STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	R 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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 a follow-up survey on August 22, 2023 and August 23, 2023.	{C 000}		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on observations, record reviews, and interviews, the facility failed to ensure medication was available and administered as ordered for 1 of 3 (#1) sampled residents related to a pain medication. The findings are: Review of Resident #1's current FL-2 dated 08/14/23 revealed: -Diagnoses included neuropathy, dementia and degenerative disc disease. -There was an order for tramadol 50 milligrams (mg) (a medication used to treat mild to moderate pain) by mouth three times a day. Review of Resident #1's August Medication Administration Record (MAR) from 08/14/23 to 08/23/23 revealed: -There was an entry for tramadol 50 mg by mouth three times a day, scheduled for 8:00 am, 1:00 pm and 8:00 pm. -There was no documentation of tramadol 50 mg	{C 330}		

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{C 330}	Continued From page 1 three times a day being administered. Telephone interview with a registered nurse (RN) at Resident #1's Primary Care Provider's (PCP) office on 08/23/22 at 10:00 am revealed: -Resident #1's last visit to the PCP's office was on 08/07/23. -Resident #1 did not have a list of current medications with him. -The PCP's Certified Medical Assistant (CMA) reviewed Resident #1's medications with him. -Tramadol had been ordered by a different provider. -The PCP signed Resident #1's current FL2 on 08/14/23 wit the order for tramadol 50 mg 3 times a day. -The PCP was unavailable for interview. Interview with Resident #1 on 08/22/23 at 8:30 am revealed: -He received his medications timely. -Staff managed his medications. Telephone interview with a pharmacist at the facility's pharmacy on 08/23/23 at 10:28 am and at 2:00 pm revealed: -Tramadol 50 mg was last dispensed from a previous order on 02/01/2023 for 90 tablets. -There was no current order for tramadol 50 mg three times a day at the pharmacy. -The facility called the pharmacy yesterday, 08/22/23, to request the medication. -After the pharmacy received the request to refill the medication, an electronic request for a refill was sent to the PCP on 08/22/23. Interview with the Medication Aide (MA on 08/23/23 at 1:25 pm revealed: -Resident #1 was not taking tramadol 50 mg three times a day.	{C 330}		

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{C 330}	Continued From page 2 -There was no tramadol 50 mg available to administer to Resident #1. -Resident #1 was routinely administered another medication for pain every morning and every evening. -Resident #1 had not complained about or acted like he was having pain on the shifts she worked. Interview with the facility's Administrator on 08/23/23 at 1:55 pm revealed: -Residents' medications were ordered and should be administered according to the current FL2 or orders. -She took Resident #1 to his appointment with his PCP on 08/07/23. -The PCP instructed Resident #1 to take another medication for pain but did not provide any instruction regarding administering Tramadol. -She was the one responsible to fax FL2s and medication orders to the contracted pharmacy and to place new orders in a folder for her review. -After reviewing, the new orders were placed in the residents' records. -She was responsible for reviewing PCP progress notes after residents' appointments. -She had not been auditing residents' medication orders compared to their MAR. -She did not know Resident #1 had an order for Tramadol 50mg on the MAR and current FL2 but was not receiving Tramadol.	{C 330}		