continued From page 6 the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to maintain communication and coordination of services provided by Hospice and facility personnel for 1 of 1 sampled resident's (Resident #23). Resident #23 was admitted to the facility on an unannounced annual survey was conducted on 03/08/21 through 03/12/21. The investigation included resident observations, interviews of alert and oriented residents, staff interviews, and record reviews. The sampled resident was not in the facility at the time of the survey.	F 849	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. F0849	

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F 849	Continued From page 7 Resident #23 was admitted to the facility on 08/31/20 with a cumulative diagnosis including chronic kidney disease, heart failure, breast malignancy, Alzheimer's disease, dementia, Schizophrenia, anxiety, pain, and history of COVID-19. Resident #23's Minimum Data Set (MDS) indicated that resident had severe cognitive impairments. The resident needed extensive assistance with toilet use, bathing, and personal hygiene. Resident #23's care plan, revised 12/31/20 identified Resident #23 had a progressive decline, and Hospice care was provided starting 09/02/20 due to progressive decline. A Medication Administration Record (MAR) dated 03/2021 for Resident #23 listed Do Not Resuscitate (DNR) order with a begin date of 09/02/20. A physician progress note dated 09/01/20 for Resident #23 revealed Hospice nurse report resident had been complaining of back pain. Resident had a history of breast cancer. Hospice reported resident's Responsible Party (RP) was considering sending patient out of the facility for evaluation with Oncology with concern for possible metastasis. A Hospice nursing note dated 02/04/21 from Resident #23's Electronic Medical Record (EMAR) was reviewed with the Director of Nursing (DON) on 03/08/21 at 12:30 PM, confirmed that the last Hospice note entered into the facility's Electronic Medical Record (EMAR)	F 849	How corrective action will be accomplished for residents affected by the deficient practice- The affected resident has been discharged. A. How the facility will identify other residents having the potential to be affected by the deficient practice. A. All hospice residents have the potential to be affected by the alleged deficient practice- The DON or designee will audit all hospice residents and ensure that all documentation/notes/care plan are all current and where facility staff have access to them. Measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur: A. The administrator and DON will meet with the Hospice Director on policy, regulations, and expectations of the facility and hospice partnership in regards to communication/timely notes/care plans being at the facility and accessible to facility staff. B. The Hospice administrator will educate hospice staff on the contractual agreement to have communication/timely notes/care plans up to date and done timely and left where facility staff have access to them. C. The DON or designee will audit all hospice residents for the above mentioned in (B) weekly for four weeks and then monthly for 3 months and bring information to the QA committee for recommendation to stop or continue	

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F 849	Continued From page 8 for Resident #23. The 02/04/21 Hospice nursing note read: "Hospice nurse in to see patient. Patient resting with eyes closed, easily awakened for assessment. No distress noted, vital signs stable (VSS). Coordinated with the Med Tech". DON said Resident #23's complete assessment with vital signs were not available for her nursing staff or MD to review. DON confirmed on 03/08/21 that in the previous 4 months, there were only 3 Hospice nursing note entries (12/01/20, 12/31/20, and 02/04/21) in Resident #23's electronic medical record. DON said it was her expectation that their Hospice Nurse provide the facility with complete visit notes, MD order updates, labs, medication changes, etc., each week, prior to her leaving the facility, and not just to place a short note in the resident's medical record every month or so. DON said their Hospice nurse needed to communicate better with a facility's nurse, not just with a Medication Aide or Tech, who were not even nurses, especially if there was an emergency, an order change, or significant change in Resident #23's condition. Four additional (late entry) Hospice notes were entered the facility's EMAR on 03/09/21 at 1:24 PM - 1:59 PM by the Hospice nurse for Resident #23. Late entry #1 note dated 03/04/21 at 11:40 AM revealed Hospice nurse in to visit with patient, no distress noted, vital signs were stable (VSS), and coordinated with Medication tech. Late entry #2 note dated 02/25/21 at 10:00 AM revealed Hospice nurse in to see patient, lying in bed in no acute distress, VSS, coordinated with nurse regarding my visit. Late entry #3 dated 02/18/21 at 11:35 AM revealed Hospice nurse in to see patient, coordinated with Medication tech regarding my visit, with instructions to call	F 849	audits. D. Daily Clinical Meeting will address all hospice visits occurring and ensure documentation in accessible and timely to facility staff. This will be ongoing. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained A. All audits and data from Daily Clinical Meeting will be brought to the QA meetings for guidance. B. The facility has initiated a QAPI plan on the above.	

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F 849	Continued From page 9	F 849		

Hospice with changes in condition. Late entry #4 dated 02/11/21 at 8:45 AM revealed Hospice nurse in to see patient, no acute distress, coordinated with Medication tech, regarding my visit, with instructions to call Hospice with changes.

An interview on 03/09/21 at 3:45 PM with the Director of Nursing (DON) revealed that it was her expectation that Hospice should have communicated more fully to facility staff as well as provided Hospice Nurse's complete visit documentation prior to leaving the facility and did not. She said Hospice failed, per their Hospice agreement dated 01/01/2016, to communicate and coordinate of services provided by facility personnel and Hospice personnel and the providing of Hospice services 24 hours per day. And failed to provide Resident #23's Hospice information from Hospice to the facility, which included resident assessments, vital signs, medications, care plan updates, physician order updates or notifications, discussions with facility nursing staff (not just med-tech/med-aides), nursing notes, and Hospice physician orders. The DON said it was her expectation that there be a complete verbal and paper communication process between Hospice and her nursing staff, and there was not.

An interview on 03/09/21 at 3:50 PM with the facility Administrator revealed that it was expectation that the Hospice Nurse follow the Nursing Facility Hospice Services Agreement dated 01/01/2016 to provide information from Hospice to the facility to include: Complete Hospice medical information, Hospice orders, and did not. The Hospice Services Agreement stated: "Nursing Facility and Hospice shall each

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F 849	Continued From page 10 prepare and maintain complete, correct and detailed clinical record concerning each Residential Hospice Patient. The Resident's Hospice clinical records shall be made available to the Attending Physician and Hospice staff. Nursing Facility and Hospice shall cause each entry made for services provided hereunder to be legible, clear, complete, and appropriately authenticated and dated in accordance with applicable policy and currently accepted standards of practice. The Hospice Patient Care Coordinator will coordinate all aspects of patient care by assuring an adequate exchange of information and facilitating communication and interaction among the Interdisciplinary Group (IDG), and between IDG and family, and Nursing Facility personnel. Section 4.6 entitled Clinical Record reads: The Hospice Patient's inpatient clinical record shall include a record of all inpatient services furnished and events regarding care that occurred at the Nursing Facility." The Administrator revealed that the facility and their contracted Hospice provider failed to communicate or share Resident #23's documentation with facility's nursing staff, which was not available to facility staff on a 24-hour basis per Hospice agreement. An interview on 03/10/21 at 10:20 AM with Nurse #1 (Hospice Nurse) revealed that it was her expectation that Resident's #23 complete Hospice medical records be available to staff on a 24 hour, 7 days per week, per facility agreement, and were not. The Hospice nurse agreed that a complete communication structure should have been set-up (verbal and written form) between facility and Hospice staff, and be present at the facility, and was not. She said she kept most of the resident's orders, assessments, and notes in	F 849		

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F 849	Continued From page 11 her computer. It was her expectation, from now on, she would print off resident #23's complete visit notes, assessments, updated orders and care plans and place them in a notebook, kept by the Director of Nursing (DON). She said she would also document after each visit, a visit summary in writing and place it in the resident's electronic medical chart, titled "Hospice Note".	F 849		