STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035028	A. BUILDING: _____ B. WING _____	R 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HEALTHCARE #1	306 LUMPKIN BLVD LOUISBURG, NC 27549

(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 an annual and follow-up survey with an exit date of 03/06/24.	C 000		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a hazard-free environment related to three unsecured oxygen (O2) tanks in a resident's room. The findings are: Observation of a resident room on 03/06/24 during the 8:00am initial tour revealed: -There were three 26-inch tall unsecured O2 tanks sitting upright on the floor next to the resident's dresser. -There was no rack or crate to stabilize the O2 tanks. Interview with the resident residing in the room on 006/24 at 8:00am revealed: -She only used oxygen at night when she was	C 078		

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C 078	Continued From page 1 sleeping. -She used the concentrator at night when she went to bed. -She did not use the O2 tanks, because they were too heavy. -She did not know how long the O2 tanks had been sitting in her room. Interview with a medication aide on 03/06/24 at 1:42pm revealed: -The resident uses the concentrator at night when she sleeps. -The resident did not use the O2 tanks. -She did not realize the O2 tanks needed to be in a crate or rack for security. Interview with the Administrator on 03/06/24 at 2:03pm revealed: -The resident was on O2 at @L/M each night. -The resident would put her O2 on when she went to bed and took it off when she got up each morning. -The O2 tanks had been in the resident's room for months, sitting in a crate. -She did not know what happened to the crate. -The O2 tanks should be secure in a crate so they will not fall.	C 078		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	C 342		

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C 342	Continued From page 2 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 2 of 3 sampled residents (#1, #2) including an as needed medication for shortness of breath (#1); and two antibiotics (#2). The findings are: Review of Resident #1's current FL-2 dated 08/11/24 revealed: -Diagnosis included chronic obstructive pulmonary disease (COPD). -There was an order for albuterol 2.5mg/3ml (used to treat wheezing) by nebulizer every 4 hours as needed for wheezing or shortness of breath. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for albuterol 2.5mg/3ml by nebulizer every 4 hours a needed for wheezing and shortness of breath.	C 342		

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C 342	Continued From page 3 -There was no documentation albuterol was administered from 01/01/24 to 01/31/24. Review of Resident #1's February 2024 eMAR revealed: -There was an entry for albuterol 2.5mg/3ml by nebulizer every 4 hours a needed for wheezing and shortness of breath. -There was no documentation albuterol was administered from 02/01/24 to 02/29/24. Review of Resident #1's March 2024 eMAR from 03/01/24 to 03/06/24 revealed: -There was an entry for albuterol 2.5mg/3ml by nebulizer every 4 hours a needed for wheezing and shortness of breath. -There was no documentation albuterol was administered 03/01/24 to 03/06/24. Interview with Resident #1 on 03/06/24 at 8:00am revealed: -She had COPD and became short of breath at times. -She used the nebulizer treatment several times a week for shortness of breath. -She used the nebulizer machine this morning, after breakfast. Interview with a medication aide (MA) on 03/06/24 at 1:42pm revealed: -She administered Resident #1 her nebulizer treatment this morning. -Resident #1 received her nebulizer treatments when she was short of breath. -She received a nebulizer treatment several times a week for shortness of breath. -She did not document on the eMAR when Resident #1 received a nebulizer treatment. -She did not know she needed to document on the eMAR each time a nebulizer treatment was	C 342		

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C 342	Continued From page 4 administered. Interview with the Administrator on 03/06/24 at 2:03pm revealed: -When the MA administers an as needed medication it should be documented in the eMAR. -The eMAR system would alert the MA in one hour to check on the resident to see if the as needed medication was effective. -She expected the MA to document on the eMAR each time an as needed medication was administered. Attempted a telephone interview with Resident #2's Primary Care Provider (PCP) on 03/06/24 at 1:15pm. 2. Review of Resident #2's current FL-2 dated 08/08/23 revealed diagnoses included diabetes mellitus, asthma, hypertension, schizoaffective disorder. a. Review of Resident #2's signed physician's order dated 01/23/24 revealed there was an order for metronidazole 500mg (used to treat infection) twice daily for seven days. Review of Resident #2's January 2024 electronic medication administration record (eMAR) from 01/23/24 to 01/30/24 revealed: -There was an entry for metronidazole 500mg twice daily for seven days with a scheduled administration time of 8:00am and 8:00pm. -There was no documentation that metronidazole 500mg was administered from 01/23/ to 01/30/23. Telephone interview with a representative for the facility's contracted pharmacy on 03/06/24 at 2:10pm revealed: -The pharmacy received an order for	C 342		

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C 342	Continued From page 5	C 342		

metronidazole 500mg twice daily for 7 days on 01/23/24.
-The pharmacy dispensed and delivered the medication to the facility on 01/23/24.
-The pharmacy dispensed 14 metronidazole on 01/23/24.
-Metronidazole was an antibiotic to treat infection.

Attempted a telephone interview with Resident #2's Primary Care Provider (PCP) on 03/06/24 at 1:15pm.

Refer to the interview with Resident #2 on 03/06/24 at 10:45am.

Refer to the interview with the medication aide (MA) on 03/06/24 at 1:42pm.

Refer to the interview with the Administrator on 03/06/24 at 2:03pm.

b. Review of Resident #2's signed physician's order dated 01/29/24 revealed there was an order for nitrofurantoin 100mg twice daily for 5 days.

Review of Resident #2's January 2024 electronic medication administration record (eMAR) from 01/29/24 to 01/30/24 revealed:
-There was an entry for nitrofurantoin 100mg twice daily for 5 days with a scheduled administration time of 8:00am and 8:00pm.
-There was no documentation nitrofurantoin 100mg was administered from 01/29/24 to 01/31/24.

Review of Resident #2's February 2024 eMAR from 02/01/24 to 02/03/24 revealed:
-There was an entry for nitrofurantoin 100mg twice daily for 5 days with a scheduled administration time of 8:00am and 8:00pm.

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C 342	Continued From page 6 -There was no documentation nitrofurantoin 100mg was administered from 02/01/24 to 02/03/24. Telephone interview with a representative for the facility's contracted pharmacy on 03/06/24 at 2:10pm revealed: -The pharmacy received an order for nitrofurantoin 100mg twice daily for 5 days on 01/29/24. -The pharmacy dispensed and delivered the medication to the facility on 01/29/24. -The pharmacy dispensed 10 nitrofurantoin 100mg on 01/29/24. -Nitrofurantoin was an antibiotic to treat infection. Attempted a telephone interview with Resident #2's Primary Care Provider (PCP) on 03/06/24 at 1:15pm. Refer to the interview with Resident #2 on 03/06/24 at 10:45am. Refer to the interview with the medication aide (MA) on 03/06/24 at 1:42pm. Refer to the interview with the Administrator on 03/06/24 at 2:03pm. _____ Interview with Resident #2 on 03/06/24 at 10:45am revealed: -The medication aide (MA) gave her medication each day. -She knew she had been to the doctor and was ordered antibiotics for infection. -She did not know if the MA gave her the antibiotics or not, but she was sure she did. -The MA gave her all of her medications. Interview with a MA on 03/06/24 at 1:42pm	C 342		

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C 342	Continued From page 7 revealed: -She administered the antibiotics as ordered to Resident #2. -She did not know why the documentation of the administration of the medications did not show on the eMAR. Interview with the Administrator on 03/06/24 at 2:03pm revealed: -Resident #2 received both antibiotics as ordered. -She did not know why the medications were not documented as administered on the eMAR. -If the MA forgot to document the administration of a medication, the eMAR would flash a warning side on the computer screen when the MA attempted to save the information she documented. -There must have been a glitch in the system for the administration of the antibiotics not to be on the eMAR.	C 342		