

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fci079113	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/13/2023
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NAME OF PROVIDER OR SUPPLIER HARRISONS CARING HANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 07/13/23.	C 000		
C 131	<p>10A NCAC 13G .0403(a) Qualifications of Medication Staff</p> <p>10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 2 of 3 sampled staff (Staff A and B) had completed medication aide (MA) training, clinical skills validation, and passed the written exam within the required timeframes.</p> <p>The findings are:</p> <p>1. Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired as a personal care aide (PCA) on 06/26/20. -Staff A completed the Medication Competency Validation Clinical Skills checklist on 07/07/20. -There was no documentation Staff A completed a 5-hour medication aide (MA) training course prior to administering medications. -Staff A completed the 15-hour MA training course on 09/08/20. -There was no documentation Staff A completed the MA written exam within 60-days of completing</p>	C 131		

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C 131	<p>Continued From page 1</p> <p>the Medication Competency Validation Clinical Skills checklist.</p> <p>-Staff A passed the MA written exam on 11/04/21.</p> <p>Interview with Staff A on 07/13/23 at 3:25pm revealed:</p> <p>-She was hired in June of 2020 and started training for the position of MA.</p> <p>-She completed her Medication Competency Validation Clinical Skills checklist and her 15-hour training within a couple months of being hired but due to the COVID-19 pandemic she was not able to schedule the MA written exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist .</p> <p>-She had not realized that over a year had passed between her MA training and when she passed her MA written exam.</p> <p>-Neither the Administrator nor the nurse who completed MA training at the facility had told her she needed to pass the written MA exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed:</p> <p>-She was responsible for ensuring all of the requirements for MA qualifications were current and complete within the required timeframes.</p> <p>-She was aware that MAs needed to take the MA written exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist.</p> <p>-She was not aware if the MA was not able to complete the MA written exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist, the skills validation needed to be completed again after passing the MA written exam.</p>	C 131		

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C 131	<p>Continued From page 2</p> <p>2. Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) on 06/12/20. -Staff B completed the Medication Competency Validation Clinical Skills checklist on 07/07/20. -There was no documentation Staff B completed a 5-hour medication aide (MA) training prior to passing medications. -Staff B completed the 15-hour MA training course on 12/10/22. -There was no documentation Staff B completed the MA written exam within 60-days of completing Medication Competency Validation Clinical Skills checklist. -Staff B passed the MA written exam on 02/01/23.</p> <p>Telephone interview with Staff B on 07/13/23 at 4:00pm revealed: -She was hired in June of 2020 and completed her Medication Competency Validation Clinical Skills checklist in July of 2020. -She had not taken her MA written exam until February 2023 because of personal scheduling conflicts. -Neither the Administrator nor the nurse who completed MA training at the facility had told her she needed to pass the written MA exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed: -She was responsible for ensuring all of the requirements for MA qualifications were current and complete within the required timeframes. -She was aware MAs needed to take the MA written exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist. -She was not aware if the MA was not able to</p>	C 131		

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C 131	Continued From page 3 complete the MA written exam within 60 days of completing the Medication Competency Validation Clinical Skills checklist, the skills validation needed to be completed again after passing the MA written exam.	C 131		
C 203	<p>10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculoosis Test And Medical Examination</p> <p>(b) Each resident shall have a medical examination prior to admission to the home and annually thereafter.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure residents' FL2s were updated annually for 2 of 3 sampled residents (#1 and #3).</p> <p>The findings are:</p> <p>1. Review of Resident #1's previous FL2 dated 06/14/22 revealed diagnoses included schizophrenia, asthma, hypertension, and chronic obstructive pulmonary disease.</p> <p>Review of Resident #1's record revealed he did not have an updated FL2 completed since 06/14/22.</p> <p>Interview with Resident #1's primary care provider (PCP) on 07/13/23 at 2:20pm revealed: -She had worked as the PCP for the facility since May 2023.</p>	C 203		

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C 203	<p>Continued From page 4</p> <p>-She was at the facility every other week. -She had not been asked to update Resident #1's FL2 until today, 07/13/23.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed: -She was the staff responsible for ensuring all the residents had FL2s updated annually. -She was aware Resident #1's FL2 was overdue to be updated. -She was prepared to have the facility's PCP update Resident #1's FL2 on 07/13/23. -She did not have a system in place to help her keep track of when each resident's FL2 was due to be updated. -She checked the resident records periodically to see if any of the FL2s were due to be updated, but she did not audit the resident records on a routine or scheduled basis.</p> <p>2. Review of Resident #3's previous FL2 dated 07/08/22 revealed diagnoses included type 2 diabetes, hypertension, unspecified intellectual disabilities, and osteoarthritis.</p> <p>Review of Resident #3's record revealed he did not have an updated FL2 completed since 07/08/23.</p> <p>Interview with Resident #1's primary care provider (PCP) on 07/13/23 at 2:20pm revealed: -She had worked as the PCP for the facility since May 2023. -She was at the facility every other week. -She had not been asked to update Resident #1's FL2 until today, 07/13/23.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed: -She was the staff responsible for ensuring all the</p>	C 203		

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C 203	Continued From page 5 residents had FL2s updated annually. -She was not aware Resident #3's FL2 was overdue to be updated. -She did not have a system in place to help her keep track of when each resident's FL2 was due to be updated. -She checked the resident records periodically to see if any of the FL2s were due to be updated, but she did not audit the resident records on a routine or scheduled basis.	C 203		
C 255	10A NCAC 13G .0903 (d) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (d) The facility shall follow-up and implement recommendations made by the licensed health professional including referral to the physician or appropriate health professional when indicated. The facility shall document follow-up on all recommendations made by the licensed health professional. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure follow-up to recommendations made by the Licensed Health Professional Support (LHPS) nurse for 2 of 3 sampled residents (#1 and #3) related to faxing an order to the pharmacy for documentation purposes (#1) and obtaining orders with parameters and adding laboratory results to the record for review (#2). The findings are: 1. Review of Resident #1's current FL2 dated 06/14/22 revealed:	C 255		

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C 255	<p>Continued From page 6</p> <p>-Diagnoses included schizophrenia, high blood pressure, chronic obstructive pulmonary disease (COPD), and asthma.</p> <p>-There was documentation Resident #1's respiration was normal, but no documentation that he was using oxygen therapy.</p> <p>Review of Resident #1's Resident Register dated 11/23/20 revealed he was admitted to the facility on 11/19/20.</p> <p>Review of Resident #1's physician order dated 01/24/21 revealed an order for oxygen at 2 liters per minute (L) via nasal cannula at night for sleep and as needed during the day for shortness of breath.</p> <p>Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 05/08/23 revealed:</p> <p>-Resident #1 had an LHPS task for oxygen administration and monitoring.</p> <p>-Resident #1's respirations were easy and unlabored.</p> <p>-Resident #1 used oxygen at 2L via nasal cannula at night for sleep and as needed for shortness of breath during the day.</p> <p>-Resident #1's oxygen concentrator was in his room, clean and in proper working order along with a portable oxygen tank secured in the closet.</p> <p>-There was a recommendation to fax Resident #1's oxygen order to the pharmacy to enter the oxygen order on the electronic medication administration record (eMAR) for documentation purposes.</p> <p>Review of Resident #1's May, June and July 2023 eMARs revealed there was no entry for oxygen 2L via nasal cannula at night or as-needed during the day.</p>	C 255		

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C 255	<p>Continued From page 7</p> <p>Observation of Resident #1's room on 07/13/23 at 12:00pm revealed: -There was an oxygen concentrator with nasal cannula tubing next to the bed and turned off. -There was a large portable oxygen tank in a secured holder in the closet.</p> <p>Interview with Resident #1 on 07/13/23 at 12:25pm revealed: -He wore his oxygen every night like his doctor wanted him to. -He sometimes needed to wear the oxygen during the day if he was feeling short of breath. -He preferred to be in his room with the door closed so he did not think the facility staff were aware of his daytime use of oxygen. -He had a spare oxygen tank in his closet if he needed it, but during the day if he was short of breath he preferred to rest in his room using his oxygen concentrator.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 07/13/23 at 1:20pm revealed: -The pharmacy had an order on file for Resident #1's oxygen dated 01/24/21 for 2L via nasal cannula every night and as-needed for shortness of breath during the day. -The pharmacy entered orders into the facility's eMAR system, and staff at the facility had to approve the orders. -If the LHPS nurse made a recommendation to the facility to have oxygen added to Resident #1's eMAR, the facility was responsible for either contacting the resident's primary care provider (PCP) to verify the recommendation, or for contacting the pharmacy directly to request they add the oxygen order to the eMAR. -The facility had not contacted the pharmacy prior</p>	C 255		

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C 255	<p>Continued From page 8</p> <p>to today, 07/13/23, to request Resident #1's oxygen order be added to the eMAR for them to document oxygen administration.</p> <p>Interview with Resident #1's PCP on 07/13/23 at 2:20pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 was ordered oxygen due to his diagnoses of COPD and asthma. -The facility had not contacted her regarding documentation for Resident #1's oxygen. -She was not aware the medication aides (MA) were not documenting administration of Resident #1's oxygen. -She expected the MAs to document when Resident #1 wore his oxygen at night or if he used it as-needed during the day. -She would want the facility to contact her with any recommendations made by the LHPS nurse. <p>Interview with a MA on 07/13/23 at 3:25pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 wore his oxygen as ordered every night. -The MAs did not document Resident #1's oxygen use because there was nowhere to document it. -The MAs did not type progress notes or charting notes so the only place they would document oxygen administration would be on the eMAR if there was an entry for it. -She was not aware the LHPS nurse recommended faxing Resident #1's oxygen order to the pharmacy for the MAs to document oxygen use. -The LHPS evaluations were given to the Administrator to follow up on any recommendations; the MAs did not review or read the LHPS evaluations. <p>Telephone interview with a second MA on</p>	C 255		

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C 255	<p>Continued From page 9</p> <p>07/13/23 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 wore 2L of oxygen at night and during the day if he needed it. -She did not document Resident #1's oxygen use because it was not on the eMAR so she did not know she needed to. -The pharmacy dropped off the LHPS nurse's evaluation sheets to the facility once she typed them up. -She did not review the LHPS evaluations, she left the LHPS evaluations for the Administrator to review. -She was not aware the LHPS nurse had recommended faxing Resident #1's oxygen order to the pharmacy to be added to the eMAR for documentation purposes. <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -She was the staff responsible for reviewing the LHPS nurse evaluations. -When the LHPS nurse came to the facility to complete the LHPS evaluations, she called the Administrator if she had any questions, but she did not always tell her over the phone what her recommendations were for each resident. -The pharmacy delivered the typed LHPS evaluations to the facility to be placed in the resident records. -Whichever MA was working when the LHPS evaluations were delivered to the facility usually filed them into the resident's record. -She would not know if the LHPS nurse had a recommendation for follow-up unless she remembered to go back into the resident record and look at the LHPS evaluation which she did not always remember to do. -She was aware the LHPS nurse could make recommendations on the LHPS evaluation to be follow-up on, but if the LHPS nurse had made a 	C 255		

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C 255	<p>Continued From page 10</p> <p>recommendation, she would let her know over the phone.</p> <p>-She did not review the residents' LHPS evaluations during her record audits because during the record audits she only looked at the medication orders.</p> <p>-She was not aware the LHPS nurse had recommended she fax Resident #1's oxygen order to the pharmacy to be added to the eMAR for the MAs to document on.</p> <p>-She was not aware that oxygen administration was not on Resident #1's eMAR because it previously had been.</p> <p>-When she audited Resident #1's eMAR each month she only looked at medication orders, so she had not noticed oxygen was not on his eMAR.</p> <p>-The MAs had not told her there was no place to document Resident #1's oxygen administration or that oxygen administration was not entered on the eMAR.</p> <p>Attempted telephone interview with the facility's LHPS nurse on 07/13/23 at 1:30pm was unsuccessful.</p> <p>2. Review of Resident #3's current FL2 dated 07/08/22 revealed:</p> <p>-Diagnoses included type 2 diabetes, hypertension, unspecified intellectual disabilities, obesity and osteoarthritis.</p> <p>-There was an order for fingerstick blood sugar (FSBS) twice daily.</p> <p>-There was an order for amlodipine (a medication used to treat high blood pressure) 5mg daily.</p> <p>-There was an order for metoprolol succinate (a medication used to treat high blood pressure) 25mg daily.</p> <p>Review of Resident #3's Resident Register dated</p>	C 255		

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C 255	<p>Continued From page 11</p> <p>06/24/22 revealed he was admitted to the facility on 06/24/22.</p> <p>Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 05/08/23 revealed:</p> <ul style="list-style-type: none"> -Resident #1 had an LHPS task for collecting and testing FSBS samples. -Resident #1's FSBS ranges for the previous 30 days were 88-203 in the morning, and 92-207 at night. -There was a recommendation to call Resident #3's primary care provider (PCP) and have parameters placed on the electronic medication administration record (eMAR) for FSBS checks. -There was a recommendation to obtain an order for weekly blood pressure checks with parameters for medication management. -There was a recommendation to place a current hemoglobin A1c (a laboratory test indicating the estimated average blood glucose for the previous 3 months) in Resident #3's record for review for diabetes management. <p>Review of Resident #3's May 2023 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm. -There was no documentation of parameters in place for when to notify the PCP. -Resident #3's FSBS values from 05/01/23 through 05/31/23 ranged from 79 to 333. -There were no entries for weekly blood pressure checks with parameters for when to notify the PCP. <p>Review of Resident #3's June 2023 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm. 	C 255		

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C 255	<p>Continued From page 12</p> <ul style="list-style-type: none"> -There was no documentation of parameters in place for when to notify the PCP. -Resident #3's FSBS values from 06/01/23 through 06/30/23 ranged from 76 to 358. -There were no entries for weekly blood pressure checks with parameters for when to notify the PCP. <p>Review of Resident #3's July 2023 eMAR from 07/01/23 through 07/13/23 revealed:</p> <ul style="list-style-type: none"> -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm. -There was no documentation of parameters in place for when to notify the PCP. -Resident #3's FSBS values from 07/01/23 through 07/13/23 ranged from 88 to 322. -There were no entries for weekly blood pressure checks with parameters for when to notify the PCP. <p>Review of Resident #3's record on 07/13/23 revealed:</p> <ul style="list-style-type: none"> -The most recent hemoglobin A1c on file was dated 04/19/22, and the result was 7.5% (normal reference range was 4.0-6.0%). -There was no documentation the PCP had been contacted regarding the LHPS nurse's recommendations from 05/08/23. <p>Interview with Resident #3 on 07/13/23 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -The MAs checked his FSBS twice daily. -His FSBS values fluctuated, but they were never really high or low causing him to feel symptomatic. -The MAs did not check his blood pressure. <p>Telephone interview with a representative from the facility's contracted pharmacy on 07/13/23 at 1:20pm revealed:</p>	C 255		

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C 255	<p>Continued From page 13</p> <ul style="list-style-type: none"> -The pharmacy had an order for staff to check Resident #3's FSBS twice daily but there were no parameters on the order. -The pharmacy did not have an order for blood pressure checks for Resident #3. <p>Interview with the Resident #3's PCP on 07/13/23 at 2:20pm revealed:</p> <ul style="list-style-type: none"> -She had not been contacted to add parameters to Resident #3's FSBS order. -She would want the MAs to contact her if Resident #3's FSBS was less than 70 and he was symptomatic, or greater than 500 and he was symptomatic. -She had not received a request from the facility for weekly blood pressure checks with parameters for Resident #3. -She checked Resident #3's blood pressure every other week when she was at the facility and he was always within a normal range. -She had not ordered a hemoglobin A1c laboratory test for Resident #3, but was planning to order routine laboratory work for all the residents that month, which would include an A1c test for Resident #3. -She would want the facility to contact her with any recommendations made by the LHPS nurse. <p>Interview with a MA on 07/13/23 at 3:25pm revealed:</p> <ul style="list-style-type: none"> -She was not aware of the LHPS nurse's recommendations for Resident #3, because the Administrator was responsible for follow-up on the LHPS evaluations. -The LHPS evaluations were given to the Administrator to follow-up on any recommendations. -Resident #3's FSBS values were stable and he was never symptomatic of having high or low blood sugar. 	C 255		

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C 255	<p>Continued From page 14</p> <p>-The MAs did not check Resident #3's blood pressure because there was no order to do so.</p> <p>Telephone interview with a second MA on 07/13/23 at 4:00pm revealed:</p> <p>-The MAs did not read or review the residents' LHPS evaluations.</p> <p>-The Administrator reviewed the LHPS evaluations and completed any recommended follow-up.</p> <p>-She was not aware of the LHPS nurse's recommendations for Resident #3 from 05/08/23.</p> <p>-Resident #3's FSBS values were never so high or low that she questioned whether to notify his PCP.</p> <p>-Resident #3 was never symptomatic of having high or low blood sugar, or high or low blood pressure.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed:</p> <p>-She was the staff responsible for reviewing the LHPS evaluations.</p> <p>-When the LHPS nurse went to the facility to complete the LHPS evaluations, she called the Administrator if she had any questions but did not always tell her over the phone what her recommendations were for each resident.</p> <p>-The pharmacy delivered the typed LHPS evaluations to the facility to be placed in the resident records.</p> <p>-Whichever MA was working when the LHPS evaluations were delivered to the facility usually filed them into the resident's record.</p> <p>-She would not know if the LHPS nurse had a recommendation for follow-up unless she remembered to go back into the resident record and look at the LHPS evaluation which she did not always remember to do.</p> <p>-She was aware the LHPS nurse could make</p>	C 255		

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C 255	<p>Continued From page 15</p> <p>recommendations on the LHPS evaluation that needed to be followed-up on, but if the LHPS nurse made a recommendation, she would let her know over the phone.</p> <p>-She did not review the resident's LHPS evaluation during her record audits because during the record audits she only looked at the medication orders.</p> <p>-She did not know when Resident #3 last had a hemoglobin A1c level drawn.</p> <p>-She was aware the LHPS nurse had recommended placing a current A1c level in Resident #3's record for review, but thought it had already been completed.</p> <p>-She thought she had requested the FSBS parameters and weekly blood pressure order for Resident #3 from his former PCP, but was not aware the orders were never obtained and added to the eMAR.</p> <p>-She had not documented her communication with Resident #3's former PCP.</p> <p>-Resident #3's current PCP started in May 2023 and she had not followed up on the LHPS nurse's recommendations with his current PCP.</p> <p>Attempted telephone interview with the facility's LHPS nurse on 07/13/23 at 1:30pm was unsuccessful.</p>	C 255		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p>	C 330		

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C 330	<p>Continued From page 16</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medication as ordered for 2 of 3 sampled residents (#1 and #2) who had an order for psychotropic medication injections every three months (#1), and who had an order to increase an anti-anxiety medication from once daily to twice daily (#2).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 06/22/22 revealed: -Diagnoses included schizophrenia. -There was an order for Invega Trinza (an antipsychotic medication used to treat schizophrenia) 546mg/1.75mL injection every 3 months.</p> <p>Review of Resident #1's mental health provider's (MHP) progress note dated 03/07/23 revealed: -The nurse visited Resident #1 that day on 03/07/23. -Invega Trinza 546mg was injected intramuscularly into the left gluteus. -Resident #1 tolerated the injection well.</p> <p>Review of Resident #1's May 2023 electronic medication administration record (eMAR) revealed: -There was an as-needed entry for Invega Trinza 546mg/1.75mL inject 546mg intramuscularly every 3 months. -There was no documentation Invega was administered from 05/01/23 through 05/31/23.</p>	C 330		

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C 330	<p>Continued From page 17</p> <p>Review of Resident #1's June 2023 eMAR revealed: -There was an as-needed entry for Invega Trinza 546mg/1.75mL, inject 546mg intramuscularly every 3 months. -There was no documentation Invega was administered from 06/01/23 through 06/30/23.</p> <p>Review of Resident #1's July 2023 eMAR from 07/01/23 through 07/13/23 revealed: -There was an as-needed entry for Invega Trinza 546mg/1.75mL, inject 546mg intramuscularly every 3 months. -There was no documentation Invega was administered from 07/01/23 through 07/13/23.</p> <p>Observation of medication on hand for Resident #1 on 07/13/23 at 11:30am revealed: -There was one unopened box containing one pre-filled syringe of Invega Trinza 546mg/1.75mL to be injected intramuscularly every 3 months. -There was a dispensed date of 05/31/23.</p> <p>Interview with Resident #1 on 07/13/23 at 12:25pm revealed: -He received an Invega injection every 3 months. -He did not keep track of when his injections were due, and he could not remember when his last Invega injection was. -The MH nurse administered his Invega injections. -He saw his primary care provider (PCP) one week prior and she had not mentioned missing an Invega injection to him. -He did not have any changes to his mood in the previous month.</p> <p>Interview with Resident #1's PCP on 07/13/23 at 2:20pm revealed: -Resident #1 was prescribed Invega to manage</p>	C 330		

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C 330	<p>Continued From page 18</p> <p>his diagnosis of schizophrenia.</p> <ul style="list-style-type: none"> -Resident #1's MH nurse went to the facility and administered his Invega injections every 3 months. -She was not aware Resident #1 did not receive his Invega injection for the month of June 2023. -There would be no adverse effects or harm for Resident #1 being one month late to receive his Invega injection. -If the MH nurse was unable to administer Resident #1's Invega injections she would start administering it. -Resident #1 had not exhibited any new or worse symptoms since missing his Invega injection. -She expected the facility to monitor when Resident #1's Invega injections were due and follow up with her if a dose was missed so that she could come to the facility and administer it to him. <p>Telephone interview with a representative from Resident #1's MHP's office on 07/13/23 at 2:25pm revealed:</p> <ul style="list-style-type: none"> -Their office provided staff who went to the facility to visit Resident #1 twice per week to provide therapy, peer support, and nurse visits. -Resident #1 had been discharged from their services in March 2023. -Resident #1's guardian had requested the discharge from their services, but she did not see documentation why. -The MH nurse's note dated 03/17/23 documented that it was her last visit to see Resident #1; there was no documentation specifying if the facility staff were notified that it was their last visit or not. -Their discharge process always included notifying the facility so she thought the facility would be aware they would not come to administer Resident #1's Invega injection in June 	C 330		

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C 330	<p>Continued From page 19</p> <p>2023.</p> <p>Interview with a medication aide (MA) on 07/13/23 at 3:25pm revealed:</p> <ul style="list-style-type: none"> -She had completed the most recent medication cart audit for the facility for the month of July 2023. -She noticed Resident #1's Invega injection was on the medication cart, but since it was a medication that he had ordered she did not realize it should have been administered in June 2023. -The Administrator usually completed the medication cart audits so she would have noticed the missed injection whenever she completed her next medication cart audit. -One of the MH nurses were supposed to come to the facility to administer Resident #1's Invega injection. -Resident #1's Invega injection was entered as an "as needed" medication on the eMAR so it never popped up as a medication that was "due" to alert the MAs to expect the MH nurse to come administer it or document on. -She had not noticed Resident #1 missed his June 2023 Invega injection. -There had been no change to Resident #1's behavior in the previous month. <p>Telephone interview with Resident #1's guardian on 07/13/23 at 5:40pm revealed:</p> <ul style="list-style-type: none"> -She was not aware that Resident #1 missed his June 2023 Invega injection. -The MH nurse had contacted her in March 2023 and discussed that the goal of their program was to assist residents with regaining their independent living, and since Resident #1 would never be able to live on his own again, she agreed to discontinuing their services. -She thought the facility staff administered 	C 330		

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C 330	<p>Continued From page 20</p> <p>Resident #1's Invega injections. -She thought the MH team would communicate with the facility that they had agreed on discontinuing services.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed: -She had not been aware that Resident #1 was discharged from the MH team services in March 2023. -She was not aware that Resident #1 did not receive an Invega injection in June 2023. -She completed medication cart audits on the 10th of each month and would have noticed Resident #1's Invega injection still on the medication cart, but one of the MAs did the medication cart audit for her this month, July 2023. -The MA who completed the medication cart audit in July 2023 did not tell her that Resident #1's Invega injection for June 2023 was still on the medication cart. -Since the MH nurse had been reliable to always come to the facility and administer Resident #1's Invega injection on time, there was nobody who was responsible for following up on his injections and ensuring their completion.</p> <p>2. Review of Resident #2's current FL2 dated 08/24/22 revealed: -Diagnoses included schizoaffective disorder, nicotine dependence, type 2 diabetes, and hypertension. -There was an order for lorazepam 0.5mg (a Schedule IV controlled substance used to treat anxiety) daily. -There was an order for lorazepam 0.5mg once daily as needed.</p> <p>Review of Resident #2's physician's order dated</p>	C 330		

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C 330	<p>Continued From page 21</p> <p>06/22/23 revealed an order to discontinue lorazepam 0.5mg once daily as needed, and start taking lorazepam 0.5mg scheduled twice daily.</p> <p>Review of Resident #2's June 2023 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for lorazepam 0.5mg take one tablet daily scheduled at 8:00am. -There was documentation lorazepam 0.5mg was administered once daily from 06/01/23 through 06/30/23. -There was an entry for lorazepam 0.5mg take one tablet daily as needed. -There was documentation the as-needed lorazepam 0.5mg was administered on 06/19/23 and 06/23/23. -There was no documentation lorazepam 0.5mg was administered twice daily as ordered from 06/22/23 through 06/30/23. <p>Review of Resident #2's controlled substance count sheet (CSCS) for June 2023 revealed:</p> <ul style="list-style-type: none"> -The CSCS was for a medication card dispensed 06/01/23 to take one 0.5mg lorazepam tablet daily, with a dispensed quantity of 30 tablets. -Lorazepam 0.5mg was documented as administered once daily from 06/10/23 through 07/09/23. <p>Review of Resident #2's July 2023 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for lorazepam 0.5mg take one tablet daily scheduled at 8:00am. -There was an entry for lorazepam 0.5mg take one tablet twice daily scheduled at 8:00am and 8:00pm with a start date of 07/06/23. -There was documentation lorazepam was administered once daily from 07/01/23 through 07/06/23. 	C 330		

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C 330	<p>Continued From page 22</p> <p>-There was documentation lorazepam was administered twice daily from 07/07/23 through 07/13/23.</p> <p>Review of Resident #2's CSCS for July 2023 revealed:</p> <p>-The CSCS was for a medication card dispensed 07/06/23 to take one 0.5mg lorazepam tablet twice daily, with a dispensed quantity of 62 tablets.</p> <p>-There was documentation lorazepam was administered twice daily from 07/10/23 through the 8:00am dose on 07/13/23 with 55 out of 62 tablets remaining.</p> <p>Observation of medication on hand for Resident #2 on 07/13/23 at 11:25am revealed there was one medication card for lorazepam 0.5mg, take one tablet twice daily, with a dispensed date of 07/06/23 and with 55 out of 61 dispensed tablets remaining.</p> <p>Interview with Resident #2 on 07/13/23 at 12:30pm revealed:</p> <p>-He had been receiving lorazepam twice daily for the previous couple of days.</p> <p>-He used to have an order to take one lorazepam as needed, but he was not familiar with his current order.</p> <p>-He had not felt more anxious than usual in the previous month.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 07/13/23 at 1:20pm revealed:</p> <p>-Resident #2's order to increase lorazepam 0.5mg from once daily to twice daily and to discontinue the as-needed lorazepam was hand-delivered to the pharmacy from facility staff on 07/06/23.</p>	C 330		

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C 330	<p>Continued From page 23</p> <ul style="list-style-type: none"> -The order was written on 06/22/23 but was not faxed to the pharmacy prior to 07/06/23 when a paper copy was dropped off. -The pharmacy dispensed one medication card for Resident #2 containing 62 tablets of lorazepam 0.5mg, take one tablet twice daily on 07/06/23. <p>Interview with Resident #2's primary care provider (PCP) on 07/13/23 at 2:20pm revealed:</p> <ul style="list-style-type: none"> -She had changed Resident #2's lorazepam order on 06/22/23 from once daily and as needed, to twice daily scheduled, because of the frequency of the use of as-needed lorazepam. -She was not aware that Resident #2 only received lorazepam once daily instead of twice daily from 06/22/23 through 07/09/23. -She saw Resident #2 one week prior and there was no marked increase in his anxiety symptoms so she was not concerned about adverse effects from his lorazepam dose not being increased as ordered. -She expected the MAs to administer lorazepam to Resident #2 how she ordered it. <p>Interview with a medication aide (MA) on 07/13/23 at 3:25pm revealed:</p> <ul style="list-style-type: none"> -She was usually the staff responsible for bringing new physician orders to the pharmacy. -There was no longer a fax machine at the facility so she dropped copies of the new orders off at the pharmacy. -She remembered Resident #2's PCP changing his lorazepam order, but she could not remember why she did not bring the order to the pharmacy until 07/06/23. -She typically brought new PCP orders to the pharmacy either the same day they were written, or the following day. -Resident #2 did not have symptoms of increased 	C 330		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	<p>Continued From page 24</p> <p>anxiety between 06/22/23 and 07/09/23.</p> <p>Telephone interview with a second MA on 07/13/23 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 had been getting agitated in the afternoons and frequently needed his as-needed lorazepam, so his PCP changed his lorazepam order to twice daily instead of once daily. -When a new medication order was written, the Administrator either faxed it to the pharmacy or delivered a copy of the order to the pharmacy, and the pharmacy entered the new order on the eMAR. -She could not remember exactly when Resident #2 started receiving lorazepam twice daily, but she noticed it popping up as due at 8:00pm the previous few days. -Resident #2 seemed to be more calm since his order was increased to twice daily. <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -When a new medication order was written by the PCP, the MAs were responsible for notifying her so that she could go to the facility and pick up a copy of the order and bring it to the pharmacy. -The staff who were responsible for bringing orders to the pharmacy were herself, or one of the MAs. -She had not been the one to deliver Resident #2's lorazepam order to the pharmacy on 07/06/23, so the MA must have done it. -It was possible that the PCP increased Resident #2's lorazepam order from once daily to twice daily on a day where she or the other MA were not working, and whichever MA was working that day did not let either of them know there was an order that needed to be delivered to the pharmacy. -Resident #2 did not have any marked increase in 	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fci079113	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/13/2023
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C 330	Continued From page 25 anxiety symptoms since 06/22/23 when his lorazepam was supposed to begin being administered twice daily. -She expected all the MAs to be responsible for keeping track of new medication orders and contacting either herself or the other designated MA to deliver a copy of new medication orders to the pharmacy as soon as possible. -She had not been aware of the delay in increasing Resident #2's lorazepam from once daily and once daily as-needed, to twice daily. -She expected medications to be administered as ordered by the PCP.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	C 342		

Division of Health Service Regulation

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C 342	<p>Continued From page 26</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the medication administration record was accurate for 1 of 3 sampled residents (#1) who had an order for oxygen.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 06/14/22 revealed: -Diagnoses included schizophrenia, high blood pressure, chronic obstructive pulmonary disease (COPD), and asthma. -There was documentation Resident #1's respiration was normal, but no documentation that he was using oxygen therapy.</p> <p>Review of Resident #1's Resident Register dated 11/23/20 revealed he was admitted to the facility on 11/19/20.</p> <p>Review of Resident #1's physician order dated 01/24/21 revealed an order for oxygen at 2 liters per minute (L) via nasal cannula at night for sleep and as needed during the day for shortness of breath.</p> <p>Review of Resident #1's May, June and July 2023 eMARs revealed there was no entry for oxygen 2L via nasal cannula at night or as-needed during the day.</p> <p>Observation of Resident #1's room on 07/13/23 at 12:00pm revealed: -There was an oxygen concentrator with nasal cannula tubing next to the bed and turned off. -There was a large portable oxygen tank in a secured holder in the closet.</p>	C 342		

Division of Health Service Regulation

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C 342	<p>Continued From page 27</p> <p>Interview with Resident #1 on 07/13/23 at 12:25pm revealed: -He wore his oxygen every night like his doctor wanted him to. -He sometimes needed to wear the oxygen during the day if he was feeling short of breath. -He preferred to be in his room with the door closed so he did not think the facility staff were aware of his daytime use of oxygen. -He had a spare oxygen tank in his closet if he needed it, but during the day if he was short of breath he preferred to rest in his room using his oxygen concentrator.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 07/13/23 at 1:20pm revealed: -The pharmacy had an order on file for Resident #1's oxygen dated 01/24/21 for 2L via nasal cannula every night and as-needed for shortness of breath during the day. -The pharmacy entered orders into the facility's eMAR system, and staff at the facility had to approve the orders. -The facility had not contacted the pharmacy prior to today, 07/13/23, to request Resident #1's oxygen order be added to the eMAR for them to document oxygen administration.</p> <p>Interview with Resident #1's primary care provider (PCP) on 07/13/23 at 2:20pm revealed: -Resident #1 was ordered oxygen due to his diagnoses of COPD and asthma. -The facility had not contacted her regarding documentation for Resident #1's oxygen. -She was not aware the medication aides (MA) were not documenting administration of Resident #1's oxygen. -She expected the MAs to document when</p>	C 342		

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C 342	<p>Continued From page 28</p> <p>Resident #1 wore his oxygen at night or if he used it as-needed during the day.</p> <p>Interview with a MA on 07/13/23 at 3:25pm revealed: -Resident #1 wore his oxygen as ordered every night. -The MAs did not document Resident #1's oxygen use because there was nowhere to document it. -The MAs did not type progress notes or charting notes so the only place they would document oxygen administration would be on the eMAR if there was an entry for it.</p> <p>Telephone interview with a second MA on 07/13/23 at 4:00pm revealed: -Resident #1 wore 2L of oxygen at night and during the day if he needed it. -She did not document Resident #1's oxygen use because it was not on the eMAR so she did not know she needed to.</p> <p>Interview with the Administrator on 07/13/23 at 4:15pm revealed: -She was not aware that oxygen administration was not on Resident #1's eMAR because it previously had been. -When she audited Resident #1's eMAR each month she only looked at medication orders, so she had not noticed oxygen was not on his eMAR. -The MAs had not told her there was no place to document Resident #1's oxygen administration or that oxygen administration was not entered on the eMAR. -She expected oxygen administration to be documented by the MAs.</p>	C 342		