Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Kim's Assisted Living
Address: 1241 Goins Rd. Pembroke, NC 28372
County: Robeson
License Number: FCL-078-114

II. Dates of Visits: 2/27/23, 4/4/23, and 4/21/23
Purpose of Visits: Complaint
Exit/Report Date: 6/2/23

Instructions to the Provider ***(please read carefully)*****:**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or Type A2 violation**, this agency may prepare an Administrative Penalty Proposal for the violation(s). Please submit any additional information within **5 days** to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13G .1004(a) Medication Administration	☐ POC Accepted _____ *DSS Initials*	
(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.		
Level of Non-Compliance: Type A2 Violation		
This rule is not met as evidenced by: **Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled residents' (#1) medication was administered as ordered as evidenced by the resident not receiving two pain medications used to treat pain which resulted in the resident suffering from withdrawl symptoms and pain.** The findings are:		

Review of Resident #1's current FL2 dated 06/23/22 revealed:
-Diagnoses included: Rheumatoid arthritis, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), anxiety disorder, depression, personal history of transient ischemic attack (TIA) cerebral infarction without residual deficits, dorsalgia, personal history of traumatic fracture, and vitamin D deficiency.
-He was ambulatory.
-A physician's order for oxycodone 10mg 4 times a day (a narcotic medication used to treat moderate to severe pain).

Review of subsequent orders for Resident #1 revealed:
-An order for oxycodone 15mg 4 times daily dated 01/20/23.
-An order for gabapentin 600mg (a medication used to treat nerve pain) 4 times daily dated 01/20/23.

Review of Resident #1's care plan dated 3/17/22 revealed:
-He was ambulatory with the use of a walker.
-He had limited range of motion in upper extremities.
-He required limited personal care assistance with bathing and dressing.

Review of Resident #1's Resident Register revealed:
-The date of admission was 03/11/22
-The date of discharge was 02/08/23

Review of Resident #1's medication administration record (MAR) for February 2023 revealed:
-There was an entry for Oxycodone 15mg 4 times daily.
-Oxycodone was documented as being administered on 02/01/23.
-Oxycodone 15mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23
-There was an entry for Gabapentin 600mg 4 times daily.
-The Gabapentin 600mg 4 times daily was documented as administered on 02/01/23.
-Gabapentin 600mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23.

Telephone interview with Resident #1 on 03/16/23 at 9:30am revealed:
-He was no longer a resident of the facility.
-He was out of his oxycodone and gabapentin medication for approximately two weeks from 02/02/23 – 02/13/23.
-He was in pain during this time.
-He went through withdrawls symptoms including upset stomach and diarrhea.
-He had back pain, leg pain, and leg swelling.
-He was told by the facility staff that they did not know where

his medicine was.
-He was told by the Administrator that she was going to find out what happened to the medicine but she never did.
-He often complained and reported to staff that he was in pain, but nothing was done.

Interview with the Supervisor in Charge (SIC) on 02/27/23 at 2:05pm revealed:
-He was hired as a personal care aide (PCA) on 06/20/20.
-He then worked as a medication aide (MA) for a short time but was no longer a MA due to not taking the medication aide exam.
-He was responsible for checking the medication drop box on the outside of the facility where the pharmacy dropped medication after hours.
-He never received oxycodone and gabapentin for Resident #1 in January 2023.

Interview with another facility staff on 02/27/23 at 2:38pm revealed:
-She worked as a PCA/SIC.
-Resident #1 was complaining of pain when he did not get his oxycodone 15mg and gabapentin 600mg from 02/02/23 – 02/07/23.
-Resident #1 was told by the other staff that the facility did not have his medications when the resident asked about them.
-Resident #1 became angry about not getting his medications.
-Resident #1's liason came to the facility on three different occasions after the resident was discharged looking for the medicine.
-Only the Administrator and the other SIC had access to the medication lock box, where the medications were kept.

Interview with the Administrator on 02/27/23 at 1:45pm revealed:
-She was aware that Resident #1's oxycodone 15mg and gabapentin 600mg medications were not available on 02/02/23.
-She called the pharmacy and inquired about the medication on that date.
-The pharmacy told her that the medications were delivered on 01/31/23.
-She asked the SIC and was informed that the medication had never been delivered.
-She had made two undocumented attempts to speak with the provider but was unsuccessful.
-She called law enforcement to inform them that the medication was missing on 02/13/23.
-A report was filed for the missing medication with law enforcement.

-She did not inform the local department of social services because she was trying to "handle things on her own".
-She questioned the SIC about the missing medications and he denied taking the medications.
-Resident #1 was the only resident in the facility with orders for controlled medications.

Telephone interview with the pharmacist on 04/24/23 at 12:25pm revealed:
-The gabapentin was delivered to the facility on 01/23/23 at 5:12pm.
-The oxycodone was delivered to the facility on 01/31/23 at 4:51pm.
-The pharmacist was not aware of theses medications being reported lost or stolen.

Follow-up telephone interview with the pharmacist on 05/23/23 at 10:00am revealed:
-The medications were delivered into the medication drop box and was not signed for by facility staff.
-The facility previously approved for control medications to be delivered without requiring a staff signature.
-The medication quantity for both the Oxycodone 15mg and Gabapentin 600mg was 120.

Telephone interview with Resident #1's pain clinic medical provider on 05/08/23 at 10:31am revealed:
-Resident #1 was prescribed oxycodone 15mg 4 times daily for severe back pain due a history of fractures in his back.
-Resident #1 had a history of back surgery.
-Resident #1 was prescribed gabapentin 600mg 4 times daily for neuropathy of the legs and feet.
-The provider learned that the resident was not receiving his medication from the residents liason on 02/13/23.
-Resident #1 was out of his oxycodone and gabapentin for approximately two weeks.
-The concern was that the resident could go into withdrawals and have had a range of symptoms from nausea to increased heart rate.
-The resident could have ended up hospitalized and/or in severe pain due not getting his medication as ordered.
-The provider was never made aware by the facility that the resident was not being administered his medication as ordered.
-The provider called the facility on 02/13/23 and verified the oxycodone and gabapentin were missing.
-On 02/13/23 she wrote new orders for oxycodone and gabapentin.

The failure of the facility to ensure pain medication was administered as ordered for 1 of 1 (Resident #1) sampled residents who was ordered 2 controlled pain medications (Oxycodone and Gabapentin) resulting in symptoms of withdrawal, and continusous unrelieved pain for two weeks resulted in substantial risk of serious physical harm, which constitutes a Type A2 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/12/23 for this violation.

THE CORRECTION DATE OF THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 3, 2023

Rule/Statute Number: 10A NCAC 13G .1008(h)
Controlled Substances

(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, the local law enforcement agency and Health Care Personnel Registry as required by state law and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

Level of Non-Compliance: Type B Violation

☐ POC Accepted

DSS Initials

This rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to report drug diversion of 1 of 1 sampled residents' (Resident #1) medication immediately to local law enforcement, the pharmacy, and healthcare personnel registry (HCPR) as required by state law which resulted in a delay in Resident #1 getting his medications.

The findings are:

Review of Resident #1's current FL2 dated 06/23/22 revealed:
-Diagnoses included: Rheumatoid arthritis, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), anxiety disorder, depression, personal history of transient ischemic attack (TIA) cerebral infarction without residual deficits, dorsalgia, personal history of traumatic fracture, and vitamin D deficiency.
-He was ambulatory.
-A physician's order for oxycodone 10mg 4 times a day (a narcotic medication used to treat moderate to severe pain).

Review of subsequent orders for Resident #1 revealed:
-An order for oxycodone 15mg 4 times daily dated 01/20/23.
-An order for gabapentin 600mg (a medication used to treat nerve pain) 4 times daily dated 01/20/23.

Review of Resident #1's resident register revealed:
-The date of admission was 03/11/22.
-The date of discharge was 02/08/23

Review of Resident #1's medication administration record (MAR) for February 2023 revealed:
-There was an entry for Oxycodone 15mg 4 times daily.
-Oxycodone was documented as being administered on 02/01/23.
-Oxycodone 15mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23
-There was an entry for Gabapentin 600mg 4 times daily.
-The Gabapentin 600mg 4 times daily was documented as administered on 02/01/23.
-Gabapentin 600mg 4 time daily was not documented as administered from 02/02/23 through 02/08/23.

Review of the police report dated 02/13/23 revealed:
-120 quatnitity of oxycodone 15mg were reported as stolen.
-The medication belonged to a resident.
-The gabapentin 600mg (120 quantity) was not included on the police report.

Review of the HCPR reports revealed:
-The 24-hour report was dated 03/03/23.
-The incident occurred on 2/2/23.
-The report was made due to diversion of resident drugs.
-Report indicates there were "missing control medications", but the name and quantitiy of medication was not listed on the report.
-The missing medication belonged to Resident #1.
-The accused individual listed was the SIC.
-The incident was reported to law enforcement on 2/13/23.
-The 5-day working report was dated 03/03/23.
-The report indicated that the administrator called the pharmacy on 02/02/23 to ask when Resident #1's oxycodone would be delivered.
-The administrator was informed by the pharmacy that the oxycodone had been delivered on 1/31/23.
-The only staff with access to the medication lock box located outside the facily, where this medication was delivered, was the SIC and Administrator.

Telephone interview with Resident #1 on 03/16/23 at 9:30am revealed:
-He was no longer a resident of the facility.
-He left the facility in early February to move out on his own.
-He was out of his oxycodone and gabapentin medication for approximately two weeks from 02/02/23 – 02/13/23.
-He was in pain during this time.
-He went through withdrawal symptoms including upset stomach and diarrhea.
-He had back pain, leg pain, and leg swelling.
-He was told by the facility staff that they did not know where his medicine was.
-He was told by the Administrator that she was going to find out what happened to the medicine but she never did.

Interview with the SIC on 02/27/23 at 2:05pm revealed:
-He was hired as a personal care aide (PCA) on 06/20/20.
-He then worked as a medication aide (MA) for a short time but was no longer a MA due to not taking the medication aide exam.
-He was responsible for checking the medication drop box on the outside of the facility where the pharmacy dropped medication after hours.
-He never received oxycodone and gabapentin for Resident #1 in January 2023.

Interview with another facility staff on 02/27/23 at 2:38pm revealed:
-She worked as a PCA/SIC.
-Resident #1 was complaining of pain when he did not get his oxycodone 15mg and gabapentin 600mg from 02/02/23 – 02/08/23.
-Resident #1 was told by the other staff that the facility did not have his medications when the resident asked about them.
-Resident #1 became angry about not getting his medications.
-Resident #1's liason came to the facility on three different occasions after the resident was discharged looking for the medicine.
-Only the Administrator and one other staff had access to the medication lock box.

Interview with the Administrator on 02/27/23 at 1:45pm revealed:
-She was aware that Resident #1's oxycodone 15mg and gabapentin 600mg medications were not available on 02/02/23.
-She called the pharmacy and inquired about the medication on that date.
-The pharmacy told her that the medication was delivered on 01/31/23.

-She asked the SIC and was informed that the medication had never been delivered.
-She did not speak with the doctor about the missing medication because she tried to contact the office but was unable to speak directly to the doctor.
-She called law enforcement to inform them that the medication was missing on 02/13/23.
-A report was filed for the missing medication with law enforcement.
-She did not inform the local department of social services because she was trying to "handle things on her own".
-She questioned the SIC about the missing medication and he denied taking the medication.
-Resident #1 was the only resident in the facility with orders for controlled medications.
-She did not notify HCPR until she was asked to do so by the local department of social services.
-She did not notify HCPR earlier because she did not feel that the SIC took the medications.

Telephone interview with the pharmacist on 04/24/23 at 12:25pm revealed:
-The gabapentin 600mg was delivered to the facility on 01/23/23 at 5:12pm.
-The oxycodone 15mg was delivered to the facility on 01/31/23 at 4:51pm.
-The pharmacist was not aware of theses medications being reported lost or stolen.

Follow-up telephone interview with the pharmacist on 05/23/23 at 10:00am revealed:
-The medication was delivered into the medication drop box and was not signed for by facility staff.
-The facility previously approved for control medications to be delivered without requiring a staff signature.
-The medication quantity for both the Oxycodone 15mg and Gabapentin 600mg was 120.

Telephone interview with Resident #1's pain clinic medical provider on 05/08/23 at 10:31am revealed:
-Resident #1 was prescribed oxycodone 15mg 4 times daily for severe back pain due a history of fractures in his back.
-Resident #1 had a history of back surgery.
-Resident #1 was prescribed gabapentin 600mg 4 times daily for neuropathy of the legs and feet.
-The provider learned that the resident was not receiving his medication from the residents liason on 02/13/23.
-Resident #1 was out of his oxycodone and gabapentin for approximately two weeks.

-The concern was that the resident could go into withdrawls and have had a range of symptoms from nausea to increased heart rate. -The resident could have ended up hospitalized and/or in severe pain due not getting his medication as ordered. -The provider was never made aware by the facility that the resident was not being administered his medication as ordered. -The provider called the facility on 02/13/23 and verified the oxycodone and gabapentin were missing. -On 02/13/23 she wrote new orders for oxycodone and gabapentin. The facility failed to ensure proper reporting of missing narcotic medications timely to local law enforcement, HCPR and the pharmacy. The failure of the facility was detrimental to the health and safety of the residents and constitutes a Type B violation. The facility provided a plan of protection in accordance with 13G .1008(h) on 02/27/23 for this violation. **THE CORRECTION DATE OF THIS VIOLATION SHALL NOT EXCEED JULY 3, 2023**		

Rule/Statute Number: 10A NCAC 13G .1006 (d) Medication Storage	☐ POC Accepted *DSS Initials*	
(d) Accessibility to locked storage areas for medications shall only be by staff responsible for medication administration, the administrator, or the administrator-in-charge.		
Level of Non-Compliance: Type B Violation		
This rule is not met as evidenced by: **Based on observations, interviews, and record reviews the facility failed to ensure that medication storage areas were maintained only by staff that were responsible for medication administration as evidenced by the SIC having the code to open the medication drop box on the outside of the facility where medication deliveries were made.** The findings are: Review of Resident #1's current FL2 dated 06/23/22 revealed: -Diagnoses included: Rheumatoid arthritis, gastroesophageal		

reflux disease (GERD), chronic obstructive pulmonary disease (COPD), anxiety disorder, depression, personal history of transient ischemic attack (TIA) cerebral infarction without residual deficits, dorsalgia, personal history of traumatic fracture, and vitamin D deficiency.
-He was ambulatory.
-He required personal care assistance with bathing and dressing.
-A physician's order for oxycodone 10mg 4 times a day (a narcotic medication used to treat moderate to severe pain).

Review of subsequent orders for Resident #1 revealed:
-An order for oxycodone 15mg 4 times daily dated 01/20/23.
-An order for gabapentin 600mg (a medication used to treat nerve pain) 4 times daily dated 01/20/23.

Review of Resident #1's resident register revealed:
-The date of admission was 03/11/22.
-The date of discharge was 02/08/23

Review of supervisor in charge (SIC) staff record revealed:
-He was hired on 06/20/20 as a personal care aide (PCA)
-He completed a 5-hour medication training on 11/03/22.
-There was no medication aide exam in his record.
-He had not completed the 10-hour medication training.
-He was no longer qualified to be a medication aide.

Interview with the SIC on 02/27/23 at 2:05pm revealed:
-He was hired as a personal care aide (PCA) on 06/20/20.
-He then worked as a medication aide (MA) for a short time but was no longer a MA due to not taking the medication aide exam.
-He was responsible for checking the medication drop box on the outside of the facility where the pharmacy dropped medication after hours.
-He never received oxycodone 15mg and gabapentin 600mg for Resident #1 in January 2023.

Interview with the Administrator on 02/27/23 at 1:45pm revealed:
-The SIC was hired as a PCA on 06/20/20.
-She was not aware that medication aides were the only staff who should have access to medications, other than the administrator.
-The SIC had access to the medication lockbox outside since his employment at the facility on 06/20/20.

Telephone interview with Resident #1 on 03/16/23 at 9:30am revealed:
-He was no longer a resident of the facility.

-He left the facility in early February to move out on his own.

Interview with another facility staff on 02/27/23 at 2:38pm revealed:
-She worked as a PCA/SIC.
-She did not have access to the medication lockbox.
-Only the Administrator and the other SIC had access to the medication lockbox.

Telephone interview with Resident #1's pain clinic provider on 05/08/23 at 10:31am revealed:
-Resident #1 was prescribed oxycodone 15mg 4 times daily for severe back pain due a history of fractures in his back.
-Resident #1 had a history of back surgery.
-Resident #1 was prescribed gabapentin 600mg 4 times daily for neuropathy of the legs and feet.
-The provider learned that the resident was not receiving his medication from the residents liason on 02/13/23.
-Resident #1 was out of his oxycodone and gabapentin for approximately two weeks.
-The concern was that the resident could go into withdrawls and have had a range of symptoms from nausea to increased heart rate.
-The resident could have ended up hospitalized and/or in severe pain due not getting his medication as ordered.
-The provider was never made aware by the facility that the resident was not being administered his medication as ordered.
-The provider called the facility on 02/13/23 and verified the oxycodone and gabapentin were missing.
-On 02/13/23 she wrote new orders for oxycodone and gabapentin.

The facility failed to ensure that only staff responsible for medication administration had access to the medication lockbox outside the facility which resulted in Resident #1's pain medication being reported missing and Resident #1 not being administered his medications from 02/02/23 – 02/07/23. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation.

The facility provided a plan of protection in accordance with 13G .1006 (d) on 05/12/23 for this violation.

THE CORRECTION DATE OF THIS VIOLATION SHALL NOT EXCEED JULY 3, 2023

Rule/Statute Number: 10A NCAC 13G .1007 (a) Medication disposition	☐ POC Accepted *DSS Initials*
(a) Medications shall be released to or with a resident upon discharge if the resident has a physician's order to continue the medication. Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents according to Rule .1004(o) of this Subchapter.	
Level of Non-Compliance: Type B Violation	
This rule is not met as evidenced by: **Based on observations, interviews, and record reviews the facility failed to release 1 of 1 sampled residents (Resident #1) medications (Oxycodone 15mg 4 times daily and Gabapentin 600mg 4 times daily) with him at discharge on 02/08/23 which resulted in Resident #1 not having his medications until 02/13/23 when a new order was written by his pain clinic provider.** The findings are: Review of Resident #1's current FL2 dated 06/23/22 revealed: -Diagnoses included: Rheumatoid arthritis, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), anxiety disorder, depression, personal history of transient ischemic attack (TIA) cerebral infarction without residual deficits, dorsalgia, personal history of traumatic fracture, and vitamin D deficiency. -He was ambulatory. -He required personal care assistance with bathing and dressing. -A physician's order for oxycodone 10mg 4 times daily (a narcotic medication used to treat moderate to severe pain). Review of subsequent orders for Resident #1 revealed: -An order for oxycodone 15mg 4 times daily dated 01/20/23. -An order for gabapentin 600mg 4 times daily (a medication used to treat nerve pain) dated 01/20/23. Review of Resident #1's resident register revealed: -The date of admission was 03/11/22. -The date of discharge was 02/08/23 Review of Resident #1's medication administration record (MAR) for February 2023 revealed: -There was an entry for Oxycodone 15mg 4 times daily. -Oxycodone was documented as being administered on 02/01/23.	

-Oxycodone 15mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23
-There was an entry for Gabapentin 600mg 4 times daily.
-The Gabapentin 600mg 4 times daily was documented as administered on 02/01/23.
-Gabapentin 600 mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23.

Review of Resident #1's list of medications dispensed at discharge revealed:
-The document listed medications that were given to Resident #1 at discharge.
-The oxycodone 15 mg was not listed.
-The gabapentin 600mg was not listed.
-The list was signed by the SIC.
-The document was not dated.

Telephone interview with Resident #1 on 03/16/23 at 9:30am revealed:
-He was no longer a resident of the facility.
-He left the facility in early February to move out on his own.
-He was not discharged with his oxycodone 15mg or gabapentin 600mg.
-He was out of his oxycodone and gabapentin medication for approximately two weeks from 02/02/23 – 02/13/23.

Interview with the SIC on 02/27/23 at 2:05pm revealed:
-Resident #1 was discharged on 02/08/23.
-He was responsible for the disposition of Resident #1's medications at discharge.
-Resident #1's medications were given at discharge with the exception of oxycodone 15mg and gabapentin 600mg.
-The facility did not have the oxycodone 15mg and the gabapentin 600mg.

Interview with the Administrator on 02/27/23 at 1:45pm revealed:
-She was aware that Resident #1's were to be released to him at discharge.
-Resident #1 was not given oxycodone 15mg at discharge on 02/08/23 because the facility did not have this medication.
-Resident #1 was not given gabapending 600mg at discharge on 02/08/23 because the facilty did not have this medication.

Telephone interview with the pharmacist on 04/24/23 at 12:25pm revealed:
-The gabapentin was delivered to the facility on 01/23/23 at 5:12pm.
-The oxycodone was delivered to the facility on 01/31/23 at

4:51pm.
-The pharmacist was not aware of theses medications being reported lost or stolen.

Follow-up telephone interview with the pharmacist on 05/23/23 at 10:00am revealed:
-The medication was delivered into the medication drop box and was not signed for by facility staff.
-The facility previously approved for control medications to be delivered without requiring a staff signature.
-The medication quantity for both the Oxycodone 15mg and Gabapentin 600mg was 120.

Telephone interview with Resident #1's pain clinic provider on 05/08/23 at 10:31am revealed:
-Resident #1 was prescribed oxycodone 15mg 4 times daily for severe back pain due a history of fractures in his back.
-Resident #1 had a history of back surgery.
-Resident #1 was prescribed gabapentin 600mg 4 times daily for neuropathy of the legs and feet.
-The provider learned that the resident was not receiving his medication from the residents liason on 02/13/23.
-Resident #1 was out of his oxycodone and gabapentin for approximately two weeks.
-The concern was that the resident could go into withdrawls and have had a range of symptoms from nausea to increased heart rate.
-The resident could have ended up hospitalized and/or in severe pain due not getting his medication as ordered.
-The provider was never made aware by the facility that the resident was not being administered his medication as ordered.
-The provider called the facility on 02/13/23 and verified the oxycodone and gabapentin were missing.
-On 02/13/23 she wrote new orders for oxycodone and gabapentin.

The facility failed to ensure all Resident #1's medications were released to him when he discharged on 02/08/23. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation.

The facility provided a plan of protection in accordance with 13G .1007 (a) on 05/12/23 for this violation.

THE CORRECTION DATE OF THIS VIOLATION SHALL NOT EXCEED JULY 3, 2023

Rule/Statute Number: 10A NCAC 13G .0902(b) Healtcare referral and follow-up	☐ POC Accepted
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	*DSS Initials*
Level of Non-Compliance: Type B Violation	

This rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to report 1 of 3 sampled residents' (Resident #1) pain medications were missing to his physician, which resulted in a delay in Resident #1 getting his medications causing Resident #1 to experience symptoms of withdrawal.

The findings are:

Review of Resident #1's current FL2 dated 06/23/22 revealed:
-Diagnoses included: Rheumatoid arthritis, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), anxiety disorder, depression, personal history of transient ischemic attack (TIA) cerebral infarction without residual deficits, dorsalgia, personal history of traumatic fracture, and vitamin D deficiency.
-He was ambulatory.
-A physician's order for oxycodone 10mg 4 times a day (a narcotic medication used to treat moderate to severe pain).

Review of subsequent orders for Resident #1 revealed:
-An order for oxycodone 15mg 4 times daily dated 01/20/23.
-An order for gabapentin 600mg (a medication used to treat nerve pain) 4 times daily dated 01/20/23.

Review of Resident #1's resident register revealed:
-The date of admission was 03/11/22.
-The date of discharge was 02/08/23

Review of Resident #1's medication administration record (MAR) for February 2023 revealed:
-There was an entry for Oxycodone 15mg 4 times daily.
-Oxycodone was documented as being administered on 02/01/23.
-Oxycodone 15mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23
-There was an entry for Gabapentin 600mg 4 times daily.
-The Gabapentin 600mg 4 times daily was documented as administered on 02/01/23.
-Gabapentin 600mg 4 times daily was not documented as administered from 02/02/23 through 02/08/23.

Interview with Resident #1 on 03/16/23 at 9:30am revealed:
-He was no longer a resident of the facility.
-He left the facility in early February to move out on his own.
-He was out of his oxycodone and gabapentin medication for approximately two weeks from 02/02/23 – 02/13/23.
-He was in pain during this time.
-He went through withdrawal symptoms including upset stomach and diarrhea.
-He had back pain, leg pain, and leg swelling.
-He was told by the facility staff that they did not know where his medicine was.
-He was told by the Administrator that she was going to find out what happened to the medicine but she never did.
-He was not aware if facilty staff called his physician or not.

Interview with the SIC on 02/27/23 at 2:05pm revealed:
-He was hired as a personal care aide (PCA) on 06/20/20.
-He then worked as a medication aide (MA) for a short time but was no longer a MA due to not taking the medication aide exam.
-He was responsible for checking the medication drop box on the outside of the facility where the pharmacy dropped medication after hours.
-He never received oxycodone and gabapentin for Resident #1 in January.
-The administrator was responsible for reporting information to the physician.

Interview with the Administrator on 02/27/23 at 1:45pm revealed:
-She was aware that Resident #1's oxycodone 15mg and gabapentin 600mg medications were not available on 02/02/23.
-She called the pharmacy and inquired about the medication on that date.
-The pharmacy told her that the medication was delivered on 01/31/23.
-She asked the SIC and was informed that the medication had never been delivered.
-She made undocumented telephone attempts to reach the provider but was unsuccessful.
-She called law enforcement to inform them that the medication was missing on 02/13/23.
-A report was filed for the missing medication with law enforcement.
-Resident #1 was the only resident in the facility with orders for controlled medications.

Telephone interview with the pharmacist on 04/24/23 at 12:25pm revealed:

-The gabapentin was delivered to the facility on 01/23/23 at 5:12pm.
-The oxycodone was delivered to the facility on 01/31/23 at 4:51pm.
-The pharmacist was not aware of theses medications being reported lost or stolen.

Telephone interview with Resident #1's pain clinic provider on 05/08/23 at 10:31am revealed:
-Resident #1 was prescribed oxycodone 15mg 4 times daily for severe back pain due a history of fractures in his back.
-Resident #1 had a history of back surgery.
-Resident #1 was prescribed gabapentin 600mg 4 times daily for neuropathy of the legs and feet.
-The provider learned that the resident was not receiving his medication from the residents liason on 02/13/23.
-Resident #1 was out of his oxycodone and gabapentin for approximately two weeks.
-The concern was that the resident could go into withdrawls and have had a range of symptoms from nausea to increased heart rate.
-The resident could have ended up hospitalized and/or in severe pain due not getting his medication as ordered.
-The provider was never made aware by the facility that the resident was not being administered his medication as ordered.
-The provider called the facility on 02/13/23 and verified the oxycodone and gabapentin were missing.
-On 02/13/23 she wrote new orders for oxycodone and gabapentin.

The facility failed to ensure that 1 of 3 sampled residents (Resident #1) healthcare referral and follow-up needs were met due to the resident being out of his pain medications (oxycodone 15mg and gabapentin 600mg) from 02/02/23 through 02/08/23 and the provider was not notified. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation.

The facility provided a plan of protection in accordance with 13G .0902 (b) on 05/12/23 for this violation.

THE CORRECTION DATE OF THIS VIOLATION SHALL NOT EXCEED JULY 3, 2023

IV. Delivered		Date:

Via:	Hand Delivered	6-5-23
DSS Signature:	Stacey Holden	Return to DSS By: 6-27-23

V. CAR Received by:	Administrator/Designee (print name):	
Yvonnie Oxendine	Signature: Yvonnie Oxendine	Date: 6-5-23
	Title: SIC	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted*	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:
Comments:			

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*