STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074043	A. BUILDING: _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAK ASSISTED LIVING	716 WALL STREET GRIFTON, NC 28530

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/15/21 - 09/16/21.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#2, #3) including errors with a diuretic to treat excess fluid build up in the body (#2) and an antibiotic used to prevent infection (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 06/21/21 revealed diagnoses included lymphedema (swelling in an extremity caused by lymphatic system blockage), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breath), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), polyneuropathy (a condition that affects peripheral nerves causing weakness, numbness, and burning pain), chronic pain, and venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin	D 358		

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D 358	Continued From page 1 changes). Review of an emergency department (ED) visit discharge summary for Resident #2 dated 07/17/21 revealed: -He was seen for lower extremity edema (swelling). -He was diagnosed with pulmonary hypertension, leg swelling, and blisters. -There was an order to begin Lasix (a medication used to treat edema and swelling caused by congestive heart failure, liver disease, kidney disease and other medical conditions) 40mg once daily. Review of a primary care provider (PCP) visit note for Resident #2 dated 08/31/21 revealed: -The resident was seen that day for lymphedema, type 2 diabetes, peripheral vascular disease, and chest pain. -He had a past medical history that included type 2 diabetes with diabetic chronic kidney disease, hypertensive heart with heart failure, congestive heart failure, peripheral vascular disease, venous insufficiency, and COPD. -The resident reported chest pain and swelling, sores, and skin color changes in his bilateral lower extremities. -He was assessed to have pitting edema up the thighs in both lower extremities with wounds that were draining. -He was diagnosed with heart failure and there was a plan to increase his Lasix for a few days due to increased edema. Review of a physician's order for Resident #2 dated 08/31/21 revealed an order to increase Lasix 40mg to 1 tablet twice daily for three days, then decrease back to once daily.	D 358		

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Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed there was no documentation the Lasix 40mg had been increased to twice daily for three days.

Review of Resident #2's September 2021 eMAR revealed there was no documentation the Lasix 40mg had been increased to twice daily for three days.

Observation of Resident #2 on 09/15/21 at 9:54am revealed:
-The resident sat in a wheelchair in his room.
-He appeared to have relaxed breathing with intermittent bouts of being mildly short of breath.
-His legs were wrapped in una boots (gauze underneath coband) bilaterally from the middle of his feet to just under his knees.
-There appeared to be minimal swelling and normal color skin around the bandages.

Interview with Resident #2 on 09/15/21 at 9:54am revealed:
-He had "bad legs" with blisters on his left leg.
-The home health nurse "was working on his legs".
-He had been in the emergency room approximately 3 months ago for treatment.

A second observation of Resident #2 on 09/16/21 at 3:50pm revealed:
-He was in his wheelchair with his legs wrapped in una boots in a common room.
-He was short of breath when speaking, taking frequent and heavy breaths in between words.
-His skin appeared more swollen than on 09/15/21 around the leg wraps slightly spilling over the top edge of the wrap just under the knees and on his feet.

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D 358	Continued From page 3 -The visible skin around the leg wraps was slightly reddened. Interview with Resident #2 on 09/16/21 at 3:50pm revealed: -He was short of breath and it bothered him all the time except when lying in bed. -The staff administered an inhaler when he needed it for shortness of breath. -His legs were more swollen and red today than yesterday (09/15/21); he didn't know why. -He took fluid pills and did not add salt to his food to address the swelling. -He did not know if he received an increased dose of Lasix 40mg for three days as his PCP ordered on 08/31/21. Interview with a medication aide (MA) on 09/16/21 revealed: -When the PCP wrote an order for a medication dosage change for a resident, the order was communicated to the Resident Care Coordinator (RCC). -The RCC then communicated the order to the pharmacy. -The pharmacy entered the new order on the resident's eMAR. -Once the eMAR order was approved by the RCC, the MAs administered the medication as ordered. Interview with the RCC-in-training on 09/16/21 at 11:49am revealed she had only been in the RCC position for one week and was not aware of a change in Resident #2's Lasix order on 08/31/21. Interview with the Administrator on 09/16/21 at 11:50am revealed: -The facility did not have an RCC from late June 2021 until last week (early September 2021).	D 358		

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-He acted as the RCC during this time period.
-He was responsible to ensure Resident #2's Lasix order had been faxed to the pharmacy, entered into the eMAR, and approved for administration.
-He missed seeing the order, did not fax it, and it was a "total oversight" that Resident #2 did not receive the Lasix 40mg twice daily for three days as ordered beginning on 08/31/21.
-The Lasix had been ordered by the PCP because Resident #2's legs were swollen.

Telephone interview with a pharmacist at the facility's contracted pharmacy provider on 09/16/21 at 4:31pm revealed:
-The pharmacy had not received an order for Resident #2 on 08/31/21 to increase his Lasix 40mg to twice daily for three days.
-Lasix was used to treat edema and excess fluid in the body.
-Not receiving Lasix could exacerbate congestive heart failure, shortness of breath, and edema.
-She expected the facility to fax orders to the pharmacy so they could fill prescriptions as ordered by Resident #2's PCP for accurate administration and treatment.

Telephone interview with Resident #2's PCP on 09/16/21 at 2:40pm revealed:
-She saw Resident #2 on 08/31/21 for chest pain, increased shortness of breath, and a history of heart failure.
-She was concerned Resident #2 could be in fluid overload with congestive heart failure on that day (08/31/21).
-She was unaware Resident #2 had not received the increased dose of Lasix 40mg twice daily for three days beginning on 08/31/21.
-She was still concerned Resident #2 could be in fluid overload today (09/16/21) and still wanted

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the resident to receive the increased dose of Lasix 40mg for three days as previously ordered.
-Not receiving the increased Lasix dose to remove excess fluid from Resident #2's body could result in atypical heart changes, chest pain, and increased shortness of breath.
-She expected the facility to administer medications as ordered.

2. Review of Resident #3's current FL-2 dated 04/27/21 revealed diagnoses included hemiplegia affected side unspecified, convulsions, essential hypertension, cerebrovascular disease, and depression disorder.

Review of Resident #3's dental visit note dated 08/20/21 revealed:
-The resident was seen for extractions (removal) of 3 teeth and a full mouth debridement (thorough removal of plaque and tartar from the teeth and gums).
-The resident was given a prescription for Amoxicillin (an antibiotic to treat and prevent infection.)

Review of Resident #3's prescription dated 08/20/21 revealed:
-There was an order for Amoxicillin 500mg 1 capsule every 8 hours until finished.
-The prescription quantity to dispense was 21 capsules (a 7-day supply).

Review of Resident #3's fax verification report for the Amoxicillin order dated 08/20/21 revealed the Amoxicillin order was faxed to the facility's contracted pharmacy on 08/20/21 at 6:01pm.

Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed:

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-There was an entry for Amoxicillin 500mg take 1 capsule every 8 hours until finished with scheduled administration times of 12:00am, 8:00am, and 4:00pm.
-The start date for the Amoxicillin was printed as 08/23/21.
-There was no Amoxicillin documented as administered from 08/20/21 - 08/22/21.
-The first dose of Amoxicillin was documented as administered at 4:00pm on 08/23/21, 3 days after the antibiotic was ordered.
-There was no documentation indicating why there was a delay in starting the antibiotic.
-There were 21 doses of Amoxicillin documented as administered from 08/23/21 - 08/30/21.

Interview with a medication aide (MA) on 09/16/21 at 2:18pm revealed:
-Something happened with the order for Resident #3's Amoxicillin that caused a delay in starting the medication but she could not recall the issue.
-If a medication was needed after 5:00pm, there was a local back up pharmacy the facility could use to get medications.
-The Administrator was responsible for handling new medication orders.

Interview with the Administrator on 09/16/21 at 3:30pm revealed:
-He was responsible for processing medications orders since the Resident Care Coordinator (RCC) position had been vacant since July 2021.
-Resident #3 did not return from his dental appointment on Friday, 08/20/21, until after 6:00pm.
-He faxed the order for the Amoxicillin to the pharmacy on Friday, 08/20/21, when the resident returned to the facility.
-He "assumed" the Amoxicillin would come in the pharmacy tote that night, 08/20/21.

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-He did not work on weekends and did not know the Amoxicillin was not in the facility until he returned to work on Monday, 08/23/21.
-He called the pharmacy on Monday morning (08/23/21) and had the order called into the back-up pharmacy.
-He picked up the Amoxicillin from the back-up pharmacy on 08/23/21 and they started administration of the antibiotic that afternoon on 08/23/21.
-The Amoxicillin should have been started immediately since it was an antibiotic.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/16/21 at 4:30pm revealed:
-The pharmacy received Resident #3's order dated 08/20/21 for Amoxicillin on 08/20/21 at 6:30pm.
-The deadline for the pharmacy to send medications the same day was 5:00pm.
-Pharmacy staff was at the pharmacy on 08/20/21 until 7:00pm.
-The facility was not contracted to receive deliveries on weekends (Saturdays and Sundays) from the pharmacy.
-The facility could have contacted the pharmacy and asked them to call in the antibiotic to the facility's back-up pharmacy that day (08/20/21).
-The pharmacy also had a 24 hour on-call service and the facility could have called anytime, nights or weekends, and requested the order be called into the back-up pharmacy.
-The facility's Administrator called the pharmacy on Monday, 08/23/21, and asked the pharmacy to call in the antibiotic order to the facility's back-up pharmacy.
-The facility did not call the pharmacy to obtain the Amoxicillin for Resident #3 prior to 08/23/21.
-The pharmacy called in the order for Resident

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D 358	Continued From page 8 #3's Amoxicillin to the back-up pharmacy on 08/23/21. -The back-up pharmacy dispensed 21 capsules of Amoxicillin 500mg on 08/23/21. -Antibiotics were used to help prevent infections for dental procedures and a delay in starting an antibiotic could increase the chances of an infection occurring. Interview with Resident #3 on 09/16/21 at 4:09pm revealed: -He had some teeth pulled in August 2021 and had problems with bleeding in his mouth for 3 to 4 days. -He did not get antibiotics after the procedure for "at least a couple of days". -He did not know why there was a delay in starting the antibiotic. -He did not get an infection from having the teeth pulled and his mouth had healed since the procedure. Telephone interview with Resident #3's dentist on 09/16/21 at 4:19pm. -He was not aware of a delay in Resident #3 starting the Amoxicillin in August 2021. -A delay in starting the antibiotic could have caused the resident to have infection or increased swelling at the sites of the extractions.	D 358		