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D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted a follow-up survey and complaint investigation on December 20, 2022 to December 21, 2022. The complaint investigation was initiated by the Martin County Department of Social Services on October 26, 2022.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider (PCP) was notified for 2 of 5 sampled residents (#2, #3,) in which a resident exhibited unsafe behaviors and was smoking in her resident room (#2) and a resident did not receive medication for 18 of 24 days he was out of the facility on leave (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 03/23/22 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension and memory impairment. -She was ambulatory and intermittently disoriented. Review of Resident #2's Resident Register revealed she was admitted on 11/29/21.	D 273		

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D 273	Continued From page 1 a. Review of the facility's Tobacco Policy dated September 2021 revealed: -Each resident was assessed for ability to smoke safely by means of an interview with the resident and responsible party, and through staff observation. -Assessments were repeated at least on admission, readmission from hospital visit and quarterly or as needed to assure safe practices. -Staff were in-serviced to provide ongoing assessment of resident smoking habits and to report to their supervisor any change in ability to smoke safely. -Residents assessed to need supervision were to be placed on a smoking schedule, smoking materials would be secured, and smoking would be supervised by staff. -The facility followed all North Carolina laws and regulations regarding the prohibition of smoking inside long-term care facilities. -If a resident did not follow the smoking policy, the resident would be counseled, and the smoking policy reviewed with the resident. -If the resident did not follow the smoking policy after counseling, the facility reserved the right to discharge the resident due to a smoking safety violation and risk. Review of Resident #2's Resident Agreement, Section VI. Miscellaneous, subsection J. Smoking and Alcohol Policy on page 18 of 24 revealed smoking may occur only in designated areas and in accordance with State law and was signed by Resident #2 and the Administrator on 11/23/22. Review of the facility's Resident Handbook & House Rules effective 08/01/13 and signed by Resident #2 on 11/23/22 revealed: -All facility buildings were non-smoking buildings.	D 273		

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-A resident may only smoke outside the building and in designated smoking areas.
-The facility reserved the right to confiscate smoking materials and tobacco products in the interest of fire safety and sanitation.
-The resident's use of smoking materials in an unauthorized area, such as the resident's room, is cause for immediate discharge.

Review of Resident #2's progress note dated 12/14/22 revealed:
-There was documentation that Resident #2's bedroom was observed to be smokey and a towel was at the bottom of the door during the 8:00pm medication pass.
-There was documentation Resident #2's primary care provider (PCP) was not notified.

Observation of Resident #2's bedroom on 12/21/22 at 11:15am revealed:
-Resident #2 was in bed and appeared to be asleep.
-The bedroom smelled strongly of old cigarette smoke.
-There was a towel rolled up on the floor by the door.

Interview with Resident #2 on 12/21/22 at 8:41am revealed:
-She bought a cigarette from another resident and smoked in her room that morning.
-She could not buy her own cigarettes because office staff would not give her money to her.
-She had a bad hip, bad knees and had trouble walking and hurt too badly to go outside.
-She smoked in her bedroom sometimes.

Second interview with Resident #2 on 12/21/22 at 5:02pm revealed:
-She smoked in her room for the last 2 months.

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-She smoked in the bathroom when she had a room mate.
-The business office manager had spoken with her about smoking about 1 month prior.

Interview with a personal care aide (PCA) on 11/17/22 at 11:43am revealed:
-Resident #2 smoked in her room on third shift and she reported it to the medication aide (MA).
-Resident #2 sprayed hair spray but she could still smell it.
-When she addressed the resident about smoking in her room, the resident denied doing so.

Interview with a second PCA on 12/21/22 at 2:21pm revealed:
-She thought Resident #2 smoked in her bedroom approximately twice weekly.
-The Resident Care Coordinator (RCC) and the Administrator had taken Resident #2's cigarettes and lighter from her and talked with Resident #2 immediately each time it was reported.
-Resident #2 was roommates with a resident that was on oxygen as long as she had worked at the facility.

Interview with a MA on 11/17/22 at 10:21am revealed:
-Other residents could smell the cigarette smoke in other rooms of the facility.
-Resident #2 had people bring cigarettes to her and leave them on the grounds and she would go out to retrieve them.

Interview with a second MA on 12/21/22 at 2:39pm revealed:
-She thought Resident #2 began smoking in her bedroom about 6 months prior and it was an ongoing issue.

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-She had never seen Resident #2 smoking in her room, but she smelled smoke in her bedroom every day.
-She had not reported to anyone that Resident #2 was smoking in her room for the last couple of months because it had been reported by other staff.
-The RCC talked with Resident #2 about smoking being prohibited inside the building but Resident #2 just would not listen.
-She thought Resident #2's PCP was aware of smoking in her bedroom, but she had not made the notification because other staff and the RCC had already told her.
-Resident #2 had roommates that were on oxygen and they had complained about her smoking inside the bedroom.

Interview with the RCC on 12/21/22 at 3:15pm revealed:
-She had never seen Resident #2 smoking in her bedroom, but she could smell the smoke when she went into the bedroom.
-Resident #2 had a private room and had never shared a room with a resident on oxygen.
-The resident next to Resident #2's room was on oxygen.
-She, the Administrator, MAs and the Ombudsman had talked with her about smoking not being allowed inside the facility.
-Fire and Emergency Management Services had walked by Resident #2's bedroom, smelled cigarette smoke and talked with Resident #2.
-There was no documentation of any of the discussions with Resident #2 regarding smoking.
-The PCP was made aware when she came to the facility to see residents but only in passing conversation and there was no documentation of formal notification.
-The PCP had not given any response or orders

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when she was told.
-It was important Resident #2's PCP was notified because smoking in the facility was dangerous and smoking with oxygen tanks nearby could cause the building to blow up.
-She should have documented all notifications to the PCP.

Interview with the Administrator on 12/21/22 at 4:11pm revealed:
-She did not remember when Resident #2 began smoking in her bedroom and would buy cigarettes from other residents or have someone drop them off without the staff knowing.
-She began hearing from staff that Resident #2's bedroom smelled of cigarette smoke in late October 2022 or early November 2022.
-She or the RCC would go down to Resident #2's bedroom each time it was reported but Resident #2 always denied smoking inside the facility.
-She had discussed the dangers of smoking inside, especially with oxygen tanks in the building, with Resident #2 3-4 times.
-Resident #2's PCP came to the facility weekly and was told of Resident #2 smoking in her bedroom but there was no formal notification and documentation of the notification.
-It was important Resident #2's PCP was notified due to safety concerns.
-She and the RCC were responsible for notifying the PCP and notifications should be documented but she was unsure what template to use in their corporate system and there was no ability to input a free hand progress note.

Interview with Resident #2's PCP on 12/21/22 at 12:02pm revealed:
-She had not been notified that Resident #2 had been smoking in her bedroom.
-She expected Resident #2 to smoke outside the

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facility.
-Smoking inside the facility presented a fire hazard especially with oxygen tanks nearby and she would have expected to be notified so a plan could be discussed with facility staff on how to address the problem.

b.Review of Resident #2's behavior notification dated 10/03/22 revealed:
-There was documentation Resident #2 attacked staff from behind while she was attending to another resident.
-There was documentation Resident #2's primary care provider (PCP) was not notified.

Interview with Resident #2's PCP on 12/21/22 at 12:02pm revealed:
-She was not notified of any aggressive behaviors for Resident #2.
-She expected to be notified of aggressive behaviors unless Resident #2 was followed by psychiatric services, in which case the psychiatric provider should be notified.
-If she had been notified, she could have reviewed Resident #2's medications and possibly made changes or consulted with psychiatry to see if a new referral was needed.

Telephone interview with the facility's contracted psychiatric provider on 12/21/22 at 10:42am revealed:
-There was a consult for Resident #2 for psychiatric services due to depression and dementia in September 2022.
-She was evaluated and discharged following the evaluation because she denied symptoms of depression and refused services and, while she does have dementia, she was able to make her own decisions at that time.
-Resident #2 denied any psychiatric diagnosis,

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became irritable during the evaluation and was difficult to gain further information.
-Resident #2 had manipulative behaviors especially where cigarette smoking was concerned.

Interview with a personal care aide (PCA) on 12/21/22 at 2:21pm revealed:
-Resident #2 cursed at staff every day when they went into her room.
-Resident #2 sometimes hollered at other residents but had not been physically aggressive towards them.
-She often threatened to slap staff and had attacked and scratched a staff member about 1 month prior.
-She had never known Resident #2 to become physically aggressive with anyone else.
-She had not reported Resident #2's aggressive behaviors to anyone because other staff had already reported it.

Interview with the medication aide (MA) on 12/21/22 at 2:38 pm revealed:
-Resident #2 would get mad with staff that went into her bedroom; usually name calling.
-She had outbursts 3-4 times each week, usually related to smoking.
-She had never seen her become physically aggressive.
-She had not reported verbal or physical aggression by Resident #2 to the Administrator or the Resident Care Coordinator (RCC) because staff had already told them.
-She did not know if Resident #2's PCP was aware of the aggressive behaviors.

Interview with the RCC on 12/21/22 at 3:15pm revealed:
-Resident #2 was verbally aggressive with staff

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about once every 10 days, usually with the business office manager (BOM).
-Resident #2 had been physically aggressive with staff in October 2022 but the incident was the first and only physical aggression she was aware of.
-Resident #2 would sometimes become verbally abusive with another resident that she considered her boyfriend.
-She had reported the incident to Resident #2's PCP but there was no documentation of the notification.
-She should have documented all notifications to the PCP.

Interview with the Administrator on 12/21/22 at 4:11pm revealed:
-Resident #2's verbal and physical aggression began in the last few months after she learned of a widow's benefit she had received.
-Resident #2 had a psychiatric evaluation about the time the aggression started but it had only been verbal aggression at that time.
-Resident #2 was sporadically verbally aggressive, and it seemed to be directed at the BOM because she thought the BOM had her money in the facility and was keeping it from her;
-Resident #2 cursed at staff and assaulted a MA.
-The PCP, and psychiatry provider, if the Resident was receiving psychiatric services at that time, should have been notified of aggressive behaviors when they occurred.
-She and the RCC were responsible for notifying the PCP and notifications should be documented on the behavioral notification form for aggression.
-She thought Resident #2's PCP was aware of the aggression.

2. Review of Resident #3's current FL-2 dated 08/03/22 revealed:
-Diagnoses included hypothyroidism, malignant

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neoplasm of prostate, diabetes mellitus II, anemia, malignant neoplasm of uvula, and vitamin D deficiency
-The resident was oriented and ambulatory.

Review of Resident #3's Resident Register dated 08/31/05 revealed:
-The resident was admitted to the facility on 08/31/05.
-The resident was his own responsible person.

Review of Resident #3's current care plan dated 09/02/22 revealed the resident required no assistance with bathing, dressing, eating, toileting, ambulation, grooming, and transferring.

Review of Resident #3's current physician orders dated 08/31/22 revealed:
-There was an order for Amlodipine 10mg daily. (Used to lower high blood pressure.)
-There was an order for Tradjenta 5mg daily. (Used to regulate high blood sugar.)
-There was an order for Bicalutamide 50mg daily. (Used to treat prostate cancer.)
-There was an order for Combigan 0.2-0.5% 1 drop in the left eye twice daily. (Used to lower high pressure in the eye.)
-There was an order for Bupropion XR 150mg every morning. (Used to treat mood disorders.)
-There was an order to Vitamin D3 25mcg (1000 unit) daily. (Used to treat low Vitamin D levels.)
-There was an order for Ferrous Sulfate 325mg daily. (Used to treat anemia.)
-There was an order for Levothyroxine 137mcg every morning. (Used to treat low functioning thyroid.)
-There was an order for Losartan-Hydrochlorothiazide 100-25mg daily. (Used to treat and lower high blood pressure.)

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Review of Resident #3's physician order dated 09/08/22 revealed an order for Mighty Shakes (a nutritional supplement) twice daily.

Review of Resident #3's Resident Contract dated 8/31/05 revealed:
-Residents were to have written authorization from a physician and be deemed capable of following self-administration guidelines established in the Pharmaceutical Policy and Procedures Manual before being allowed to keep (prescription & over the counter) medications in their possession (when out of the facility).
-To help ensure resident safety, residents who leave the premises were required to have a responsible party sign a release form which relieves the Facility of responsibility during the time the resident is away from the facility indicating the date & time of departure, name & telephone number of the responsible person, and the expected time of return.

Review of the facility's Sign In/Sign Out policy dated September 2021 revealed:
-Residents were asked to sign in and out when leaving the community.
-Residents leaving for extended periods should notify facility staff so that necessary medications could be prepared prior to the resident's departure.
-A sign-out register would be maintained indicating the resident's departure time, expected date and time of return, and the name and telephone number of the responsible party.

Review of the facility's Medication Leaving/Returning policy dated September 2021 revealed:
-When a resident left the facility and needed his/her medications before returning, the following

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procedures would be followed:
-When more than one dosage was required for temporary leave of a resident, the medication would be packaged and released in their entirety by medication staff.
-Staff would document all medication leaving the community using the Medication Release Form.
-Multi-dose packs, individual pill bottles, and single dose blister packs would be prepared according to the specific time period the resident would be out of the community.
-The original container and directions for administration would be provided to the resident or responsible party.
-The resident or responsible party would sign a medication release form with acknowledgement of receipt and return of medications.
-Staff would print a Resident Flow Sheet to send with the medication release form.
-Documentation would be kept in the community, readily available, and would include the medication name, quantity released, and quantity returned.
-Upon the resident's return, a medication aide (MA) or the Resident Care Coordinator (RCC) must do an immediate medication count to ensure correct number of medications had been returned.
-If the resident returns with the incorrect amount of medications the facility would have the resident or family member sign with a staff witness the amount returned and notify the pharmacy and prescribing physician.

Review of the facilty's Missed or Refused Medication policy dated September 2021 revealed:
-Steps would be taken to avoid missed or refused doses of medications.
-Missed or refused medications would be

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documented in the resident's electronic medication administration record (eMAR) and the provider would be notified with documentation.
-The MA or RCC would notify the prescribing provider of the missed or refused medications immediately using the Medication Notification form after 3 consecutive refusals unless the medications were related to diabetes, Coumadin, or seizure disorders.
-The RCC would evaluate the resident refusals and contact the primary care provider (PCP) if the resident continually refused medications and would document the notification in the communication on the Care Coordinator Meeting Progress Note.

Review of Resident #3's medication release form for resident leave of absence sheet dated 09/17/22 revealed:
-The resident was given the following medications with instructions for use in his possession upon leaving the facility:
-Amlodipine 10mg quantity of 6 doses.
-Bicalutamide 50mg quantity of 6 doses.
-Combigan 0.1-0.5% quantity of 1.
-Lumigan 0.1% quantity of 1.
-Bupropion XR 150 mg quantity of 6 doses.
-Ferrous Sulfate 325mg quantity of 6 doses,
-Losartan-Hydrochlorothiazide 100 mg/35mg quantity of 6 doses.
-Vitamin D3 1000u quantity of 6 doses.
-Tradjenta 5mg quantity of 9 doses.
-Levothyroxine 137mcg quantity of 9 doses.
-The was no documentation of any medication quantities upon the resident's return to the facility.
-The document was not signed by a staff member or the resident.

Review of Resident #3's facility record revealed:
-There was no documentation of a Resident Flow

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Sheet in which the resident recorded mediations taken while on leave.
-There was no documentation the PCP was notified the resident was on extended leave and was not provided with enough medication on hand for the time he was out of the facility.
-There was no documentation that the facility contacted the resident in regard to his medications.

Review of the facility sign out sheets revealed:
-Resident #3 failed to sign out on 09/17/22 or sign back in on 10/12/22.
-Resident #3 did not notify staff of his return date or leave contact information.

Review of Resident #3's progress notes dated 10/07/22 revealed the transportation coordinator contacted the resident concerning an upcoming appointment and encouraged the resident to return to the facility.

Review of Resident #3's September 2022 eMAR revealed:
-There was an entry for Amlodipine 10mg daily.
-Amlodipine was documented as not administered from 09/18/22-09/30/22 due to being out of the facility.
The resident received 6 doses of Amlodipine upon leaving the facility and did not have enough medication on hand for 7 of 13 doses.
-There was an entry for Bicalutamide 50mg daily.
-Bicalutamide was documented as not administered 09/18/22-09/30/22 due to being out of the facility.
-The resident received 6 doses of Bicalutamide upon leaving the facility and did not have enough medication on hand for 7 of 13 doses.
-There was an entry for Bupropion 150mg daily.
-Bupropion was documented as not administered

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D 273	Continued From page 14 09/18/22-09/30/22 due to being out of the facility. -The resident received 6 doses of Bupropion upon leaving the facility and did not have enough medication on hand for 7 of 13 doses. -There was an entry for Ferrous Sulfate 325mg daily. -Ferrous Sulfate was documented as not administered 09/18/22-09/30/22 due to being out of the facility. -The resident received 6 doses of Ferrous Sulfate upon leaving the facility and did not have enough medication on hand for 7 of 13 doses. -There was an entry for Losartan-Hydrochlorothiazide 100-25mcg daily. -Losartan-Hydrochlorothiazide was documented as not administered 09/18/22-09/30/22 due to being out of the facility. -The resident received 6 doses of Losartan-Hydrochlorothiazide upon leaving the facility and did not have enough medication on hand for 7 of 13 doses. -There was an entry for Vitamin D3 25mcg (1000 Unit) daily. - Vitamin D3 was documented as not administered 09/18/22-09/30/22 due to being out of the facility. -The resident received 6 doses of Vitamin D3 upon leaving the facility and did not have enough medication on hand for 7 of 13 doses. -There was an entry for Levothyroxine 137mcg daily. -Levothyroxine was documented as not administered 09/18/22-09/30/22 due to being out of the facility. -The resident received 9 doses of Levothyroxine upon leaving the facility and did not have enough medication on hand for 4 of 13 doses. -There was an entry for Tradjenta 5mg daily. -Tradjenta was documented as not administered 09/18/22-09/30/22 due to being out of the facility.	D 273		

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D 273	Continued From page 15 -The resident received 9 doses of Tradjenta upon leaving the facility and did not have medication on hand for 4 of 13 doses from 09/18/22-09/30/22. -There was an entry for nutritional supplement twice daily. -The nutritional supplement was documented as not administered 09/18/22-09/30/22 due to being out of the facility. -The resident did not receive any nutritional supplements upon leaving the facility and did not have enough nutritional supplements on hand for 26 of 26 doses. Review of Resident #3's October 2022 eMAR revealed: -There was an entry for Amlodipine 10mg daily. -Amlodipine was documented as not administered 10/01/22-10/11/22 due to being out of the facility. -The resident did not have Amlodipine on hand for 11 of 11 doses from 10/01/22-10/11/22. -There was an entry for Bicalutamide 50mg daily. -Bicalutamide was documented as not administered 10/01/22-10/11/22 due to being out of the facility. -The resident did not have Bicalutamide on hand for 11 of 11 doses from 10/01/22-10/11/22. -There was an entry for Bupropion 150mg daily. -Bupropion was documented as not administered 10/01/22-10/11/22 due to being out of the facility. -The resident did not have Bupropion on hand for 11 of 11 doses from 10/01/22-10/11/22. -There was an entry for Ferrous Sulfate 325mg daily. -Ferrous Sulfate was documented as not administered 10/01/22-10/11/22 due to being out of the facility. -The resident did not have Ferrous Sulfate on hand for 11 of 11 doses from 10/01/22-10/11/22. -There was an entry for	D 273		

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Losartan-Hydrochlorothiazide 100-25mcg daily.
-Losartan-Hydrochlorothiazide was documented as not administered 10/01/22-10/11/22 due to being out of the facility.
-The resident did not have Losartan-Hydrochlorothiazide on hand for 11 of 11 doses from 10/01/22-10/11/22.
-There was an entry for Vitamin D3 25mcg (1000 Unit) daily.
- Vitamin D3 was documented as not administered 10/01/22-10/11/22 due to being out of the facility.
-The resident did not have Vitamin D3 on hand for 11 of 11 doses from 10/01/22-10/11/22.
-There was an entry for Levothyroxine 137mcg daily.
-Levothyroxine was documented as not administered 10/01/22-10/11/22 due to being out of the facility.
-The resident did not have Levothyroxine on hand for 11 of 11 doses from 10/01/22-10/11/22.
-There was an entry for Tradjenta 5mg daily.
-Tradjenta was documented as not administered 10/01/22-10/11/22 due to being out of the facility.
-The resident did not have Tradjenta on hand for 11 of 11 doses from 10/01/22-10/11/22.
-There was an entry for nutritional supplements twice daily.
-The nutritional supplement was documented as not administered 10/01/22-10/11/22 due to being out of the facility.
-The resident did not have any nutritional supplement on hand for 22 of 22 doses.

Telephone interview with the facility's previous contracted pharmacy on 12/22/22 at 2:02pm and 01/03/23 at 3:41pm revealed they were unable to provide information due to the facility no longer contracting with the pharmacy.

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Telephone interview with the medical records department front end manager at the facility's previous contracted pharmacy on 01/03/23 at 3:50pm revealed:
-Tradjenta was dispensed to the facility for Resident #3 on 09/19/22 with a 30-day supply.
-The Amlodipine, Losartan-HCTZ, Ferrous Sulfate, Bupropion, Vitamin D-3, and Bicalutamide were dispensed in multi-dose packets to the facility for Resident #3 on 10/01/22 with a 7-day supply.
-Levothyroxine was dispensed to the facility for Resident #3 on 09/19/22 with a 30-day supply.
-Levothyroxine was returned in a quantity of 13 tablets for destruction on 09/28/22 but the pharmacy did keep record of multi-dose packets returned for destruction due to there being multiple medications in each packet; they are just thrown in the trash.
-The facility was responsible and should have documentation of any medications that were returned to the pharmacy for destruction.
-The pharmacy stopped contracting with the facility on 10/03/22 and did not provide any more medications to the facility for Resident #3 after that date.

Telephone interview with Resident #3 on 12/21/21 at 3:44pm revealed:
-He had been gone from the facility in September and October 2022 and usually left the facility for about two weeks at a time.
-The facility never called him to notify him that his medications had come in or about obtaining more medication while he was gone; they only called him to notify him of his upcoming appointments.
-He did not always sign out when he left the facility and sometimes ran out of medication but knew it was important to take his medication.
-He did not refill his medications while he had

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been gone at any other pharmacy and did not come back to the facility to get more medications.

Interview with a personal care aide (PCA) on 12/21/22 at 2:21pm revealed:
-Resident #3 was oriented and helpful around the facility.
-Resident #3 sometimes left the facility for about two weeks at a time about once a month.

Interview with a MA on 12/21/22 at 2:39pm revealed:
-Resident #3 was usually gone two about weeks when he left the facility, but the longest he had been gone was almost a month.
-The resident liked to leave the facility about once a month.
-Resident #3 sometimes ran out of his medications when he left the facility.
-Resident #3 was told by an MA when he left the facility how many days of medication he was provided.
-Resident #3 sometimes called the facility when he was gone and would tell the facility when he planned to come back.

Interview with the transportation coordinator on 12/21/22 at 3:40pm revealed:
-She called Resident #3 about his upcoming appointments when he was out of the facility but did not discuss his medications.
-Resident #3 was smart and intelligent but could sometimes be forgetful.

Interview with the RCC on 12/21/22 at 3:15pm revealed:
-Resident #3 was oriented and usually left the facility about once a month for approximately one week at a time.
-Resident #3 would periodically call facility staff

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when he was gone.
-When Resident #3 was gone in September and October she recalled him calling to inquire about one particular medication and asked to speak with another resident.
-When she asked Resident #3 when he was coming back, and the resident replied "soon".
-Resident #3's PCP was notified "in a passing conversation" the resident was out of the facility, but she did not formally notify the PCP that he was out of the facility and was not provided with enough medication for the time frame he was gone.
-She did not think to notify the PCP because Resident #3 was his own responsible party.
-It was the MA's, Administrator's, or her responsibility to notify Resident #3's PCP that the resident was out of the facility and did not have enough mediations to take them as ordered.
-Resident #3 had underlying health issues and needed his medications as ordered.

Interview with the Administrator on 12/21/22 at 4:12pm revealed:
-Resident #3 was oriented, alert, helped staff, and liked to keep busy.
-Resident #3 was forgetful but never confused.
-Resident #3 would leave the facility randomly, and it varied how long he would stay gone but usually about 1-2 weeks.
-She thought Resident #3 spoke with the RCC when he was gone in September and October and told the resident he needed his medications.
-It was important for Resident #3 to take his medications for his general health and stability.
-The facility called the resident when he was gone and offered to bring the resident back to the facility, but he refused.
-There was no formal documentation that Resident #3's PCP had been notified the resident

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was out of the facility and had not been provided with enough medications to take as ordered.
-She thought the passing conversation with the PCP about Resident #3 had been sufficient.
-Resident #3's PCP should have been notified that he was out of the facility for an extended period of time without enough medications so she could have been given the opportunity to provide orders to guide care and be aware of any issues that may arise from him not having his medications.

Telephone interview with Resident #3's PCP on 12/20/22 at 3:58 pm revealed:
-She would be concerned if the resident left the facility and did not take his medication.
-She expected the facility to adhere to their sign out policy and to ensure the resident had enough medication to take as ordered.
-She expected to be notified if the resident was out of the facility and did not have enough medication to take as ordered.
-It was the resident's responsibility to take his medication when out of the facility but she expected the facility to be able to get a hold of him and ensure he had enough medication.
-She expected the facility to know when the resident was to return and would be concerned if the resident did not return in time to have enough medication to take as ordered.
-Resident #3 had diagnoses of hypertension, pulmonary hypertension, and thyroid disorder.
-If the resident missed medications ordered to treat his medical diagnoses, he could have complications such as fatigue, weight gain, weakness, increased blood pressure, chest pain, palpitations, fainting, shortness of breath, buildup of pressure in the pulmonary arteries in the heart, stroke, or coma.

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D 273	Continued From page 21 Interview with Resident #3's PCP on 12/21/22 at 12:02 pm revealed: -The facility had not notified her that the resident was out of the facility in September and October without enough medications to take as ordered. -She expected to be notified if Resident #3 was out of the facility so she could provide orders to guide the resident's care, possibly send an order for his medications to a pharmacy near him so he could maintain his medication regime as ordered. -She would have also encouraged Resident #3 to come back and take his medications as ordered and to educate him on the risks of not taking his medications as ordered. _____ The facility failed to ensure notification for referral and follow up to the primary care provider (PCP) for 2 of 5 sampled residents (#2, #3) in which Resident #2 was smoking in her resident room and near oxygen tanks which was a fire hazard and placed herself and other residents at risk of injury. Resident #2 also exhibited both verbal and physically aggressive behaviors on multiple occasions in which an assessment and services may have been ordered. Resident #3's PCP was not notified that he had been out of the facility on leave for an extended period of time (24 days) in which he was only provided 6 days worth of medication, and did not get his medication refilled or pick up the medication that came into the facility while he was out on leave, which put him at risk for complications such as fatigue, weight gain, weakness, increased blood pressure, chest pain, palpitations, fainting, shortness of breath, buildup of pressure in the pulmonary arteries in the heart, stroke, or coma due to diagnoses of diabetes, hypertension, pulmonary hypertension, and thyroid disorder. The failure of the facility was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation.	D 273		

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D 273	Continued From page 22 _____ The facility provided a plan of protection in accordance with G.S. 131D-34 received on 12/20/22. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 4, 2023.	D 273		