STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010013	A. BUILDING: _____ B. WING _____	06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF OAK ISLAND	2910 PINE PLANTATION PARKWAY OAK ISLAND, NC 28461

(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 complaint investigation on 06/02/22 and 06/03/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Primary Care Provider (PCP) of the acute health care needs for 1 of 5 sampled residents (#4) related to a lymphedema compression pump. Review of Resident #4's current FL-2 dated 01/06/22 revealed: -Diagnoses included cerebral infarction, seizures, depression, hyperlipidemia, aphasia, right sided hemiparesis, lymphedema uses pump and difficulty walking. -There was nothing selected for orientation status. -He was semi-ambulatory using a wheelchair. Review of Resident #4's physician's order dated 12/27/21 revealed there was an order to elevate the resident's legs or use a lymphedema compression pump (external compression applied to a limb by a machine used to treat lymphedema) for one hour twice daily. Telephone interview with a nurse at Resident #4's PCP's office on 06/03/22 at 11:00am revealed the PCP wrote an order dated 01/17/22 for the resident to have lymphedema compression to the	D 273		

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D 273	Continued From page 1 legs and chest Review of Resident #4's electronic medication administration record (eMAR) dated December 2021 revealed: -There was an entry to use a lymphedema pump 60 minutes twice a day (may use in recliner supine) at 8:00am and 8:00pm. -There was a start date of 12/16/21 and a discontinued date of 12/29/21. -There was documentation the lymphedema pump was used from 12/17/22 to 12/28/22 at 8:00am and 8:00pm. -There was documentation by a medication aide (MA) the lymphedema compression order was discontinued on 12/29/21 at 8:00am. Review of Resident #4's eMAR dated January 2022 revealed: -There was no entry for the lymphedema compression device. -There was an entry for acute charting due to swelling related to lymphedema and vital signs were documented every shift from 01/05/22 - 01/08/22. Review of Resident #4's eMAR dated February 2022 - June 2022 revealed there was no entry for the lymphedema compression device and there was no entry for acute charting related to lymphedema. Interview with the Administrator on 06/03/22 at 10:30am revealed Resident #4 did not have a lymphedema compression pump when she began working at the facility in March 2022. Interview with a personal care assistant (PCA) on 06/03/22 at 8:55am revealed that she had seen the lymphedema compression device in Resident	D 273		

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#4's room but she had not assisted Resident #4 with using the device and had not seen the device in use.

Interview with the Resident Care Coordinator (RCC) on 06/03/22 at 10:45am revealed:
-In mid-April 2022, she was told by the Licensed Health Professional Support (LHPS) nurse the facility could not provide services for Resident #4's lymphedema compression pump because the facility did not have licensed staff to supervise the resident and the device.
-She never saw Resident #4's lymphedema compression pump since starting to work at the facility in mid-April 2022.

Telephone interview with the LHPS nurse on 06/03/22 at 10:50am revealed:
-Around December 2021, she discovered during a facility visit Resident #4 had a lymphedema compression pump.
-The device consisted of a sleeve that was to be worn over Resident #4's chest.
-The sleeve compressed from Resident #4's chest and below which affected the resident's internal organs.
-She thought she removed Resident #4's lymphedema compression pump from his room during that facility visit and gave to the former RCC.
-She told the former RCC the facility could not provide lymphedema compression pump services to Resident #4 because the facility did not have licensed staff.
-Around December 2021, she notified Resident #4's PCP the facility could not provide services for the resident's lymphedema compression pump because the facility did not have licensed staff.

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D 273	Continued From page 3 Interview with the lead medication aide (MA)/supervisor in 06/03/22 at 11:30am revealed: -She observed a MA/Supervisor apply a compression pump to Resident #4's legs and abdomen in December 2021. -The compression pump consisted of long sleeves from Resident #4's ankles to his knees and wrapped around his back and abdomen. -She was working at the facility for two weeks when Resident #4's lymphedema compression pump was discontinued by his PCP in December 2021. -She never applied the lymphedema compression pump to Resident #4 because she had not been trained to apply the device. -She did not know how her initials were documented on Resident #4's eMAR as applying the lymphedema compression pump to the resident. A second interview with the Administrator on 06/06/22 at 11:37am revealed: -There was no documentation that the LHPS nurse notified Resident #4's PCP the facility could not provide services to Resident #4 for the lymphedema compression pump. -She could not find a discontinuation order for Resident #4's lymphedema compression pump. A second interview with a nurse at Resident #4's PCP's office on 06/03/22 at 11:39pm revealed: -The resident's family member called 12/28/21 and requested the PCP to write an order for a lymphedema compression pump for Resident #4. -She could not locate an order before 01/17/22 for the lymphedema compression pump. -There was documentation dated 03/10/22 that the lymphedema compression pump would benefit the resident, but the facility was uncomfortable using the device.	D 273		

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D 273	Continued From page 4 -She did not how Resident #4's PCP obtained the information documented on 03/10/22. -There was no documentation the facility notified the PCP they were not able to provide lymphedema compression pump services to the resident. Interview with a MA/Supervisor on 06/03/22 at 11:45am revealed: -After she started in December 2021, she received a video in-service on a lymphedema compression pump for Resident #4. -The device was to be placed on one leg, one arm, and around his chest and was attached to a pump. -She was told by the lead MA/Supervisor after the in-service not to apply the device to Resident #4. -She entered a discontinuation order for Resident #4's lymphedema compression pump the end of December 2021 because it was discontinued. -She could not find the PCP discontinuation order for Resident #4's lymphedema compression pump. -She did not remember how she obtained the discontinuation order. -She did not remember applying the lymphedema compression pump to Resident #4. -She did not remember documenting in Resident #4's December 2021 eMAR that she applied the lymphedema compression pump to the resident. Telephone interview with the former Administrator on 06/03/22 at 10:11am revealed: -Resident #4's lymphedema compression device was ordered before he started working at the facility. -He was advised from his corporate nurse that Resident #4's lymphedema compression device was a skilled service and the facility could not provide assistance with the use of this device.	D 273		

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-He was notified Resident #4's responsible party that the facility was unable to use the lymphedema compression device and he was working on transferring Resident #4 to a skilled nursing facility for further management of the device.

Telephone interview with Resident #4's Occupational Therapist (OT) on 06/03/22 at 12:00pm revealed:
-She treated Resident #4 for lymphedema from September 2021 to November 2021.
-Resident #4's legs were always red and hard.
-Resident #4 had Stage 2 lymphedema (swelling that does not go away with elevation and the tissue is firmer and scarred due to stagnant lymph).
-Prior to discharge in November 2021, she referred Resident #4 to a DME company for a lymphatic compression pump to decrease the fluid in his legs and arms as a result of lymphedema.
-Part of the arm sleeve was placed around Resident #4's chest to keep the arm sleeve secured.
-The device would apply some pressure to Resident #4's chest but she was unsure of the amount.
-Sometime after November 2021, Resident #4's family member told her the facility would not apply the lymphatic compression pump.
-Lymphedema was a lifelong diagnosis and would worsen over time without management.

Telephone interview with Resident #4's compression pump lymphedema specialist on 06/03/22 at 12:50pm revealed:
-Resident #4 was ordered a lymphedema compression pump used to treat lymphedema and was to be applied to the leg and arm for one

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hour in the morning and one hour in the afternoon.
-Resident #4's lymphedema compression pump was mailed to the facility about one month after ordered by the company sometime towards the end of 2021.
-He provided training to staff on how to use the bio compression pump via a telephone video conference once staff called to tell him the device had arrived.
-Resident #4 needed to be positioned to where his hips were flexed less than 90 degrees when using the device, for the bio compression pump to work properly.
-Sometime after the in service, staff told him Resident #4 could not use the device because the resident became short of breath when laying down.
-He told staff to position Resident #4 in the recliner with his hips less than 90 degrees and his legs down.
-Positioning the resident in the recliner would prevent the need for Resident #4 to lay down and his hips would be flexed less than 90 degrees.
-He told staff to notify Resident #4's PCP the resident was unable to use the lymphedema compression pump.
-He told staff to contact him once they spoke with Resident #4's PCP of the inability to use the lymphedema compression pump.
-Staff never contacted him back.
-He could not be specific on the date the lymphedema compression pump was ordered for Resident #4, when it was received by the facility, or when he provided in-service to staff for the lymphedema compression pump because he did not have access to his electronic documentation.
-He could not be specific on staff names/titles because he did not have access to his electronic documentation.

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D 273	Continued From page 7 -Resident #4's lymphedema could worsen without the lymphedema compression pump. Attempted telephone interview with Resident #4's PCP on 06/03/22 at 9:35am and was unsuccessful.	D 273		