STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067013	A. BUILDING: _____ B. WING _____	R-C 09/22/2021

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LIGHT HOUSE VILLAGE	182 VILLAGE DRIVE JACKSONVILLE, NC 28546

(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
D 000	Initial Comments The Adult Care Licensure Section conducted a annual and follow-up survey on 09/21/21-09/22/21.	D 000		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure snacks were served as evidence by residents not being served snacks during first shift. The findings are: Interview with a resident on 09/21/21 at 8:28am revealed: -He did not get snacks every day. -He was last offered a snack a couple days ago. -He would like to receive a snack every day. Interview with another resident on 09/21/21 at 8:42am revealed: -He received snacks occasionally. -He received one snack on 09/20/21. -He would like to receive snacks daily. Observation of dining room, women's hallway and men's hallway on 09/21/21 between 9:50am-	D 298		

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D 298	Continued From page 1 11:00am revealed snacks were not served in the dining room and were not passed to residents in their rooms. Interview with the first personal care aide (PCA) on 09/21/21 at 11:36am revealed: -She did not serve snacks to any residents this morning. -She thought the dietary aide (DA) served the snacks to the residents. Interview with the second PCA on 09/21/21 at 11:39am revealed she did not serve snacks to any residents this morning. Interview with the DA on 09/21/21 at 11:40am revealed: -He served snacks to one resident who was sitting in the dining room around 10:30am. -He did not serve snacks to any other residents in the facility this morning.	D 298		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 358		

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D 358	Continued From page 2	D 358		

reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 18 residents (Resident #3) with an order to use portable oxygen continuously and an oxygen concentrator when he was in bed for dyspnea (difficult or labored breathing).

The findings are:

Review of Resident #3's current FL-2 dated 05/25/21 revealed:
-Diagnoses included chronic obstructive pulmonary disorder (COPD), heart failure, and diabetes mellitus.
-He was semi-ambulatory and used a walker.

Review of Resident #3's physician orders dated 09/07/21 revealed an order for portable oxygen (O2) at 2 liters continuous via nasal cannula.

Review of Resident #3's physician orders dated 08/12/21 revealed an order for O2 at 2 liters via nasal cannula anytime in bed for shortness of breath/wheezing.

Observation for Resident #3 on 09/21/21 at 8:49am revealed:
-He was ambulating in his wheelchair down the hallway.
-He did not have on his portable O2.

Review of Resident #3's September 2021 electronic medication record (eMAR) revealed:
-There was an entry for O2 at 2 liters via nasal cannula anytime in bed for shortness of breath/wheezing.
-There was no documentation that the O2 was administered.
-There was no entry for portable O2.

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D 358	Continued From page 3 Interview with Resident #3 on 09/21/21 at 3:41pm revealed: -He did not "feel well", because he did not feel like he had enough O2. -He was supposed to be on portable o2, but he had not received his portable O2 tank. -His oxygen concentrator in his room had been making a loud screeching noise and leaking water for the past 3 or 4 days. -He told someone a couple of days ago and on 09/21/21, but he did not remember who he told. -No one checked on his oxygen concentrator. -He put his O2 on a night by himself and took it off in the morning. -He filled the water bottle attached to his concentrator nightly by himself, but the water would only last for 2 hours. -He had not been able to sleep because his O2 concentrator did not work like it use to. Interview with a medication aide (MA) on 09/21/21 at 3:46pm revealed: -Resident #3's portable O2 was the 02 concentrator that was in his room. -Resident #3 had an order for as needed (PRN) O2 at 2 liters via nasal cannula anytime in bed for shortness of breath/wheezing. -The facility contracted pharmacy entered the o2 order in as PRN on the eMAR. -She had not received a report that Resident #3's O2 concentrator was not working. -She tried to turn on Resident #3's O2 concentrator but the concentrator did not work on 09/21/21. -She was going to call Resident #3's medical equipment company that supplied his O2. Interview with a customer service representative at Resident #3's medical equipment company revealed:	D 358		

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D 358	Continued From page 4 -She had not received an O2 order for Resident #3 since 01/06/20. -The order received on 01/06/20 was for a 10-liter O2 concentrator and 1 portable O2 tank. Interview with the manager of Resident #3's medical equipment company on 09/22/21 at 10:32am revealed: -The 10-liter oxygen concentrators did not stop working often. -He received a call on 09/21/21 that the 10-liter oxygen for Resident #3 did not work. -For the concentrator to stop working someone turned the knob on the concentrator too far to the left or right, the air filters need to be cleaned, and the humidifier bottle needed to be filled with distilled water. -When the O2 concentrator and portable O2 were delivered on 01/06/20 his delivery person would have given education to the resident and staff on how to use both properly. Interview Resident #3's primary care physician (PCP) on 09/22/21 at 8:10am revealed: -She ordered the O2 because he had dyspnea, COPD, and heart failure. -A diagnosis of COPD and heart failure meant that his lungs were restricted and it was hard for O2 to travel through his body tissues. -She should have been notified immediately if Resident #3's O2 concentrator did not work. -She expected facility staff to assist Resident #3 with putting his O2 on at night and taking it off in the morning. -She was not aware Resident #3 did not have his portable O2. -She did not check her messages so she did not know if the facility notified her that Resident #3's O2 concentrator was not working and Resident #3 did not have his portable O2.	D 358		

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D 358	Continued From page 5 Interview with the second shift MA that worked on 09/07/21 on 09/22/21 at 12:01pm revealed: -She worked as a MA on the second shift on 09/07/21. -She was notified by the Resident Care Coordinator (RCC)/MA when she came in on the second shift on 09/07/21 that Resident #3 was ordered portable O2. -She was notified that the portable O2 order was sent to the facility contracted pharmacy on 09/07/21 and they would deliver the portable O2 on 09/07/21. -The portable O2 was not delivered on 09/07/21. -She did not notify the RCC or Administrator that Resident #3's portable O2 was not delivered. -She had not seen Resident #3 with portable O2. -She had not checked on Resident #3's portable O2 order since 09/07/21. -Resident #3 put his O2 on himself when he laid down and filled the O2 concentrator with water. -She would make sure that Resident #3's O2 concentrator was on when he went to bed at night. Interview with a Pharmacist at the facility contracted pharmacy on 09/22/21 revealed: -Resident #3 received an order for O2 at 2 liters via nasal cannula anytime in bed for shortness of breath/wheezing on 08/12/21. -The order was put in the eMAR as PRN because there was no standing time. -She would not have called Resident #3's PCP to clarify a standing time for the O2. -The facility would be responsible to call Resident #3's to clarify the O2 order. Interview with Resident #3's POA on 09/22/21 at 10:20am revealed: -She last saw Resident #3 last week.	D 358		

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-She called and talked to Resident #3 two or three times per week.
-Resident #3 wore portable O2 for a while for his asthma and COPD.
-He did not complain about his O2 or breathing when she talked to him.

Observation of Resident #3 on 09/22/21 at 12:10pm revealed he was sitting in his wheelchair in the hallway with his portable O2 on.

The second interview with Resident #3 on 09/22/21 at 12:10pm revealed:
-He received a new O2 concentrator last night.
-He felt "a lot better" and he slept like a "baby" last night and this morning.
-He felt like he had enough O2.

Interview with the BOM on 09/22/21 at 8:45am revealed:
-Resident #3's PCP gave her an order for portable O2 for Resident #3 on 09/07/21.
-She gave the order to the RCC/MA on 09/07/21.
-She did not know what the RCC/MA did with the order after she gave it to her.

Interview with the Administrator on 09/21/21 at 4:30pm revealed:
-She was not aware that Resident #3's O2 concentrator was not working for the past 3 or 4 nights.
-She was not aware that the MA thought Resident #3s O2 order was PRN.
-She was not aware that Resident #3 had an order for portable O2.
-She expected Resident #3's portable O2 order to be sent to his medical equipment company immediately after the physician wrote the order.

Interview with the Administrator on 09/22/21 at

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D 358	Continued From page 7 8:30am revealed: -When Resident #3's PCP wrote orders while in the facility the PCP gave the orders to the Business Office Manager (BOM). -The BOM gives the orders for medical equipment and O2 to the MA that worked the shift when the physician was there. -The MA on shift was responsibile to send orders to the medical equipment company. -The MA was expected to fill out a new order tracking form after they have sent the order to the medical equipment company. -She usually checked the new order tracking forms monthly but had not in over a month. -She expected Resident #3 to have received his O2 within 24 hours after the physician ordered it. -She expected the MA to put Resident #3's O2 on him whenever he was in bed and when he got up in the morning. -When the MA put Resident #3's O2 on him at night they were expected to check the concentrator for any defects, check the hosing, and fill up the humidifier with distilled water if needed. -The MA were responsible to monitor and clean Resident #3's O2 concentrator. -If the MA found any issue with the O2 concentrator they were expected to call the medical equipment company immediately and then notify her. Attempted a telephone interview with the RCC/MA who worked on 09/07/21 on 09/22/21 at 8:05am and 11:00am was unsuccessful. _____ The facility failed to ensure medications were administered as ordered for 1 resident (#3) who had a diagnosis of heart failure, dyspnea, and COPD which caused his lungs to be restrictive	D 358		

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D 358	Continued From page 8 and not allow the flow of O2 through his body, who was ordered portable O2 and did not receive and the current concentrator had not worked in the past 3 or 4 days and causing the resident to have trouble breathing. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/21/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 5, 2021.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer	D912		

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D912	Continued From page 9 medications as ordered by a licensed prescribing practitioner for 1 of 18 residents (Resident #3) with an order to use portable oxygen continuously and an oxygen concentrator when he was in bed for dyspnea (difficult or labored breathing). [Refer to Tag D371 NCAC 13F .1004(n) Medication Administration (Type B Violation)].	D912		