Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Landings of Oak Island
Address: 2910 Pine Plantation Parkway, Oak Island, NC
County: Brunswick
License Number: HAL-010-013

II. Date(s) of Visit(s): 4/25/23 and 4/28/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 05/17/23

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 an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 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 13F .1004 Rule/Statutory Reference: 10A NCAC 13F .1004 Medication Administration (a) An adult 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 A1 Violation Findings: This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the administration of medication in accordance with the physician's orders and the facility's policies and procedures for 1 of 5 sampled residents (#2), who was admitted to the facility after hospitalization and did not receive medications prescribed to treat pneumonia, congestive heart failure, atrial fibrillation, and blood clots. Review of the facility's medication administration policies dated November 2018 revealed medications were to be	☐ POC Accepted _____ *DSS Initials*	

administered in accordance with written orders of the prescriber.

Review of Resident #2's current FL-2 dated 11/03/22 revealed:
-Diagnoses included essential hypertension, chronic stage 3 kidney disease, monoclonal gammopathy, and benign prostatic hyperplasia.
-Resident #2's recommended level of care was assisted living.
-Resident #2 communicated verbally, was ambulatory, had recommended blood pressure checks monthly, and had normal respirations.

Review of Resident #2's hospital discharge summary dated 3/27/23 revealed:
-On 03/21/23 Resident #2 was seen at his Primary Care Provider's (PCP) office for coughing and wheezing and was sent to the hospital for "new-onset atrial fibrillation" and the resident was admitted.
-Hospital admission diagnoses included atrial fibrillation, congestive heart failure and pneumonia.
-Resident #2 remained hospitalized for 5 days and was discharged back to the facility on 03/27/23 with 5 new medication orders.
-There was an order for Eliquis (used as a blood thinner to prevent blood clots) 5mg one tablet by mouth to be given two times daily.
-There was an order for Lasix (used to reduce fluid to treat congestive heart failure) 20mg one tablet by mouth to be given one time daily.
-There was an order for Metoprolol Succinate (used to regulate blood pressure to treat atrial fibrillation) 50mg one tablet by mouth to be given one time daily.
-There was an order for Doxycycline Monohydrate (used to treat infections) 100mg one capsule by mouth to be given every 12 hours for 5 days.
-There was an order for Magnesium Oxide (used to treat irregular heartbeat) 400mg one tablet by mouth to be given one time daily.
-Resident #2 was scheduled to have a hospital follow-up appointment with his PCP on 04/11/23.

Review of Resident #2's hospital visit progress notes with a faxed time stamp of receipt by the facility on 03/24/23 at 1:54pm revealed:
-On 03/21/23 Resident #2 was admitted to the hospital with diagnoses of atrial fibrillation, congestive heart failure, and

pneumonia.
-Resident #2's new medication orders included Eliquis, Lasix, Metoprolol Succinate, Doxycycline Monohydrate, and Magnesium Oxide.

Review of Resident #2's electronic progress notes for March and April 2023 revealed:
-On 03/21/23 there was an entry stating the facility's Resident Care Manager (RCM) received telephone notification from Resident #2's PCP office informing her Resident #2 was being sent from his PCP appointment to the hospital due to him having atrial fibrillation.
-On 03/24/23 there was an entry the RCM spoke with Resident #2's responsible party and learned the resident had fluid buildup around his heart.
-On 03/29/23 there was note documented as a late entry indicating Resident #2 returned to the facility on 03/27/23 and it was documented as an "ER visit only"; the question that stated follow-up appointments was documented as "N/A"; the question that stated medication was clarified and faxed to the pharmacy was documented as "N/A".
-On 04/13/23 there was an entry that Resident #2 returned from the hospital with "no changes" and there were no other details given.

Review of Resident #2's PCP visit note dated 04/11/23 revealed:
-Resident #2 visited his PCP office for a hospital follow-up from his last hospital stay on 03/21/23 to 03/27/23.
-Resident #2 arrived at the visit positive for weakness and fatigue, with chest tightness and shortness of breath, a pulse rate of 146 (normal range 60-100), and a new onset of atrial fibrillation with a rapid heart rate.
-The facility sent a list of Resident #2's current medications with the resident to the appointment and the new medications prescribed for the resident to take when he returned to the facility on 03/27/23, were not on the list.
-The PCP called the facility and the staff confirmed the resident had not been getting the new medications prescribed in March.
-Resident #2 had "a frail baseline and needed "urgent evaluation and intervention at the emergency department" and emergency services were called and transported Resident #2 to the hospital.

Review of Resident #2's hospital discharge summary dated 04/13/23 revealed:

-On 04/11/23 Resident #2 was sent to the hospital by his PCP due to atrial fibrillation with a rapid heartbeat of 140.
-Resident #2's hospital admitting diagnoses included a new acute pulmonary embolism, atrial fibrillation, decompensated congestive heart failure, bilateral pneumonia, and hypertension.
-Upon review, it was determined that Resident #2 did not receive his prescribed Lasix, Metoprolol, or Eliquis when he was discharged from the hospital to the facility on 03/27/23.
-The resident had a B-Type natriuretic peptide (BNP) test (a BNP over 900 for someone over the age of 75 is a sign of heart failure) which was highly elevated at 11,291 and the resident's symptoms "were severe."
-Resident #2 was given Lasix, Metoprolol, and Eliquis while in the hospital, and his symptoms "returned to baseline."
-Resident #2 was discharged back to the facility on 04/13/23.

Review of Resident #2's electronic Medication Administration Record (eMAR) from 03/27/23 through 04/11/23 revealed:
-There was no entry for Eliquis and no documentation of the medication being administered between 03/27/23 and 04/11/23.
-There was no entry for Lasix and no documentation of the medication being administered between 03/27/23 and 04/11/23.
-There was no entry for Metoprolol Succinate and no documentation of the medication being administered between 03/27/23 and 04/11/23.
-There was no entry for Doxycycline Monohydrate and no documentation of the medication being administered between 03/27/23 and 04/11/23.
-There was no entry for Magnesium Oxide Monohydrate and no documentation of the medication being administered between 03/27/23 and 04/11/23.

Telephone interview with the newly assigned Executive Director (ED) on 05/01/23 at 3:13pm revealed:
-After Resident #2 was hospitalized in April, she was made aware he had not been getting his medications as prescribed.
-The facility staff learned the resident had not been receiving his new medications when the PCP called to ask if the medications were begin administered.
-The former Resident Care Manager (RCM) did not "check off the orders" when Resident #2 returned from the hospital to the facility on 03/27/23.
-This meant the RCM did not review Resident #2's

hospital record to confirm if there were any new orders and for this reason, the resident's new medications were not added to his MAR for administration or ordered from the pharmacy.

Telephone interview with the former RCM on 05/09/23 at 2:06pm revealed:
-During March and April 2023, when she was working at the facility as the RCM.
-When Resident #2 returned from the hospital in March 2023, she was the staff responsible for checking for new orders, ensuring new medications were added to the MAR, and ordering the new medications from the pharmacy.
-"Ideally", she would have reviewed Resident #2's hospital discharge summary when the resident returned from the hospital to confirm any new orders.
-If she had reviewed Resident #2's discharge summary and would have seen the new orders, the next steps would have been for her to order the medications from the pharmacy and ensure the medications were added to the MAR.
-She did not know why she did not review Resident #2's discharge summary when he returned from the hospital.
-No matter what the reason, it would have been her responsibility to ensure receipt and review of Resident #2's discharge summary.
-She did not know Resident #2 was not receiving his medications as prescribed until 04/11/23 when Resident #2 went to the PCP office for his hospital follow-up appointment and the PCP called the facility to inquire about the medications.

Telephone interview with Resident #'2's Power of Attorney (POA) on 05/09/23 at 1:21pm reviewed:
-Resident #2 was prescribed new medications during his hospital stay in March 2023 and he was not sure what happened, but the resident was never given the medications when he returned to the facility.
-"Apparently, there was some type of a communication breakdown at the facility."
-The facility staff indicated to him that they were not given the orders for the new medications.
-He had a limited understanding of what happened, but from what he knew, Resident #2 not receiving his medications was what precipitated the need for him to have to be readmitted to the hospital.

Telephone interview with Resident #2's PCP on 05/03/23 at 2:27pm revealed:
-On 03/21/23 he saw Resident #2 at his office and sent him by ambulance to the hospital due to the resident being in need of emergency care for coughing, wheezing, and atrial fibrillation.
-Resident #2 was treated at the hospital for congestive heart failure, atrial fibrillation, and pneumonia.
-He prescribed Resident #2 new medications which he started at the hospital and was to continue upon returning to the facility.
-The resident was prescribed Lasix, "to treat his congestive heart failure", Metoprolol, "to control his heart rate due to his atrial fibrillation, and Eliquis "a blood thinner to prevent him from having blood clots or a stroke".
-On 04/11/23 when the resident came to the office for his hospital follow-up appointment, he reported tightness in his chest and shortness of breath.
-The reason he was "tipped off" that the resident may not be receiving his new medications was when he reviewed the medication list the facility sent with the resident to his appointment, he did not see Lasix, Metoprolol, or Eliquis on the list.
-He immediately called the facility and spoke with a staff person, he did not know who, that confirmed the resident had not been receiving his new medications.
-The staff person did not know why the resident had not been receiving the medications.
-He did not realize it at the time, but the resident also did not get two of his other newly prescribed medications which were doxycycline to treat his pneumonia and magnesium oxide to treat his atrial fibrillation.
-His office called an ambulance and had the resident transported to the hospital.
-The fact that the resident did not receive his medications "One hundred percent contributed to the resident ending up having to be sent back to the hospital" and when he got to the hospital, he was diagnosed with a pulmonary embolism which was "a direct result of him not getting his blood thinner."
-The potential negative outcomes of Resident #2 not getting his medications as prescribed "without a doubt could have been death."

The facility failed to ensure Resident #2 received an antibiotic to treat pneumonia, two medications to treat irregular heartbeat, a medication to treat congestive heart failure, and a medication to prevent blood clots. After fifteen days without

the prescribed medications, the resident required emergency hospitalization to treat pneumonia, a pulmonary embolism, atrial fibrillation, and decompensated heart failure. The facility's failure to administer medications prescribed to treat Resident #2's health conditions resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. The Plan of Protection (POP) in accordance with G.S. 131D-34 was received on 05/02/23. THE CORRECTIVE DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED **06/16/23**		

IV. Delivered Via:	Hand Delivered	Date: 05/17/23
DSS Signature:	Jammie Robinson	Return to DSS By: **06/07/23**

V. CAR Received by:	Administrator/Designee (print name): LISA ASH	
	Signature: Lisa Ash	Date: 5/17/23
	Title: Executive Director	

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:		

Facility Name:

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