STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL057011	A. BUILDING: _____ B. WING _____	R 06/23/2023

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MARS HILL RETIREMENT COMMUNITY	170 SOUTH MAIN STREET MARS HILL, NC 28754

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 06/21/23 through 06/23/23.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents who had an order for acetaminophen for pain (Resident #3). The findings are: Review of Resident #3's current FL2 dated 01/05/23 revealed: -Diagnoses included osteoporosis, chronic kidney disease, anxiety disorder. -Resident #3 was documented as ambulatory and needed no assistance with activities of daily living (ADLs). Review of the resident register for Resident #3 revealed an admission date of 01/02/23. Review of Resident #3's care plan dated 01/31/23	D 276		

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D 276	Continued From page 1	D 276		

revealed all ADL's were documented as independent.

Review of Resident #3's Clinical Staff Observation/Question form for the Physician dated 02/02/23 revealed:
-There was documentation by the Resident Care Director (RCD), Resident #3 was "having severe back pain" due to moving boxes in her room.
-Resident #3 was asking for Ibuprofen for her pain.

Review of Resident #3's physician order dated 02/02/23 revealed an order for Ibuprofen 400mg-600mg three times daily as needed for pain that had not been clarified for Resident #3 to be able to use.

Review of Resident #3's primary care providers (PCP) initial visit on 02/08/23 revealed:
-Additional diagnoses of hypothyroidism, broken pelvis and bursitis.
-The primary diagnosis was documented as acute low back pain without sciatica (pain radiating on the sciatic nerve which runs down one or both legs from the back).
-There was a concern of back pain for 2 weeks, which was severe the last few days.
-The PCP recommended Resident #3 be evaluated by local orthopedic urgent care providing comprehensive orthopedic, spine and pain management care.

Review of the local orthopedic urgent care visit note dated 02/10/23 revealed:
-There was a diagnosis of lumbar spondylosis (osteoarthritis).
-There was a referral to physical therapy for low back pain secondary to lumbar sacral somatic dysfunction (localized change in the muscle

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related to edema and swelling) and lumbar spondylosis (age related wear and tare of the spinal disc).

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was no pain medication available for administration for Resident #3 on 01/02/23-01/31/23.
-There was no entry for acetaminophen 325mg take 2 tablets every 4 hours as needed for pain and call the PCP if pain persists had been activated from the standing orders for 02/01/23-02/20/23 .

Review of Resident #3's February 2023 eMAR revealed:
-There was no pain medication available for administration for Resident #3 on 02/01/23-02/08/23 until 9:00pm on 02/08/23.
-There was no entry for Ibuprofen.
-There was no entry acetaminophen 325mg take 2 tablets every 4 hours as needed for pain and call the PCP if pain persists had been activated from the standing orders for 02/01/23-02/20/23.
-There was an entry for acetaminophen 500mg ex-str three times daily beginning 02/08/23 at 9:00pm.

Interview with a medication aide (MA) on 06/22/23 at 11:07am revealed:
-Resident #3 was at the facility a few days when she began having back pain.
-She went from being able to going downstairs on the elevator to the dining room to staying in the bed most of the time.
-The only thing Resident #3 ever asked for was her pain medication.
-The tramadol, ordered on 02/08/23, for her back

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pain was all the pain medication that she had administered.
-She did not recall administering Resident #3 any acetaminophen for pain.
-She did not remember why she did not initiate the acetaminophen 325mg in the standing orders for Resident #3's pain before the tramadol was initiated.

Interview with a second MA on 06/22/23 at 11:30am revealed:
-Resident #3 used a walker and would go to the dining room when she was first admitted.
-She thought Resident #3 had hurt her back moving some boxes in her room a few days after she moved in.
-She did not know why the acetaminophen for the standing orders was not initiated for Resident #3's pain.
-Resident #3 was also not someone who ate well because her back pain made her feel bad and she did not want to eat.
-Resident #3 would ask for something for pain when her back was hurting.
-She thought Resident #3 took tramadol for pain.
-There was acetaminophen available on the standing orders that could have been initiated for pain.
-She sometimes forgot about the standing orders being available for administration.

Interview with a family member of Resident #3 on 06/22/23 at 8:31am revealed:
-Resident #3 had been a resident at the facility from 01/20/23- 2/20/23.
-Resident #3 experienced problems with back pain during her stay.
-Resident #3 asked for Ibuprofen and acetaminophen for pain medication and had not received it.

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D 276	Continued From page 4 -She had discussed her concerns with the previous Administrator and the Resident Care Director (RCD) when Resident #3 resided at the facility. Interview with the Health and Wellness Director (HWD) on 06/22/23 at 1:25pm revealed: -She was responsible to ensure orders were clarified and initiated as ordered. -Resident #3 met with the facility physician on 02/08/23 to establish care. -Resident #3 shared with her that her back was hurting from moving boxes in her room about a week after she had moved in. -Resident #3 asked her for Ibuprofen for her back pain on 02/02/23. -She had faxed a request to Resident #3's previous PCP related to complaints of severe back pain. -The previous PCP responded but the facility could not accept the order as written, as it was for 400mg to 600mg and a specific dose was needed before being implemented. -She was not sure why there was no clarification of the order for the Ibuprofen and she did not know why the standing order for acetaminophen was not initiated. -Resident #3 went from 02/02/23- 02/08/23 without any pain medication for her back pain. Interview with the facility Family Advisor on 06/22/23 at 2:40pm revealed: -New residents and families would come to her with issues and concerns. -If the resident or a family member shared a concern she would notify the appropriate department manager and that would be where her responsibility ended. -There was not a process in place to to follow-up on concerns.	D 276		

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-She visited with Resident #3 and a family member who shared Resident #3 was not receiving her pain medication as ordered.

Telephone interview with the facility contracted pharmacist on 06/22/23 at 4:49pm revealed:
-They had not received an order for Ibuprofen as needed or for the standing order acetaminophen 325mg to be initiated.
-If the order had been received then it would have automatically been entered into the computer system and it would show up on the eMAR and the medication would have been sent to the facility.
-The facility had the acetaminophen 325mg on hand and they would have been able to administer the acetaminophen 325mg as soon as the MA initiated the standing order.

Interview with a MA on 06/23/23 at 1:20pm revealed:
-She did not know Resident #3 had physician's standing orders signed by the PCP.
-She did not know why she or the other MAs did not initiate the acetaminophen order to treat Resident #3's back pain from 02/02/23 through 02/08/23.
-When Resident #3 complained of back pain, the MA working should have checked to see if the standing physician's orders were signed, activated the acetaminophen order, and administered the acetaminophen to Resident #3.

Interview with the HWD on 06/23/23 at 3:30pm revealed:
-Not all physician's standing orders were entered into the resident's eMAR, only the medications that were initiated by the MA.
-Most medications on the physician's standing orders were house stock medications and were

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D 276	Continued From page 6 kept stocked at the facility so the medications were available to administer when needed. -Resident #3 had signed standing physician's orders and the acetaminophen 325mg should have been activated by a MA and administered to Resident #3 for back pain. -She did not know why the MAs did not initiate the standing order for the acetaminophen 325mg for Resident #3 when Resident #3 complained of back pain when there were no other medications on the eMAR to treat pain. Interview with a MA on 06/23/23 at 3:35pm revealed: -Resident #3 had standing orders signed by the provider for use if she needed them. -She did not recall initiating any standing orders for Resident #3. -Once Resident #3 had a physicians order for pain (tramadol) she would not have initiated the standing orders. -If the standing orders were not initiated and Resident #3 had no other orders for pain medication she would have done without until the physician wrote an order for pain medication or a MA initiated the standing order. _____ The facility failed to implement acetaminophen as ordered by the primary care provider (PCP) for 1 of 5 sampled residents (#3) who had acute back pain. The facility's failure to implement acetaminophen 325mg 2 tablets every 4 hours as needed for pain resulted in Resident #3 experiencing pain with no medication for pain being administered for at least 7 days and was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation	D 276		

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D 276	Continued From page 7 on 06/23/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 7, 2023.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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 (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 interview and record review the facility failed to implement a physicians order for 1 of 5 sampled residents who had an order for Ibuprofen for pain (Resident #3). The findings are: Review of Resident #3's current FL2 dated 01/05/23 revealed: -Diagnoses included osteoporosis, chronic kidney disease, anxiety disorder. -Resident #3 was documented as ambulatory and no needed assistance with activities of daily living (ADLs).	D 344		

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D 344	Continued From page 8 Review of the resident register for Resident #3 revealed an admission date of 01/02/23. Review of Resident #3's physician order dated 02/02/23 revealed an order for Ibuprofen 400mg-600mg three times daily as needed for pain. Review of Resident #3's Clinical Staff Observation/Question form for the Physician dated 02/02/23 revealed: -There was documentation by the Resident Care Director (RCD), Resident #3 was "having severe back pain" due to moving boxes in her room. -Resident #3 was asking for Ibuprofen for her pain. Review of Resident #3's February 2023 eMAR revealed there was no entry for Ibuprofen 400mg-600mg three times daily as needed from 02/01/23-02/20/23. Interview with the Health and Wellness Director on 06/22/23 at 1:25pm revealed: -She was responsible to ensure orders were clarified and initiated as ordered. -Resident #3 had shared with her that her back was hurting from moving boxes in her room about a week after she had moved in. -Resident #3 had asked for Ibuprofen for her back pain on 02/02/23. -She had faxed a request to Resident #3's previous PCP for an order for Ibuprofen related to her experiencing "severe back pain". -The PCP had responded but the facility could not accept the order as written as it was for 400mg to 600mg and the facility had to have a specific dose before being able to implement the order. -She was not sure why there was not a	D 344		

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D 344	Continued From page 9 clarification order for the Ibuprofen. -Resident #3 went from 02/02/23- 02/08/23 at 9:00pm with no medications being administered for her back pain. Telephone interview with the medical records staff at the previous primary care physician (PCP) office on 06/23/23 at 9:25am revealed: -There was a request for an order for Ibuprofen for pain for Resident #3 from the facility. -The physician had responded with an order on 02/02/23 for Ibuprofen 400mg-600mg three times daily as needed. -There was no request for a clarification order for the Ibuprofen.	D 344		