STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035028	A. BUILDING: _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HEALTHCARE #1	306 LUMPKIN BLVD LOUISBURG, NC 27549

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 22, 2021.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#1 and #2) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 04/30/20 revealed diagnoses included congestive heart failure, arthritis of knee, gastro-esophageal reflux disease, obesity, schizophrenia, hypertension, and hyperlipidemia. Review of Resident #1's Resident Register revealed an admission date of 05/31/19.	C 202		

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C 202	Continued From page 1 Review of Resident #1's tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test given on 04/15/19 and read negative on 04/17/19. -There was no documentation of a second TB skin test. Interview with Resident #1 on 04/22/21 at 4:15 pm revealed: -He thought he had a TB skin test completed prior to his admission to the facility in 2019. -He thought the TB skin test was negative. -He did not have a chest x-ray for TB. -He had a TB skin test more than once, but he could not recall the dates. Telephone interview with the Supervisor in Charge (SIC) on 04/22/21 at 4:39pm revealed: -She could not say that she saw Resident #1's second TB skin test during her record review. -She was unsure if he had a second TB skin test. Telephone interview with the Administrator on 04/22/21 at 3:01pm revealed: -She thought Resident #1 had a TB skin test upon admission. -She did not know where the documentation for Resident #1's TB skin test was located and thought it was in Resident #1's record. Refer to the interview with the medication aide (MA) on 04/22/21 at 12:57pm. Refer to telephone interview with the SIC on 04/22/21 at 4:39pm. Refer to the telephone interview with the Administrator on 04/22/21 at 3:01pm.	C 202		

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C 202	Continued From page 2 2. Review of Resident #2's current FL-2 dated 12/09/20 revealed diagnoses included human immunodeficiency virus, left knee replacement, hypertension, and bipolar disorder depressed mood. Review of Resident #2's Resident Register revealed there was no Resident Register to review. Review of Resident #2's tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test given on 11/07/17 and read as negative on 11/09/17. -There was no documentation of a second TB skin test. Also, please check the formatting of this paragraph. Interview with Resident #2 on 04/22/21 at 3:22pm revealed: -She had a TB skin test completed in 2017 before her admission to the facility. -Her TB skin test was negative. -She did not remember having another TB skin test once she was admitted. Telephone interview with the Supervisor in Charge (SIC) on 04/22/21 at 4:39pm revealed she thought Resident #2's record was thinned, and her second TB skin test was in another record. Refer to the interview with the medication aide (MA) on 04/22/21 at 12:57pm. Refer to telephone interview with the SIC on 04/22/21 at 4:39pm. Refer to the telephone interview with the Administrator on 04/22/21 at 3:01pm.	C 202		

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C 202	Continued From page 3 Interview with the medication aide (MA) on 04/22/21 at 12:57pm revealed: -The residents had their first TB skin test upon admission, and the second TB skin test was completed at the local health department or by the primary care provider (PCP). -She did not know the time limits for when the second TB skin test was completed after the first TB skin test. -The Administrator was responsible for ensuring the residents obtained the second TB skin test. Telephone interview with the Supervisor in Charge (SIC) on 04/22/21 at 4:39pm revealed: -She came to the facility once a week and reviewed the medications, medication administration records (MARs), appointments, primary care provider (PCP), and spoke with the residents. -She knew all the residents had their second TB skin test, because she had reviewed the residents' records. Telephone interview with the Administrator on 04/22/21 3:01pm revealed she was responsible for ensuring residents had a completed TB skin test upon admission to the facility.	C 202		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website,	C 212		

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http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the Resident Register was completed within 72 hours of admission for 2 of 3 sampled residents (#2 and #3).

The findings are:

1. Review of Resident #2's current FL-2 dated 12/09/20 revealed diagnoses included human immunodeficiency virus, left knee replacement, hypertension, and bipolar disorder depressed mood.

Review of Resident #2's Resident Register revealed:
-There was a resident register that was incomplete.
-Half of the first page of Resident #2's Resident Register was completed and the remainder of the document was blank.
-There were no signatures on the document.

Interview with Resident #2 on 04/22/21 at 3:22pm revealed she had a guardian and had lived at the facility since 2017.

Refer to the telephone interview with the Administrator on 04/22/21 at 3:01pm.

2. Review of Resident #3's current FL-2 dated

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C 212	Continued From page 5 04/06/21 revealed diagnoses included schizophrenia, cannabis use disorder sustained remission, and cocaine use disorder sustained remission. Review of Resident #3's record revealed there was no resident register. Interview with Resident #3 on 04/22/21 at 4:20pm revealed: -He had resided at the facility for 5 years. -He had a guardian whom he spoke with on the telephone approximately every 3 to 4 months. Telephone interview with the Administrator on 04/22/21 at 3:01pm revealed: -She thought Resident #3's Resident Register was in his record and it just could not be located on 04/22/21. -She thought it was under another tab because her Supervisor in Charge had reorganized the residents' records. Refer to the telephone interview with the Administrator on 04/22/21 at 3:01pm. _____ Telephone interview with the Administrator on 04/22/21 at 3:01pm revealed: -She knew she was supposed to complete a new resident's register within 72 hours of admission. -She had not completed the Resident Registers for some residents because she filled the document out based on what residents were able to tell her at admission. -She had not attempted to speak with the residents' guardians to assist her in completing the document. -She was at the facility weekly. -She was responsible for ensuring the resident register was completed within 72 hours of	C 212		

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C 212	Continued From page 6 admission.	C 212		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure blood pressure (BP) checks were implemented and documented as ordered for 1 of 3 sampled residents with orders for weekly BP checks (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 04/30/20 revealed: -Diagnoses included congestive heart failure, arthritis of knee, gastro-esophageal reflux disease, obesity, schizophrenia, hypertension, and hyperlipidemia. -There was an order for weekly blood pressure (BP) monitoring. Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry to check weight and blood pressure, without a scheduled time. -There was a blood pressure reading of 173/105	C 249		

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C 249	Continued From page 7	C 249		

documented for 02/07/21.
-There were no other blood pressure readings documented.

Review of Resident #1's March 2021 MAR revealed:
-There was an entry to check weight and blood pressure, without a scheduled time.
-There was a blood pressure reading of 159/112 documented for 03/07/21 and 130/70 documented for 03/17/21.
-There were no other blood pressure readings documented.

Review of Resident #1's April 2021 MAR revealed:
-There was an entry to check weight and blood pressure, without a scheduled time.
-There was a blood pressure reading of 130/76 documented for 04/15/21.
-There were no other blood pressure readings documented.

Observation of Resident #1 on 04/22/21 at 4:26pm revealed the medication aide (MA) obtained Resident #1's BP and Resident #1's BP was 153/90.

Interview with the MA on 04/22/21 at 12:57pm revealed:
-The facility's policy was that all residents had their BPs checked monthly and documented on the MARs.
-She did not know Resident #1 had an order on his current FL-2 for weekly BP monitoring.
-The Supervisor in Charge (SIC) reviewed FL-2s and any orders from the primary care provider (PCP).
-The SIC let staff know of any new orders and she was not told Resident #1 had weekly BP

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C 249	Continued From page 8 monitoring. -She had only obtained monthly BPs for Resident #1. Interview with Resident #1 on 04/22/21 at 4:15pm revealed: -He had his BP monitored by the staff when the MA was able, and his BP was obtained when his PCP came to the facility. -Staff had to place the BP cuff on his wrist because his arm was too big for the BP cuff. -Staff had to try multiple times to obtain his BP because the cuff had to be in the right position. Telephone interview with the Administrator on 04/22/21 at 3:01pm revealed: -She expected staff to obtain BP's as ordered by the PCP. -She did not know Resident #1 had BP's ordered weekly. -She had not reviewed Resident #1's BPs. -She was responsible for ensuring residents' blood pressures were checked as ordered and documented. Attempted telephone interview with Resident #1's PCP's office on 04/22/21 at 2:19pm.	C 249		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or	C 315		

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C 315	Continued From page 9 (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents related to a medication used to treat psychiatric disorders (#2). The findings are: Review of Resident #2's current FL-2 dated 12/09/20 revealed: -Diagnoses included blood borne infectious disease, left knee replacement, hypertension, and bipolar disorder depressed mood. -There was a medication order for divalproex sodium delayed release (DR) 500mg take two tablets (used to treat seizure disorders, psychiatric disorders, and to prevent migraine headaches) twice daily. Review of Resident #2's physician orders revealed: -There was an order dated 04/20/20 for divalproex sodium DR 500mg take two tablets at bedtime. -There was a second order dated 04/04/21 for divalproex sodium DR 500mg take two tablets at bedtime. Review of Resident #2's February, March, and	C 315		

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C 315	Continued From page 10 April 2021 medication administration record (MAR) revealed: -There was an entry for divalproex sodium DR 500mg take two tablets at bedtime, scheduled for 8:00pm. -There was documentation of administration of divalproex sodium DR 500mg from 02/01/21 to 04/21/21 at 8:00pm. Observation of Resident #2's medications on hand on 04/22/21 at 12:50pm revealed: -There were 8 tablets remaining in a bubble pack for divalproex sodium DR 500mg dispensed on 02/12/21. -There were 2 tablets per bubble in the bubble pack. -There were 60 tablets dispensed and the medication label indicated take two tablets at bedtime. -The date indicated that this order was written was 04/20/20. Interview with Resident #2 on 04/22/21 at 3:22pm revealed she did not know the names of her medication. Telephone interview with a representative at the facility contracted pharmacy on 04/22/21 at 2:21pm revealed: -The facility was on cycle fill and medications were sent mid-month each month for residents. -There was an order for Resident #2 for divalproex sodium DR 500mg two tablets at bedtime date 04/20/20. -Resident #2's PCP sent a prescription dated 04/04/21 for divalproex sodium DR 500mg take two tablets at bedtime. -Sixty tablets of divalproex sodium DR 500mg was dispensed on 04/15/21. -Two tablets were placed in each bubble so that	C 315		

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C 315	Continued From page 11	C 315		

administration was easy for staff at the facility.
-The pharmacy did not have a copy of Resident #2's FL-2 dated 12/09/20.

Interview with the medication aide (MA) on 04/22/21 at 12:57pm revealed:
-The Supervisor in Charge (SIC) filled out Resident #2's FL-2 and she could tell by the writing on the FL-2.
-She did not know Resident #2's FL-2 had a different order for divalproex sodium.
-She had administered Resident #2's divalproex sodium at nighttime not in the morning.
-She administered two tablets of divalproex sodium to Resident #2 at nighttime, 8:00pm.
-If an order was changed, the PCP usually told staff while they were onsite.
-She was not told by Resident #2's PCP that the divalproex sodium was changed to twice daily as indicated on the FL-2.
-She thought Resident #2's PCP signed the FL-2 and did not know the divalproex sodium DR order was changed from bedtime to twice daily.

Telephone interview with the SIC on 04/22/21 at 4:39pm revealed:
-She filled out the FL-2 and entered the divalproex sodium.
-She did not think she entered the wrong frequency.
-She used the residents' MARs when filling out the FL-2's.
-She did not know the divalproex sodium DR order on the FL-2 was not the same as entries on Resident #2's MARs.
-She had to review it whenever she came to the facility again.
-She did not know Resident #2 was not receiving divalproex sodium DR as ordered twice daily on the FL-2 in February and March 2021.

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C 315	Continued From page 12 Telephone interview with the Administrator on 04/22/21 at 3:15pm revealed: -The SIC filled out the FL-2 and provided it for the PCP to sign when she visited the facility. -She instructed the staff to send the FL-2s to the pharmacy only when the pharmacy requested. -If the pharmacy reviews recommended that residents' FL-2s be sent to the pharmacy the staff were supposed to send it. -She was not onsite at the facility daily and she did not review resident FL-2s or pharmacy reviews. -The SIC reviewed residents' FL-2s and ensured the medications were on the MARs. -The MAs were supposed to review residents' FL-2s in the absence of the SIC. -She did not know Resident #2's current FL-2 had a different order for divalproex sodium DR. -She thought the SIC made a clerical error on Resident #2's FL-2. -The SIC and the MAs were responsible for ensuring the medication orders were clarified and matched the medications sent from the pharmacy. Attempted telephone interview with Resident #2's PCP's office on 04/22/21 at 2:19pm and 2:53pm.	C 315		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of	C 342		

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C 342	Continued From page 13 medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of medication administration records for 1 of 3 sampled residents (#2), including a medication used for pain relief and a topical medication used for muscle pain relief. The findings are: 1. Review of Resident #2's current FL-2 dated 12/09/20 revealed: -Diagnoses included human immunodeficiency virus, left knee replacement, hypertension, and bipolar disorder depressed mood. -There was no order for a muscle and joint cream. a. Review of Resident #2's subsequent orders dated 03/11/21 revealed there was an order for muscle and joint cream apply to arthritic joints every six hours as needed for joint pain.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035028	A. BUILDING: _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HEALTHCARE #1	306 LUMPKIN BLVD LOUISBURG, NC 27549

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C 342	Continued From page 14 Review of Resident #2's March 2021 medication administration records (MAR) revealed there was no entry for muscle and joint cream. Review of Resident #2's April 2021 MAR revealed: -There was an entry for muscle rub ultra-strength cream apply to arthritic joint pain every six hours as needed. -There was documentation of administration of muscle rub twice daily without a specified time from 04/01/21 to 04/21/21. Observation of Resident #2's medications on hand on 04/22/21 at 12:41pm revealed there was one opened 42.5 gram tube of muscle rub available for administration. Telephone interview with Resident #2's pharmacist on 04/22/21 at 2:21pm revealed: -Resident #2 had an order for muscle rub dated 03/11/21. -Resident #2 had one tube of muscle rub dispensed once on 03/12/21. -The pharmacy supplied MARs for the facility and sent the next months' MARs with the cycle fill at mid-month. -The new order for Resident #2's muscle rub would not appear on the March 2021 MARs because the March 2021 MARs were sent mid-month in February 2021. -Staff at the facility would have to add the new order to Resident #2's March 2021 MAR. Interview with the medication aide on 04/22/21 at 12:57pm revealed: -She had not placed Resident #2's muscle rub on the March 2021 MARs. -She administered it to Resident #2 because the resident had complaints of knee pain.	C 342		

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C 342	Continued From page 15 Refer to telephone interview with the Administrator on 04/22/21 at 3:01pm. b. Review of Resident #2's current FL-2 dated 12/09/20 revealed there was a medication order for oxycodone-acetaminophen 7.5-325mg take one tablet twice daily as needed for chronic pain. Review of Resident #2's subsequent physician orders revealed: -There was a prescription/order dated 01/25/21 for a Percocet taper as follows: take one tablet three times daily for one week, take one tablet twice daily for one week, take one tablet daily for one week, then take one tablet every other day for one week as needed for chronic pain taper. -There were no refills for this prescription/order and the instruction was "available to fill 01/31/21". Review of Resident #2's February 2021 medication administration records (MAR) revealed: -There was a printed entry for oxycodone-acetaminophen 7.5-325mg take one tablet twice daily as needed for chronic pain. -There was documentation of administration of oxycodone-acetaminophen 7.5-325mg from 02/01/21 to 02/14/21 three times daily without any times specified. -One the back of the MAR were entries from 02/01/21 to 02/04/21 at 9:00am, 3:00pm, and 9:00pm and on 02/05/21 at 9:00am. -There was another handwritten entry for Percocet 7.5-325mg one tablet three times daily for one week, scheduled for 8:00am, 2:00pm, and 8:00pm. -There was documentation of administration of Percocet from 02/06/21 to 02/12/21 at 8:00am, 2:00pm and 8:00pm.	C 342		

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C 342	Continued From page 16	C 342		

-There was a third handwritten entry for Percocet 7.5-325mg one tablet twice daily for one week, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of Percocet from 02/13/21 to 02/19/21 at 8:00am and 8:00pm.
-There was a fourth handwritten entry for Percocet 7.5-325mg one tablet daily for one week, scheduled for 8:00pm.
-There was documentation of administration of Percocet from 02/20/21 to 02/26/21 at 8:00pm.
-There was a fifth handwritten entry for Percocet 7.5-325mg one tablet every other day for one week, scheduled for 8:00pm.
-There was documentation of administration of Percocet on 02/03/21, 02/05/21, and 02/07/21 at 8:00pm.

Review of Resident #2's March and April 2021 MAR revealed:
-There was an entry oxycodone-acetaminophen 7.5-325mg take one tablet twice daily as needed for chronic pain.
-There was no documentation of administration of oxycodone-acetaminophen.

Observation of Resident #2's medications on hand on 04/22/21 at 12:41pm revealed there were no Percocet tablets available for administration.

Interview with Resident #2 on 04/22/21 at 3:22pm revealed:
-She took Percocet for knee pain because she had a knee replacement over a year ago.
-The physician at the pain clinic no longer prescribed it for her pain.

Telephone interview with Resident #2's pharmacist on 04/22/21 at 1:40pm revealed:

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C 342	Continued From page 17 -Resident #2 had a prescription dated 01/25/21 for Percocet taper without any refills. -Resident #2's prescribed Percocet taper was as follows: one tablet three times daily for one week, one tablet twice daily for one week, one tablet daily for one week, and one tablet every other day for one week. -Resident #2 no longer had Percocet as an active medication. -Resident #2's Percocet taper was dispensed on 02/01/21 for 46 tablets which was enough to complete the taper. -The prescription arrived at the pharmacy after the delivery date of the February 2021 MARs to the facility. -Staff would have to enter any orders after the new MARs were delivered to the facility. -The order appeared on the March and April MARs because there was no request to remove the entry from the facility. Interview with the medication aide (MA) on 04/22/21 at 12:57pm revealed: -She had transcribed Resident #2's Percocet order onto the February 2021 MARs because her signature was at the bottom of the February 2021 MARS as the reviewer. -She also knew that she transcribed the order because of the handwriting. -She saw that the final week of the taper was written at the beginning of the month of February 2021. -She saw that she documented twice for the same dose she had administered to Resident #2 on 02/03/21, 02/05/21 and from 02/06/21 to 02/21/21. -She made the errors on Resident #2's MARs, but she administered it to her as ordered. -Resident #2 no longer had Percocet tablets ordered because the physician who ordered the	C 342		

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C 342	Continued From page 18 pain medication weaned the resident off of Percocet. -She did not realize she had transcribed the final of week of the tapered dose of Resident #2's Percocet was marked on the wrong portion of the dates of the month of February 2021. Telephone interview with the Supervisor in Charge (SIC) on 04/22/21 at 4:39pm revealed: -She had not reviewed Resident #2's Percocet taper on the February MARs. -She did not know it was not transcribed correctly and there were days when there was duplicate documentation. Telephone interview with the Administrator on 04/22/21 at 3:01pm revealed: -She had not reviewed the MARs to ensure Resident #2's Percocet taper was transcribed correctly. -She was not able to see the prescription to compare it with the February and March 2021 MAR to determine what happened. -She did not know the Percocet tape was not accurate on the February 2021 MAR. Refer to telephone interview with the Administrator on 04/22/21 at 3:01pm. _____ Telephone interview with the Administrator on 04/22/21 at 3:01pm revealed: -The pharmacy provided MARs for the facility. -Whomever was no duty, received the next months' MARs and placed them in the MAR book. -Staff reviewed the new MARs by comparing them to the previous months MARs. -The MAs and SIC were responsible for ensuring residents' MARs were accurate.	C 342		