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	HAL070005	A. BUILDING: _____ B. WING _____	R 11/09/2023

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a Follow Up Survey on 11/08/23 to 11/09/23.	{D 000}		
{D 280}	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support review and evaluation was completed for 2 of 5 (#3 and #4) sampled residents related to a resident who had a suppository medication ordered (#3) and a resident who had an order for oxygen (#4).	{D 280}		

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{D 280}	Continued From page 1 The findings are: 1. Review of Resident #3's current FL-2 dated 04/18/23 revealed diagnoses included dementia, hypertension, thyroid disorder, and coronary artery disease. Review of Resident #3's physician medication order dated 04/25/23 revealed there was an order for Bisacodyl laxative rectal suppository 10mg, insert 1 suppository rectally every 24 hours as needed for constipation if no bowel movement in 2 days. Review of Resident #3's Licensed Health Professional Support (LHPS) Evaluation dated 10/25/23 revealed: -The LHPS review and evaluation was completed by the previous Health and Wellness Director (HWD), who was a Registered Nurse (RN). -The LHPS personal care task provided included escorts and transfers. -The resident received hospice care. -The resident was totally dependent on staff for all activities of daily living (ADL's), feeding, and ambulation. -There was no task listed for the administration of a suppository medication. Interview with the Health and Wellness Coordinator (HWC) on 11/09/23 at 12:55pm revealed the Health and Wellness Director (HWD) was responsible for for completing the LHPS review and evaluation for Resident #3. Interview with the HWD on 11/09/23 at 12:25pm revealed she was not sure if administering a suppository medication was an LHPS task.	{D 280}		

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{D 280}	Continued From page 2 Interview with the Administrator on 11/09/23 at 1:40pm revealed she was not aware administering a suppository medication was an LHPS task. Refer to the interview with the HWC on 11/09/23 at 12:55pm. Refer to the interview with the HWD on 11/09/23 at 12:25pm. Refer to the interview with the Administrator on 11/09/23 at 1:40pm. 2. Review of Resident #4's current FL-2 dated 08/22/23 revealed: -Diagnoses included hypertension, stage 3 kidney disease, peripheral artery disease, rheumatoid arthritis, mixed hyperlipidemia, history of atrial fibrillation, right lung cancer and pulmonary emphysema. -There was an order for oxygen (O2) 2 liter continuously. Review of Resident #4's record on 11/08/23 revealed there was no documentation of a Licensed Health Professional Support (LHPS) evaluation completed for Resident #4. Interview with Resident #4 on 11/09/23 at 9:23am revealed: -Staff had not checked the O2 levels. -He checked the O2 levels. Interview with the medication aide (MA) on 11/09/23 revealed: -She had checked Resident #4's O2 daily and had not noticed any irregularities. -She was trained on how to administer and check the O2 of residents.	{D 280}		

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{D 280}	Continued From page 3 Interview with the Health and Wellness Coordinator (HWC) on 11/09/23 at 12:21pm revealed: -She did not know that an LHPS had not been completed for Resident #4. -She was aware of Resident #4 use of O2. -The Health and Wellness Director (HWD) was the person responsible for completing the LHPS. Interview with the HWD on 11/09/23 at 8:41am revealed: -She was hired as the HWD on 10/09/23 and began completing chart audits on all of the residents. -Resident #4 had been listed as "not applicable" on the chart audit reconciliation log for updating his LHPS. -She completed an LHPS for Resident #4 on 11/08/23 and provided a copy of the LHPS. Interview with the Administrator on 11/08/23 at 4:08pm revealed: -Resident #4 had not been completed by the previous HWD. -She would have the HWD to complete an LHPS for Resident #4. Refer to the interview with the Health and Wellness Coordinator (HWC) on 11/09/23 at 12:55pm. Refer to the interview with the Health and Wellness Director (HWD) on 11/09/23 at 12:25pm. Refer to the interview with the Administrator on 11/09/23 at 1:40pm. _____ Interview with the HWC on 11/09/23 at 12:55pm revealed:	{D 280}		

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{D 280}	Continued From page 4 -She was a Licensed Practical Nurse (LPN). -She was not responsible for completing the LHPS review and evaluation for residents. Interview with the HWD on 11/09/23 at 12:25pm revealed: -She was an RN and responsible for completing the LHPS review and evaluation for residents -It was important LHPS reviews and evaluations were up-to-date and accurate to ensure staff were qualified and knowledgeable regarding the individualized care plan for a resident. Interview with the Administrator on 11/09/23 at 1:40pm revealed the HWD was responsible for completing the LHPS review and evaluation for residents. -The LHPS review and evaluation was important because it identified the care needs of the resident and ensures staff know how to administer the medication.	{D 280}		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication orders were maintained in the residents' records for 1 of 5 sampled residents (#4) related to orders for controlled medication.	D 345		

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D 345	Continued From page 5 The findings are: Review of Resident #4's current FL-2 dated 08/22/23 revealed: -Diagnoses included hypertension, stage 3 kidney disease, peripheral artery disease, rheumatoid arthritis, mixed hyperlipidemia, history of atrial fibrillation, right lung cancer and pulmonary emphysema. -There was not an order for Oxycodone-Acetaminophen 5-325mg 1 tablet as needed (PRN) every 4 hours. Review of Resident #4's Self-Administration of Medication Review (Quarterly) dated 08/31/23 revealed: -There had been no changes in Resident #4's medication since the last assessment. -Resident #4 could fully identify the expiration for all medications. -Resident #4 was able to properly state situation warranting the use of PRN medications with assistance. -Staff were to document the use of PRN medications with assistance. Observation of medications on hand on in the resident's room 11/09/23 at 9:23am revealed: -There was a bottle of Oxycodone-Acetaminophen 5- 325mg 1 tablet every 4 hours PRN. -There were 2 tablets in the bottle. -The amount dispensed was 36 tablets. -There was a dispense date of 04/10/19. -There was a discard date after 04/09/20. Review of Resident #4's October 2023 electronic medication administration record (eMAR) revealed there were no entries of	D 345		

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D 345	Continued From page 6 Oxycodone-Acetaminophen 5-325mg documented for administration. Interview with Resident #4 on 11/09/23 at 9:23am revealed: -He had an order for self-administration of all of his medication. -He has been taking the Oxycodone-Acetaminophen 5-325mg when he was in pain. -He last self-administered the 1 Oxycodone-Acetaminophen 5-325mg on 11/07/23. -Staff had not checked daily to see if he had been taking his medications as ordered. -Staff had not checked in his medication when he was admitted to the facility. Interview with the medication aide (MA) on 11/09/23 at 11:13am revealed: -Resident #4 had an order for self-administration of medication. -She had not observed Resident #4's self-administering his medications. -She had not documented on the MAR of Resident #4 taking his medication. -She was not aware of Resident #4 having the Oxycodone-Acetaminophen 5-325mg. Interview with the Health and Wellness Coordinator (HWC) on 11/09/23 at 12:21pm revealed: -She was not aware Resident #4 had the Oxycodone in his possession. -The Health and Wellness Coordinator (HWD) was the person responsible for completing a medication reconciliation and self-administration of medication for all residents. -Resident #4 had a medication reconciliation completed when he was admitted to the facility.	D 345		

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D 345	Continued From page 7 -The MAs do not document on the MAR for residents who administer their own medication. Interview with the HWD on 11/09/23 at 12:26pm revealed: -She had not completed cart audits for residents who had self-administration of medication orders. -She was not aware of Resident #4 having the Oxycodone in his possession. -Resident #4 did not have medication reconciliation completed when he was admitted to the facility. -She and the HWC were the persons responsible for completing a medication reconciliation for residents. Interview with the Administrator on 11/09/23 at 1:38pm revealed: -Resident #4 did not inform staff he had the Oxycodone in his possession. -Staff had not been made aware of Resident #4 having the Oxycodone because the medication was not listed on his FL2. -The HWC and HWD were the persons responsible for ensuring all residents medications orders were current. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 11/09/23 at 12:06pm was unsuccessful.	D 345		
D 412	10A NCAC 13F .1010 (e) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.	D 412		

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D 412	Continued From page 8	D 412		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide pharmaceutical services that ensured accurate records of the receipt of medications were maintained in the facility for 1 of 5 sampled residents (#4).

The findings are:

Review of Resident #4's current FL-2 dated 08/22/23 revealed:
-Diagnoses included hypertension, stage 3 kidney disease, peripheral artery disease, rheumatoid arthritis, mixed hyperlipidemia, history of atrial fibrillation, right lung cancer and pulmonary emphysema.
-There was not an order for Oxycodone-Acetaminophen 5-325mg 1 tablet as needed (PRN) every 4 hours.

Interview with Resident #4 on 11/09/23 at 9:23am revealed:
-He was admitted to the facility on 08/23/23.
-He had an order for self-administration of all of his medication.
-He has been taking the Oxycodone-Acetaminophen 5-325mg when he was in pain.
-He last self-administered the 1 Oxycodone-Acetaminophen 5-325mg on 11/07/23.
-Staff had not checked in his medication when he was admitted to the facility.

Interview with the Health and Wellness Coordinator (HWC) on 11/09/23 at 12:21pm

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D 412	Continued From page 9	D 412		

revealed:
-She was not aware Resident #4 had the Oxycodone in his possession.
-The Health and Wellness Coordinator (HWD) was the person responsible for completing a medication reconciliation for all residents.
-Resident #4 had a medication reconciliation completed when he was admitted to the facility.

Interview with the HWD on 11/09/23 at 12:26pm revealed:
-She had not completed cart audits for Resident #4 because he had a self-administration of medication order.
-She was not aware Resident #4 had the Oxycodone in his possession.
-Resident #4 did not have a medication reconciliation completed when he was admitted to the facility.
-She had not known why the medication reconciliation for Resident #3 had not been completed prior to her hire.
-She and the HWC were the persons responsible for completing a medication reconciliation for residents.

Interview with the Administrator on 11/09/23 at 1:38pm revealed:
-Resident #4 did not inform staff he had the Oxycodone in his possession.
-Staff had not been made aware of Resident #4 having the Oxycodone because the medication was not listed on his FL2.
-The HWC and HWD were the persons responsible for completing medication reconciliation for all new residents.

Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 11/09/23 at 12:06pm was unsuccessful.

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