Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL051062 | A. BUILDING: _____ B. WING _____ | C 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CLASSIC CARE HOMES # 1 | 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and Johnston County Department of Social Services conducted a complaint investigation on June 14, 2023 and June 15, 2023. The complaints were initated on 03/29/23, 05/19/23, and 05/23/23 by Johnston County Department of Social Services. | D 000 | | |
| D 125 | 10A NCAC 13F .0403(a) Qualifications Of Medication Staff<br><br>10A NCAC 13F .0403 Qualifications Of Medication Staff<br>(a) Adult 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. Readopted Eff. July 1, 2021.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff E) who was administering medications had completed the medication aide employment verification or the state approved medication administration training courses as required.<br><br>The findings are:<br><br>Review of Staff E's personnel record revealed: | D 125 | Problem be corrected by having a 15 Hours Training class for all current Med Aide and paperwork in each file and Med Aide verification form paperwork has been sent out to get verification and once form received it will be put in Med Aide files. New Med Aide when coming onboard will be required to have all paperwork in before starting work. The Business Office Manager was trained on all paperwork that is a state requirement for all Med Aide to have in their files.<br><br>The Administrator and Owners, HR going forward will be the one who monitors employee files.<br><br>The 15 Hours Training Class will be done on July 12th, and 13th,2023. | The 15 Hours Training Class will be done on July 12th, and 13th,2023 . |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Angie Peedin — Administrator — 6-30-23



Angie Peedin, Administrator 06/30/2023

Revised 07/25/2023,
Angie Peedin, Administrator

Received via email 07/28/23 Administrator
Reviewed and Acknowledged 07/31/23. -dC

Revised 07/28/2023
Angie Peedin, Administrative

Angie Peedin
Administrator

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| D 125 | Continued From page 1<br>-Staff E was hired as a medication aide (MA) on 06/15/22.<br>-There was documentation of a medication administration clinical skills competency validation checklist completed on 06/15/22.<br>-Staff E had passed the MA written exam on 07/22/03.<br>-There was an incomplete MA verification form with the qualified work dated 03/24/16 for the 24-month time period between 10/01/15 - 09/30/17.<br>-There were no verification dates for the 24-month time periods between 10/01/11 - 09/30/13, 10/01/13 - 09/30/15, 10/01/17 - 09/30/19, or 10/01/19 - 09/30/21 to validate Staff A worked as a qualified MA during those time periods.<br>-There were no other MA verification forms on file for Staff E.<br>-There was documentation of passing skills for handwashing, application of alcohol-based hand rub, putting on and removing gloves, and general medication administration preparation steps, on 09/06/22.<br>-There was undated documentation for a 5-hour medication course for adult care homes that did not include a pass or fail grade.<br>-There was no certificate documenting Staff E successfully completed the 5-hour, 10-hour, or 15-hour state approved medication administration training courses.<br><br>Interview with Staff E on 06/15/23 at 9:14am revealed:<br>-He had been employed at the facility for one year.<br>-He was a MA.<br>-His responsibilities included medication administration and assisting/providing personal care to residents. | D 125 | | |

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| D 125 | Continued From page 2<br>-He had been a MA for over 20 years.<br><br>Review of residents' March 2023 - June 2023 medication administration records (MARs) revealed:<br>-Staff E documented the administration of medications to residents on 03/01/23, 03/04/23, 03/08/23, 03/23/23, and 03/24/23 at 7:00am, 8:00am, 12:00pm, 1:00pm, and 5:00pm.<br>-Staff E documented the administration of medication to residents on 05/15/23 and 05/18/23 at 7:00am, 8:00am, 9:00am, and 12:00pm.<br><br>Interview with the Administrator on 06/15/23 at 11:52am revealed:<br>-She thought Staff E had completed the 15-hour state approved medication administration training course at another facility but she could not find a certificate.<br>-Staff E had not completed the 5-hour, 10-hour, or 15-hour state approved medication administration training courses at this facility because she thought he had already completed it at another facility.<br>-The Business Office Manager (BOM) was responsible for checking personnel files to make sure all staff qualifications were completed and on file.<br>-She did not have a system to check behind the BOM to make sure staff qualifications were completed and on file.<br><br>Interview with the BOM on 06/15/23 at 11:57am revealed:<br>-She was responsible for the personnel files.<br>-Staff E was hired prior to her being the BOM so she was not aware Staff E did not have documentation of completing the 5-hour, 10-hour, or 15-hour state approved medication administration training courses. | D 125 | | |

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| D 125 | Continued From page 3<br>-She had last audited the personnel files a few months ago and she could not remember if Staff E had documentation of completing any of the state approved MA training courses at that time. | D 125 | | |
| D 297 | 10A NCAC 13F .0904(d)(1) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure residents were served nutritionally adequate and palatable meals including food being served burned on multiple occasions.<br><br>The findings are:<br><br>Interview with a resident on 06/14/23 at 9:07am revealed:<br>-The food was not good sometimes.<br>-The food was burned sometimes.<br>-Last week, the beans were burned, and they had a "scorched taste".<br><br>Interview with a second resident on 06/14/23 at 9:38am revealed: | D 297 | | |

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| D 297 | Continued From page 4<br>-Food served was not good at times.<br>-There was a burnt taste to the food.<br>-Beans were recently served burnt.<br><br>Interview with a third resident on 06/14/23 at 9:46am revealed:<br>-Sometimes staff burned the food and would serve it burned.<br>-About 5 months ago, the soup was burned, and the resident could not eat it.<br>-Last week at breakfast (could not recall which day), the grits were burned.<br>-The food was prepared in a sister facility next door and sometimes the food was cold when it was served because they had to bring it from next door.<br><br>Interview with a fourth resident on 06/14/23 at 9:49am revealed:<br>-Sometimes the meals were not good.<br>-Some of the meat was not good.<br>-She got something different to eat if she did not like the food served.<br>-Sometimes the food was burnt.<br><br>Interview with a fifth resident on 06/14/23 at 9:50am revealed:<br>-Sometimes the food was served cold.<br>-She had grits served last week that were burned and potatoes that were cold.<br>-They had not missed any meals and they got enough to eat.<br><br>Interview with a sixth resident on 06/14/23 at 10:00am revealed:<br>-They tended to have the same food a lot, such as a lot of rice, string beans, chicken and pork chops.<br>-Sometimes the food was burned.<br>-About two weeks ago, the vegetable soup was | D 297 | Administrator has spoken with the cook, explained the complaint about how the food is being prepared and served to the residents. Administrator retrained cook for 3 days how she needs to prepare her big items the day before, how to look at the quantity of items, serving size, how to make sure that she follows the menu along with the substitute for the NCS, NSA, so it wouldn't feel like she has to rush to have meals ready for resident.<br><br>Training done on 07/07/,2023, 07/08/2023, 07/09/2023.<br><br>This will be monitored by the Med Aide daily and Administrator monitor twice a week unless there's any complaint from resident then monitoring will be moved up to four times a week until satisfaction is met and resident happy.<br><br>Training day held for employees on 6/30/2023 on Nutrition and Food Service.<br><br>Another training day set on Nutrition and Food for 08/04/2023 for all employees | completed 07/09/2023<br><br>completed 6/30/2023<br><br>completed by 8/4/2023 |

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| D 297 | Continued From page 5<br>burned, and it tasted "scorched".<br>-Sometimes the bottom of the rolls was burned.<br>-They had alternatives like noodles or peanut butter and jelly sandwiches.<br><br>Observation of the facility on 06/14/23 at 10:55am revealed the menu dated 06/15/23 was posted in the dining room.<br><br>Observation of the lunch meal preparation on 06/15/23 revealed garlic bread was on the sheet pan after having been taken from the oven with dark brown crust on one side.<br><br>Interview with the cook on 06/14/23 at 12:55pm revealed:<br>-The toast from today got a little over done because she was trying to get the salad prepared.<br>-She took pride in serving good food.<br><br>Interview with the Business Office Manager (BOM) on 06/14/23 at 2:35pm revealed:<br>-Some residents told her that the food was sometimes burned.<br>-She was told the soup was burned last week.<br>-The cook that was responsible for the burned soup was no longer employed at the facility.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:10pm revealed:<br>-Residents frequently complain to her about the food being burned.<br>-The soup last week was burned.<br>-The rolls were sometimes hard.<br>-A couple of pieces of the toast cooked today were burned on the bottom. | D 297 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration | D 358 | | |

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| D 358 | Continued From page 6<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents (#1, #2, #3) sampled including errors with three medications used to treat moderate to severe pain for a resident with terminal cancer (#3), an antibiotic for a resident with pneumonia (#3), a medication used to treat mood disorders and behaviors for a resident requiring hospitalization for behaviors (#1), and a medication used to treat and prevent constipation (#2).<br><br>The findings are:<br><br>Review of the facility's Medication Administration Policies and Procedures (undated):<br>-The facility's contracted pharmacy's standard hours of operation are 9:00am to 5:00pm, Monday through Friday.<br>-In the case of an emergency, the contracted pharmacy may be contacted to fill and deliver medications at any time.<br>-Normal delivery would be between 6:00pm and 7:00pm, Monday through Friday.<br>-Medications shall be administered per physician orders and shall be documented on the MAR | D 358 | Correction for D358 and D367<br><br>All Charts audits have been done; All Cart audit has been done by Pharmacy.<br><br>Tracking system book has been put in place to follow daily to assure that all orders, lab, referral, treatment, and that all medications are in the facility by following the tracking system book to ensure that residents that residents needs are met daily and provider orders are follow as written. Med Aide also were retrained on Pharmacy Polices and Procedures about back up Pharmacy and what to do when medication are needed as this is part of the tracking system book too.<br><br>This is monitored daily by Med Aide, RCC and Administrator monitoring three times a week.<br><br>Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and continue with ongoing training.<br><br>All Med Aide received hand copies of the tracking system for theirs reference guide, copies placed in the MAR's book for reference too.<br><br>RCC monitor daily and Administrator monitor three times a week and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | completed 06/28/2023<br><br>completed 06/30/2023<br><br>completed 06/13/2023 and 06/23/2023 for retraining<br><br>completed 06/30/2023 |

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| D 358 | Continued From page 7<br>immediately after administration.<br>-Medications shall be ordered when the medication card showed there was only an 8-day supply on hand.<br>-The MA was responsible for filling out the refill/reorder request form.<br>-The request form should be given to the RCC or Administrator before noon so it could be faxed to the pharmacy.<br>-The medication would be delivered to the facility within __ business days (the number of days was left blank).<br>-When a new medication was ordered, most physician's offices would electronically prescribe (e-scribe) the prescription.<br>-If not escribed, the Administrator or RCC should fax the prescription to the pharmacy.<br><br>1. Review of Resident #3's current FL-2 dated 05/23/23 revealed diagnoses included history of brain tumor, history of squamous cell carcinoma, chronic pain syndrome, type 2 diabetes, and hypothyroidism.<br><br>a. Review of Resident #3's oncology provider visit note dated 03/16/23 revealed:<br>-The resident was administered an immunotherapy infusion for lung cancer.<br>-There was an order to start Fentanyl 12mcg/hr patch, place 1 patch on skin every third day. (Fentanyl is a controlled substance used to treat moderate to severe pain.)<br><br>Review of Resident #3's physician's order dated 04/17/23 revealed an order for Fentanyl 25mcg/hr patch, place 1 patch on the skin every third day.<br><br>Review of Resident #3's prescription from the oncology provider dated 05/02/23 revealed an order for Fentanyl 12mcg/hr patch, place 1 patch | D 358 | | |

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| D 358 | Continued From page 8<br>on the skin every third day.<br><br>Review of a clarification request faxed to Resident #3's oncology provider on 05/02/23 revealed:<br>-The facility staff requested to clarify if the resident was to receive Fentanyl 12mcg/hr patch or Fentanyl 25mcg/hr patch.<br>-The oncology provider signed the clarification on 05/09/23 to discontinue Fentanyl 25mcg/hr patch and to start Fentanyl 12mcg/hr patch, apply 1 patch to skin every 3 days.<br><br>Review of Resident #3's hospital chest scan with contrast dated 05/04/23 revealed:<br>-The resident's history included hypoxia (low levels of oxygen in body tissues) and right lower lobe lung cancer.<br>-There was a new moderate pericardial effusion (a build up of too much fluid in the sac around the heart) along the lateral border of the heart.<br>-There was near complete collapse of the right lung, likely due to the occlusion (blockage) of the right lung airway presumably by the increasing size of the tumor.<br>-The right middle lobe and lower lobe pulmonary arteries were occluded by presumed direct extension of the primary lung tumor.<br><br>Review of Resident #3's hospital discharge summary dated 05/10/23 revealed:<br>-The resident's discharge diagnoses included squamous cell lung cancer, hypoxia, pericardial effusion, fever, and hypotension (low blood pressure).<br>-The resident was admitted on 05/04/23 with chief complaint of weakness, fever, and low blood pressure.<br>-The resident's chest scan was significant for near complete collapse of the lunch likely due to | D 358 | | |

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| D 358 | Continued From page 9<br>occlusion of the right lung airway presumably by increasing size of tumor.<br>-There was an order to continue Fentanyl 12mcg/hr patch apply 1 patch to skin every 3 days.<br><br>Review of Resident #3's March 2023 medication administration record (MAR) revealed:<br>-There was a handwritten entry for Fentanyl 12mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm.<br>-The blocks on the MAR were highlighted every 4th day with the blocks in between marked out with an "X".<br>-The first dose was documented as administered on 03/20/23.<br>-The next dose was documented as administered 4 days later on 03/24/23, instead of every 3 days.<br>-The last dose documented in March 2023 was 4 days later on 03/28/23, instead of every 3 days.<br>-There was a total of 3 Fentanyl 12mcg/hr patches documented as administered in March 2023.<br><br>Review of Resident #3's controlled substance (CS) count sheets for Fentanyl revealed there was no CS count sheet available for any doses administered in March 2023.<br><br>Review of Resident #3's April 2023 MAR revealed:<br>-There was an entry for Fentanyl 12mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm.<br>-The blocks on the MAR were highlighted every 4th day with the blocks in between marked out with an "X".<br>-The first dose was documented as administered on 04/01/23, 4 days after the dose administered on 03/28/23, instead of every 3 days. | D 358 | Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and will continue to be oriented monthly on the policies and procedures and documentation for the next 6 months until satisfactory improvement is shown.<br><br>All Med Aide received hand copies for theirs reference guide. Training Should be completed byDec.15,2023.<br><br>RCC and Administrator daily and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | Training to be completed by Dec. 15,2023 |

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| D 358 | Continued From page 10<br>-Fentanyl 12mcg/hr patch was documented on 04/05/23 and 04/09/23, 4 days apart instead of 3 days apart.<br>-The next dose was documented as administered 5 days later on 04/14/23, instead of 3 days.<br>-Fentanyl 12mcg/hr patch was documented as administered on 0417/21, 04/21/23, 04/25/23, and 04/29/23, all 4 days apart instead of every 3 days.<br>-There was a total of 8 Fentanyl 12mcg/hr patches documented as administered in April 2023.<br>-There was no entry for Fentanyl 25mcg/hr patch and none documented as administered.<br><br>Review of Resident #3's CS count sheets for Fentanyl 12mcg/hr patch dated 04/12/23 revealed:<br>-There were 2 CS count sheets dated 04/12/23.<br>-The first sheet had a quantity received of 4 Fentanyl 12mcg/hr patches.<br>-There were 4 patches documented as administered: 04/14/23, 04/17/23, 04/21/23, and 04/26/23, leaving a balance of 0.<br>-The second sheet had a quantity received of 6 Fentanyl 12mcg/hr patches.<br>-None of the 6 patches were documented as administered, leaving a balance of 6 patches.<br>-There was no CS count sheet for Fentanyl patches administered from 04/01/23 - 04/13/23.<br><br>Review of Resident #3's CS count sheets for Fentanyl revealed there was no CS count sheet available for Fentanyl 25mcg/hr.<br><br>Review of Resident #3's May 2023 MAR revealed:<br>-There was a computer printed entry for Fentanyl 25mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm. | D 358 | | |

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| D 358 | Continued From page 11<br>-Staff initialed 05/01/23 and 05/03/23 as administered.<br>-Staff initials were circled on 05/02/23 with no reason documented.<br>-Staff initials were circled on 05/04/23 due to the resident being out of the facility (in hospital from 05/04/23 - 05/10/23).<br>-There was a handwritten note indicating the order changed on 05/10/23.<br>-There was a handwritten entry for Fentanyl 12mcg/hr patch, apply 1 patch to dry, clean skin once every 3 days.<br>-There was a handwritten note that the hospital put on Fentanyl patch on 05/09/23.<br>-There was a dot on the MAR marking doses due every 3 days starting on 05/12/23.<br>-Documentation for 05/12/23 was blank with no reason noted.<br>-Fentanyl 12mcg/hr was documented as administered on 05/15/23 and again 10 days later on 05/25/23.<br>-There other doses due every 3 days were blank with no reason for the omissions.<br>-Documentation at 8:00pm on 05/11/23, 05/12/23, 05/15/23, and 05/17/23 - 05/19/23 were blank with no reasons documented.<br><br>Review of Resident #3's CS count sheet for Fentanyl 12mcg/hr patch dated 03/17/23 revealed:<br>-The quantity received was documented as 6 Fentanyl 12mcg/hr patches.<br>-There were 6 patches documented as administered: 05/03/23, 05/15/23, 05/19/23, 05/25/23, 05/31/23, and 06/04/23, leaving a balance of 0.<br><br>Review of Resident #3's June 2023 MAR revealed:<br>-There was a computer printed entry for Fentanyl | D 358 | Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and will continue to be oriented monthly on the policies and procedures and documentation for the next 6 months until satisfactory improvement is shown.<br><br>All Med Aide received hand copies for theirs reference guide. Training Should be completed byDec.15,2023.<br><br>RCC and Administrator daily and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | Training to be completed by Dec. 15,2023 |

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| D 358 | Continued From page 12<br>12mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm.<br>-Fentanyl 12mcg/hr patch was documented as administered on 06/04/23, 10 days after the last documented dose on 05/25/23.<br>-Fentanyl 12mcg/hr patch was documented as administered on 06/07/23 and 06/09/23, only 2 days apart.<br>-The last dose was documented as administered on 06/12/23, with the next dose to be administered highlighted as 06/16/23, 4 days later.<br><br>Review of Resident #3's CS count sheet for Fentanyl 12mcg/hr patch dated 05/02/23 revealed:<br>-There were 2 CS count sheets dated 05/02/23.<br>-The first sheet had a quantity received of 6 Fentanyl 12mcg/hr patches.<br>-There were 2 patches documented as administered: 06/09/23 and 06/12/23, leaving a balance of 4 patches.<br>-The second sheet had a quantity received of 4 Fentanyl 12mcg/hr patches.<br>-None of the 4 patches were documented as administered, leaving a balance of 4 patches.<br><br>Review of Resident #3's medications on hand on 06/15/23 at 9:08am and 9:56am revealed:<br>-There was a supply of Fentanyl 12mcg/hr patches dispensed on 04/12/23 with 6 patches remaining.<br>-There was a supply of Fentanyl 12mcg/hr patches dispensed on 05/02/23 with 8 patches remaining.<br>-There was a total supply of 14 Fentanyl 12mcg/hr patches remaining.<br>-There was no Fentanyl 25mcg/hr patches on hand. | D 358 | | |

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| D 358 | Continued From page 13<br>Review of the facility's pharmacy return sheets revealed 10 of 10 Fentanyl 25mcg/hr patches dispensed on 04/17/23 were returned to the pharmacy on 05/09/23.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-She was aware Fentanyl patch was supposed to be applied every 3 days.<br>-She had tried to tell the Administrator and the Resident Care Coordinator (RCC) that it was not set up correctly on the MARs (could not recall when).<br>-She administered the Fentanyl patch according to the marked off blocks on the MAR.<br>-She could tell when Resident #3 was in pain because the resident would try not to move.<br>-If the resident moved, the resident would "holler out" in pain.<br><br>Interview with the Administrator on 06/14/23 at 4:38pm revealed:<br>-The RCC usually marked the MARs and transcribed the orders on the MARs.<br>-The RCC usually checked the MARs for accuracy a couple of days before the new month started.<br>-The RCC did daily checks on the MARs for accuracy.<br>-If the RCC did not check the MARs, then she usually checked the MARs.<br>-She checked for holes (omissions), prn documentation, and to make sure orders were marked off correctly.<br>-She did not realize Resident #3's Fentanyl ordered every 3 days was set up for every 4 days or longer in some cases.<br>-The MAR should have been marked for every third day.<br>-She had not noticed the Fentanyl was marked | D 358 | Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and will continue to be oriented monthly on the policies and procedures and documentation for the next 6 months until satisfactory improvement is shown.<br><br>All Med Aide received hand copies for theirs reference guide. Training Should be completed byDec.15,2023.<br><br>RCC and Administrator daily and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | Training be completed byDec.15,2023 |

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| D 358 | Continued From page 14<br>incorrectly and she also administered the Fentanyl patch and had not noticed it.<br><br>Attempted telephone interview with the RCC on 06/15/23 at 10:00am was unsuccessful.<br><br>Interview with Resident #3 on 06/14/23 at 4:35pm revealed:<br>-She had pain sometimes as high as 10 on a scale of 1 - 10 (with 10 being the most severe pain).<br>-The pain was usually in her mid-back area.<br>-Staff applied a pain patch to her skin but she was not sure how often it was changed.<br>-She did not answer when asked if she was currently in pain.<br><br>Telephone interview with a registered nurse (RN) at Resident #3's oncology provider's office on 06/16/23 at 12:42pm revealed:<br>-There was no reason why Resident #3 should not have received the Fentanyl patch every 3 days.<br>-Resident #3 had terminal lung cancer and needed the Fentanyl patch applied every 3 days to help control her pain.<br>-Applying the Fentanyl patch more than every 3 days would cause the effects of the pain medication to wear off and lead to uncontrolled pain.<br>-Resident #3 usually complained of right sided back pain.<br><br>b. Review of Resident #3's oncology provider visit notes dated 06/01/23 revealed:<br>-The resident had advanced lung cancer.<br>-There was a referral to hospice.<br><br>Review of Resident #3's hospice provider visit orders dated 06/12/23 revealed: | D 358 | | |

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| D 358 | Continued From page 15<br>-Staff reported the resident was starting to have a hard time swallowing crushed medications in applesauce or pudding.<br>-The hospice provider ordered comfort medications.<br>-There was an order for Morphine Concentrate 0.25ml prefilled syringes every 4 hours as needed (prn) for pain or shortness of breath. (Morphine Concentrate is a controlled substance used for moderate to severe pain.)<br><br>Review of Resident #3's June 2023 medication administration record (MAR) on 06/14/23 revealed:<br>-There was a handwritten entry for Morphine Concentrate 0.25ml prefilled syringes, take 1 syringe by mouth every 4 hours prn for pain / shortness of breath.<br>-There was an arrow drawn to the block dated 05/13/23.<br>-No Morphine was documented as administered.<br><br>Interview with Resident #3 on 06/14/23 at 4:35pm revealed:<br>-She had pain sometimes as high as 10 on a scale of 1 - 10 (with 10 being the most severe pain).<br>-The pain was usually in her mid-back area.<br>-Staff applied a pain patch to her skin but she was not sure how often.<br>-She was not sure if she received any other medications for pain.<br>-She did not answer when asked if she was currently in pain.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-There was no Morphine Concentrate on hand for Resident #3.<br>-The MAs could order medications but she | D 358 | | |

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| D 358 | Continued From page 16<br>usually told the Resident Care Coordinator (RCC).<br>-They sometimes received the medication within 24 hours of sending the order to the pharmacy and sometimes they received the medication the same night.<br>-She had let the RCC know that Resident #3's Morphine Concentrate was not available at the facility (could not recall when).<br>-She could tell when Resident #3 was in pain because the resident would try not to move.<br>-If the resident moved, the resident would "holler out" in pain.<br>-If the resident asked for anything for pain, she would administer prn Tramadol because that was what she had on hand.<br>-If the Tramadol did not help with the pain, she would administer Morphine Concentrate if she had any available.<br><br>Attempted telephone interview with the RCC on 06/15/23 at 10:00am was unsuccessful.<br><br>Interview with the Administrator on 06/14/23 at 4:38pm revealed:<br>-The facility had not received Resident #3's Morphine Concentrate yet and she was not sure why.<br>-She would contact the pharmacy to find out why the order dated 06/12/23 for Morphine Concentrate had not been dispensed and sent to the facility.<br><br>Second interview with the Administrator on 06/14/23 at 5:31pm revealed:<br>-She contacted the pharmacy today, 06/14/23, and there was a delay in dispensing the Morphine because there was no quantity to dispense included.<br>-She just notified the hospice provider about the | D 358 | | |

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| D 358 | Continued From page 17<br>Morphine Concentrate.<br>-The Morphine Concentrate should be delivered to the facility tonight.<br><br>Review of Resident #3's medications on hand on 06/15/23 at 9:08am and 9:56am revealed:<br>-There was a supply of Morphine Concentrate 100mg/5ml prefilled syringes dispensed on 06/14/23 with 84 prefilled syringes containing 0.25ml each (total of 21ml).<br>-There were 2 plastic bags containing the supply of Morphine Concentrate prefilled syringes.<br>-Bag 1 of 2 contained 32 of 33 Morphine Concentrate prefilled syringes.<br>-Bag 2 of 2 contained 51 of 51 Morphine Concentrate prefilled syringes.<br><br>Review of Resident #3's controlled substance (CS) count sheet for Morphine Concentrate prefilled syringes dated 06/14/23 revealed the first and only dose of Morphine Concentrate was documented as administered on 06/15/23 at 9:15am.<br><br>Observation of Resident #3 on 06/15/23 at 11:55am revealed:<br>-The resident was lying in bed and appeared sleepy as she was closing her eyes frequently.<br>-Her voice was weak and low when she spoke.<br><br>Interview with Resident #3 on 06/15/23 at 11:55am revealed:<br>-When asked if she was in pain, the resident stated she did not know.<br>-She did not know if she had received any Morphine Concentrate that morning.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/15/23 at 11:04am revealed: | D 358 | Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and will continue to be oriented monthly on the policies and procedures and documentation for the next 6 months until satisfactory improvement is shown.<br><br>All Med Aide received hand copies for theirs reference guide. Training Should be completed byDec.15,2023.<br><br>RCC and Administrator daily and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | Training to be completed by Dec. 15,2023 |

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| D 358 | Continued From page 18<br>-The pharmacy received the order for Morphine on 06/12/23 but they had to get clarification on the quantity to be dispensed.<br>-She was not sure if the facility contacted the pharmacy regarding the Morphine and the pharmacist who processed the prescription was not available.<br><br>Telephone interview with Resident #3's hospice nurse on 06/15/23 at 10:30am revealed:<br>-The order for Morphine Concentrate was written during her visit with the resident on Monday, 06/12/23.<br>-The resident was actively declining so hospice comfort medications, including the Morphine Concentrate, were ordered.<br>-The resident also had active orders for Fentanyl patch and Tramadol as needed (prn).<br>-The Morphine Concentrate was to be used for pain and shortness of breath.<br>-She gave a handwritten order to the facility and entered it into her electronic data.<br>-The hospice provider then reviewed the information and sent an electronic prescription (e-script) to the pharmacy.<br>-She had no way of knowing when the e-script was sent to the pharmacy.<br>-The facility staff knew to call hospice if a resident was in pain because she had told them to.<br>-If the hospice provider had known the resident was in pain, they could have assessed the pain and made sure the Morphine Concentrate was available.<br>-The orders for the comfort medications, including Morphine Concentrate, were there to make sure they were available if a resident needed them.<br>-She was not aware the resident was having pain that Fentanyl and Tramadol were not relieving.<br>-Morphine Concentrate could help relieve any | D 358 | | |

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| D 358 | Continued From page 19<br>breakthrough pain not relieved by the Fentanyl patches and Tramadol.<br><br>c. Review of Resident #3's hospital discharge summary dated 05/10/23 revealed:<br>-The resident's discharge diagnoses included squamous cell lung cancer, hypoxia (low levels of oxygen in the body), pericardial effusion (build up of too much fluid in the sac around the heart), fever, and hypotension (low blood pressure).<br>-The resident was admitted on 05/04/23 with chief complaint of weakness, fever, and low blood pressure.<br>-The resident's chest scan was significant for near complete collapse of the lunch likely due to occlusion of the right lung airway presumably by increasing size of tumor.<br><br>Review of Resident #3's oncology provider visit notes dated 06/01/23 revealed:<br>-The resident had advanced lung cancer.<br>-There was a referral to hospice.<br>-There was an order for Hydromorphone 1mg every 3 hours as needed for pain. (Hydromorphone is a controlled substance used to treat moderate to severe pain.)<br>-There was a printed prescription dated 06/01/23 for the Hydromorphone signed by the oncology provider attached to the visit notes.<br><br>Review of Resident #3's hospice provider visit orders dated 06/12/23 revealed:<br>-Staff reported the resident was starting to have a hard time swallowing crushed medications in applesauce or pudding.<br>-The hospice provider ordered comfort medications.<br>-There was an order to discontinue Hydromorphone and start Morphine Concentrate 0.25ml prefilled syringes every 4 hours as needed | D 358 | Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and will continue to be oriented monthly on the policies and procedures and documentation for the next 6 months until satisfactory improvement is shown.<br><br>All Med Aide received hand copies for theirs reference guide. Training Should be completed byDec.15,2023.<br><br>RCC and Administrator daily and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | Training to be completed by Dec. 15,2023 |

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| D 358 | Continued From page 20<br>for pain or shortness of breath. (Morphine Concentrate is a controlled substance used for moderate to severe pain.)<br><br>Review of Resident #3's June 2023 medication administration record (MAR) revealed:<br>-There was a handwritten entry for Hydromorphone 1mg/ml liquid take by mouth every 3 hours as needed with the date 06/01/23 written below the entry.<br>-There was no Hydromorphone documented as administered.<br>-There was a handwritten note the order was discontinued on 06/12/23.<br><br>Review of Resident #3's medications on hand on 06/15/23 at 9:08am and 9:56am revealed there was no Hydromorphone available.<br><br>Review of Resident #3's controlled substance (CS) count sheets revealed there was no CS count sheet for Hydromorphone.<br><br>Review of the facility's pharmacy return sheets revealed no Hydromorphone had been returned to the pharmacy.<br><br>Review of the facility's June 2023 pharmacy delivery and dispensing records revealed no Hydromorphone had been dispensed for Resident #3.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/15/23 at 11:04am revealed the pharmacy did not have an order for Hydromorphone and never dispensed any for Resident #3.<br><br>Interview with Resident #3 on 06/14/23 at 4:35pm revealed: | D 358 | | |

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| D 358 | Continued From page 21<br>-She had pain sometimes as high as 10 on a scale of 1 - 10 (with 10 being the most severe pain).<br>-The pain was usually in her mid-back area.<br>-Staff applied a pain patch to her skin but she was not sure how often it was changed.<br>-She was not sure if she received any other medications for pain.<br>-She did not answer when asked if she was currently in pain.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-The MAs could order medications but she usually told the Resident Care Coordinator (RCC).<br>-They sometimes received the medication within 24 hours of sending the order to the pharmacy and sometimes they received the medication the same night.<br>-She did not recall Resident #3 ever having any Hydromorphone for pain.<br>-She could tell when Resident #3 was in pain because the resident would try not to move.<br>-If the resident moved, the resident would "holler out" in pain.<br>-If the resident asked for anything for pain, she would administer prn Tramadol (used to treat mild to moderate pain) because that was what she had on hand.<br><br>Interview with the Administrator on 06/14/23 at 4:38pm revealed:<br>-She did not know why Resident #3's Hydromorphone was never sent to the facility.<br>-The order was in the resident's record.<br>-The RCC usually processed new orders.<br><br>Attempted telephone interview with the RCC on 06/15/23 at 10:00am was unsuccessful. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 358 | Continued From page 22<br><br>Telephone interview with a registered nurse (RN) at Resident #3's oncology provider's office on 06/16/23 at 12:42pm revealed:<br>-Resident #3 had terminal lung cancer and usually complained of right sided back pain.<br>-The oncology provider ordered Hydromorphone due to the resident's poorly controlled pain.<br>-"That's horrible" that Hydromorphone was not available if the resident needed it to help control her pain.<br>-A "hard" copy prescription for the Hydromorphone was signed on 06/01/23 and given to the resident at the appointment.<br><br>d. Review of Resident #3's hospital discharge summary dated 05/10/23 revealed:<br>-The resident's discharge diagnoses included squamous cell lung cancer, hypoxia (low levels of oxygen in the body), pericardial effusion (build up of too much fluid in the sac around the heart), fever, and hypotension (low blood pressure).<br>-The resident was admitted on 05/04/23 with chief complaint of weakness, fever, and low blood pressure.<br>-The resident had anemia and a chest scan was significant for near complete collapse of the lunch likely due to occlusion of the right lung airway presumably by increasing size of tumor.<br>-The resident's sputum culture came back and had Methicillin-resistant Staphylococcus aureus (MRSA). (MRSA is bacteria that causes difficult-to-treat infections.)<br>-There was an order to take Doxycycline 100mg 1 capsule 2 times a day for 10 days. (Doxycycline is an antibiotic used to treat infections.)<br>-The start date was listed at 05/10/23 with an end date of 05/20/23.<br><br>Review of Resident #3's May 2023 medication | D 358 | | |

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| D 358 | Continued From page 23<br><br>administration record (MAR) revealed:<br>-There was a handwritten entry for Doxycycline 100mg take 1 capsule twice a day for 10 days scheduled for 8:00am and 8:00pm.<br>-There was an arrow drawn to start the first dose at 8:00am on 05/11/23.<br>-Staff circled initials at 8:00am on 05/11/23 and 05/12/23 with no reason documented.<br>-Documentation at 8:00pm on 05/11/23, 05/12/23, 05/15/23, and 05/17/23 - 05/19/23 were blank with no reasons documented.<br>-The first documented dose of Doxycycline being administered was 05/13/23 at 8:00am, 3 days after it was ordered to be administered.<br>-There were 18 doses of Doxycycline 100mg capsules documented as administered from 05/13/23 - 05/23/23.<br><br>Review of Resident #3's medications on hand on 06/15/23 at 9:08am and 9:56am revealed there was no Doxycycline available in the medication cart.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/15/23 at 11:04am revealed the pharmacy never received the order dated 05/10/23 for Doxycycline and never dispensed any Doxycycline for Resident #3.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-She thought Resident #3's Doxycycline was delayed in starting because it was not available in the facility to administer.<br>-She administered the Doxycycline once it was received.<br>-She thought the Doxycycline was dispensed by the hospital pharmacy but she was not sure.<br>-She was not sure why all doses of the | D 358 | | |

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| D 358 | Continued From page 24<br><br>Doxycycline were not documented as administered.<br>-The Resident Care Coordinator (RCC) usually processed new medication orders.<br><br>Attempted telephone interview with the RCC on 06/15/23 at 10:00am was unsuccessful.<br><br>Interview with the Administrator on 06/14/23 at 4:38pm revealed:<br>-Resident #3's Doxycycline should have been dispensed when it was ordered on 05/10/23 and the entire dose should have been administered.<br>-Sometimes it could take the facility 1 to 2 days to get medications after they had faxed the orders to the pharmacy and she did not know why.<br>-The facility supposedly had a back-up pharmacy but it was not used because if an order was sent electronically to the facility's contracted pharmacy after hours, the prescription could not be accessed by the back-up pharmacy to fill the prescription.<br><br>Telephone interview with a registered nurse (RN) at Resident #3's oncology provider's office on 06/16/23 at 12:42pm revealed the delay in starting the resident Doxycycline and not getting the full dose could have resulted in a worsening infection for the resident.<br><br>Telephone interview with Resident #3's primary care provider (PCP) on 06/15/23 at 11:01am revealed:<br>-The Doxycycline should have been started when the medication was ordered.<br>-A delay in starting the antibiotic and not getting the full dosage could have made the resident's infection worse.<br><br>2. Review of Resident #1's current FL-2 dated | D 358 | | |

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| D 358 | Continued From page 25<br><br>05/10/23 revealed diagnoses included chronic obstructive pulmonary disease, schizoaffective disorder bipolar, hypertension, vitamin B12 deficiency, and vitamin D deficiency.<br><br>a. Review of a physician's order for Resident #1 dated 10/18/22 revealed an order for Divalproex DR (used to psychiatric disorders and seizure disorders) 500mg tablet every 12 hours.<br><br>Review of Resident #1's March 2023 medication administration records (MARs) revealed:<br>-There was a printed entry for Divalproex Sod DR 500mg tablet two times a day and scheduled at 8:00am and 8:00pm.<br>-There were circled initials on the MAR for 03/25/23 through 03/28/23 at 8:00am and 8:00pm.<br>-There was documentation in the medication notes on the back of the MARs that Resident #1's Divalproex was not administered on 03/25/23 at 8:00am, 03/27/23, 03/28/23 at 8:00am and 8:00pm due to resident refusals.<br>-There was no documentation that provided a reason for the Divalproex not administered at the scheduled times for 03/25/23 at 8:00pm through 03/28/23 at 8:00pm.<br><br>Review of a local hospital emergency department encounter dated 03/28/23 revealed:<br>-Resident #1 was brought to the hospital by the police department:<br>-The resident was reported by facility staff to have behaviors of aggression, intimidation, and not taking her medications.<br>-Resident #1 was discharged from the local hospital on 03/30/23 to an inpatient psychiatric facility.<br><br>Interview with a Medication Aide (MA) on | D 358 | | |

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| D 358 | Continued From page 26<br><br>06/14/23 at 3:35pm revealed:<br>-Resident #1 usually did not refuse medications.<br>-If Resident #1 was not administered prescribed psychiatric medications, there would be "a problem".<br>-The resident would fuss and curse.<br>-Depakote helped Resident #1 to be "normal".<br>-"Normal" meant nice and the resident talked to staff.<br>-She remembered a weekend when Resident #1 would not take her medications but did not remember the date of the occurrence. The resident had to be sent to the hospital.<br><br>Interview with a second MA on 06/15/23 at 9:15am revealed:<br>-Resident #1 had been in the hospital.<br>-Resident #1 usually had a hospitalization when her psychiatric medications were not available to be administered.<br>-Resident #1's medication refusals were "not a lot".<br>-Resident #1 "acts out" when her medications were not available.<br>-There had been a 4 to 7 day timespan for ordered medications to be received at the facility.<br>-The MA documented a reason on the resident's MAR of either medication refused, on order, or unavailable when the medication was not administered to the resident.<br>-The MA notified the Administrator and RCC when Resident #1's medication was unavailable for administration.<br>-The MA was instructed to write on a piece of paper those medications needed and the RCC or Administrator would fax the request to the contracted pharmacy provider.<br>-The RCC or Administrator ordered medication from the pharmacy until about four weeks ago when the MAs were informed by the Administrator | D 358 | | |

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| D 358 | Continued From page 27<br>that the MAs could order medications from the contracted provider pharmacy or backup pharmacy.<br><br>b. Review of a physician's prescription order for Resident #1 dated 04/12/23 revealed:<br>-There was an order for Oxcarbazepine (a seizure medication used to treat bipolar disorder) 150mg tablet twice daily.<br>-There was an unsigned printed handwritten note that read "received order on 4-25-23 but still waiting for clarification to come back".<br><br>Review of a hospital discharge medication summary for Resident #1 dated 04/12/23 revealed:<br>-Oxcarbazepine 150mg tablet twice daily was listed as a medication for Resident #1.<br>-The entry for the Oxcarbazepine 150mg tablet twice daily was circled.<br>-There was an unsigned handwritten entry that read "we do not have in house".<br><br>Review of Resident #1's April 2023 medication administration records (MARs) revealed:<br>-There was a printed entry for Oxcarbazepine 150mg take one tablet twice daily for mood and scheduled at 8:00am and 8:00pm.<br>-There were circled initials on the MAR for 04/26/23 and 04/27/23 at 8:00am, and 04/26/23 at 8:00pm.<br>-There was documentation of administration beginning on 04/27/23 at 8:00pm through 04/29/23 at 8:00pm.<br>-There was no documentation of administration for 04/30/23 scheduled doses at 8:00am and 8:00pm.<br><br>Review of medication notes documented on the back of the Resident #1's April 2023 MARs | D 358 | | |

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| D 358 | Continued From page 28<br>revealed:<br>-On 04/26/23, the MA documented "Oxcarbazepine 150mg - has been order[ed] - not given".<br>-On 04/26/23 at 8:00pm, the MA documented "Oxcarbazepine 150mg on back order with pharmacy, not given".<br>-On 04/28/23 at 8:00pm, the MA documented "Oxcarbazepine 150mg on back order with pharmacy, not given".<br><br>Interview with a Medication Aide (MA) on 06/14/23 at 3:35pm revealed:<br>-Resident #1 usually did not refuse medications.<br>-If Resident #1 was not administered prescribed psychiatric medications, there would be "a problem".<br>-The resident would fuss and curse.<br>-She remembered a weekend when Resident #1 would not take her medications but did not remember the date of the occurrence. The resident had to be sent to the hospital.<br>-Medications were reordered when the amount of medication on hand was in the last row on the medication package.<br>-The Resident Care Coordinator (RCC) was responsible for reordering medications prior to a week ago when the MA's were given permission to reorder medications from the contracted pharmacy provider.<br>-The RCC was responsible for transcribing new orders to the MARs.<br>-Resident #1 was prescribed Trileptal (brand name for Oxcarbazepine used to treat mood disorders).<br>-She did not think the Oxcarbazepine was available for administration when Resident #1 was sent out to the hospital in May 2023.<br>-She administered medications based on what was transcribed to the MARs. | D 358 | | |

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| D 358 | Continued From page 29<br><br>Interview with the Administrator on 06/14/23 at 4:50pm revealed:<br>-Medications ordered from the contracted provider pharmacy were received at the facility in 1 - 2 days sometimes.<br>-Physician orders were e-scripted to the contracted provider pharmacy.<br>-The facility usually did not get a copy of the prescription.<br>-Medication could not be ordered from the backup pharmacy provider without a prescription.<br><br>Interview with a second MA on 06/15/23 at 9:15am revealed:<br>-Resident #1 had been in the hospital.<br>-Resident #1 usually had a hospitalization when her psychiatric medications were not available to be administered.<br>-Resident #1's medication refusals were "not a lot".<br>-Resident #1 "acts out" when her medications are not available.<br>-There had been a 4 to 7 day timespan for ordered medications to be received at the facility.<br>-The MA documented a reason on the resident's MAR of either medication refused, on order, or unavailable when the medication was not administered to the resident.<br>-The MA notified the Administrator and RCC when Resident #1's medication was unavailable for administration.<br>-The MA was instructed to write on a piece of paper those medications needed and the RCC or Administrator would fax the request to the contracted pharmacy provider.<br>-The RCC or Administrator ordered medication from the pharmacy until about four weeks ago when the MAs were informed by the Administrator that the MAs could order medications from the | D 358 | | |

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| D 358 | Continued From page 30<br>contracted provider pharmacy or backup pharmacy.<br><br>Attempted interview with the RCC on 06/15/23 at 9:59am was unsuccessful.<br><br>Interview with the Administrator on 06/15/23 at 10:35am revealed:<br>-The facility was having a hard time getting the Oxcarbazepine from the pharmacy.<br>-The pharmacy was waiting for a clarification from the prescribing physician because the pharmacy did not think Resident #1 needed to be on Depakote (used to treat behaviors and control seizure activity) and Oxcarbazepine.<br>-When Resident #1 returned to the facility on 04/12/23 from an inpatient behavioral hospital, the resident was prescribed the Oxcarbazepine.<br>-Resident #1 was not being administered the Depakote or Oxcarbazepine from 04/12/23 to 04/28/23 because the discharge instructions were to discontinue the Depakote.<br>-The Oxcarbazepine was requested from the contracted provider pharmacy by the RCC on the date Resident #1 returned to the facility.<br>-The Oxcarbazepine was finally received on 04/25/23 and started on 04/28/23.<br>-She expected resident medications to be received at the facility on the same day as the prescription is faxed to the pharmacy.<br>-If the resident's medication was not in the facility, she expected the backup pharmacy to be used.<br>-Staff could not use the backup pharmacy when the facility did not have the prescription because the prescriptions were e-scripted to the contracted provider pharmacy.<br><br>Telephone interview with a pharmacy technician at the contracted provider pharmacy on 06/15/23 at 11:04am revealed: | D 358 | | |

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| D 358 | Continued From page 31<br>-The pharmacy received a prescription for Oxcarbazepine 150mg tablet twice daily for Resident #1 on 04/12/23.<br>-The pharmacy filled the prescription for Oxcarbazepine 150mg tablet twice daily on 04/27/23 after receiving a clarification for the Oxcarbazepine from the provider.<br>-The pharmacy took the responsibility for obtaining the clarification order from the provider when needed and notified the facility that waiting on clarification from the provider.<br><br>Telephone interview with the pharmacist at the contracted pharmacy provider on 06/15/23 at 11:58am revealed:<br>-The pharmacy had not received a physician's order to discontinue Depakote and was not aware Resident #1 was not being administered the Depakote while waiting for the clarification for the Oxcarbazepine from the provider.<br>-Resident #1 could experience extreme mood changes, aggression, and acting different if the resident was not administered medications as ordered for mood.<br><br>Telephone interview with the prescribing psychiatric provider on 06/15/23 at 3:40pm revealed:<br>-She did not know why Resident #1 was not administered the Oxcarbazepine as ordered after a recent psychiatric hospitalization from 03/30/23 - 04/12/23.<br>-The Oxcarbazepine was supposed to replace the Depakote.<br>-The Oxcarbazepine was initiated while Resident #1 was hospitalized.<br>-If the resident was not being administered medication as ordered, there was concern for a return of the agitation. | D 358 | | |

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| D 358 | Continued From page 32<br>Resident #1 was not available for interview due to a current hospitalization.<br><br>Interview with the Administrator on 06/14/23 at 9:21am revealed:<br>-Resident #1 was hospitalized about one week ago.<br>-Resident #1 was "acting out, beating on staff cars, coming up in your face, cursing".<br>-This was "probably her fifth time being sent out".<br><br>Review of hospital discharge information for Resident #1 revealed:<br>-Resident #1 was admitted to the local hospital behavioral unit on an involuntary basis on 05/15/23 - 05/30/23 for behavioral management and medication non-compliance.<br>-Resident #1 was seen at a local hospital emergency department on 06/05/23 on an involuntary basis with worsening paranoia, agitation, aggression, and poor medication adherence.<br>-Resident #1 was admitted to the local hospital behavioral unit through the emergency department on 06/19/23 due to combative behavior.<br><br>3. Review of Resident #2's current FL-2 dated 01/31/23 revealed:<br>-Diagnoses included major vascular neurodegenerative intracerebral hemorrhage, asthma, gastroesophageal reflux disease (GERD), and history of substance abuse.<br>-There was an order for DocQLace 100mg twice daily (DocQLace is used to treat constipation).<br><br>Review of Resident #2's April 2023 medication administration record (MAR) revealed:<br>-There was an entry for DocQLace 100mg, give one capsule twice daily, scheduled for | D 358 | | |

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| D 358 | Continued From page 33<br>administration at 8:00am and 8:00pm.<br>-Staff had initialed and circled the entries from 04/21/23 to 04/24/23 at 8:00am.<br>-Staff had initialed and circled the entries from 04/21/23 to 04/23/23 at 8:00pm.<br>-There was documentation on the back of the MAR the medication was "on order" and "not given" for entries 04/21/23, 04/22/23, and 04/23/23 at 8:00am.<br>-There was no documentation on the back of the MAR for the 8:00pm doses.<br><br>Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.<br><br>Interview with a medication aide (MA) on 06/14/23 at 1:12pm revealed:<br>-She administered medications to Resident #2.<br>-She put her initials beside each medication entry when she administered the medication.<br>-If a medication was not administered, the reason should be documented on the back of the MAR.<br>-Resident #2 was not administered the DocQLace from 04/21/23 to 04/24/23 because the medication was not in the facility.<br>-She let the Resident Care Coordinator (RCC) or Administrator know when a medication needed to be refilled.<br>-She did not know why the pharmacy had not delivered the medication.<br>-She could not remember if Resident #2 complained of any stomach issues during that time.<br><br>Interview with Administrator on 06/14/23 at 2:55pm revealed:<br>-She was aware Resident #2 had not been administered DocQLace from 04/21/23 to 04/24/23. | D 358 | | |

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| D 358 | Continued From page 34<br>-She sent a refill request to the pharmacy but it had not been delivered.<br>-She did not remember Resident #2 complaining of any stomach issues during this time.<br><br>The facility failed to administer medications as ordered to 3 of 3 residents sampled. Resident #3 who had terminal lung cancer was administered a Fentanyl pain patch too far apart on multiple occasions resulting in breakthrough pain and pain described by the resident as high as 10 on a scale of 0 to 10 with 10 being the highest pain level. Resident #3's order for Hydromorphone, a prn pain medication was never implemented and there was a delay in implementing a prn order for Morphine Concentrate, again resulting in breakthrough pain for the resident. Resident #1 missed multiple doses of a medication for mood disorders and behaviors resulting in the resident acting out and requiring inpatient psychiatric hospitalization. This failure of the facility to administer medications as ordered resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/14/23 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 15, 2023. | D 358 | Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and will continue to be oriented monthly on the policies and procedures and documentation for the next 6 months until satisfactory improvement is shown.<br><br>All Med Aide received hand copies for theirs reference guide. Training Should be completed byDec.15,2023.<br><br>RCC and Administrator daily and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | Training to be. completed by Dec. 15,2023 |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the | D 367 | | |

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| D 367 | Continued From page 35<br>following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(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).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 3 sampled residents (#1, #2, #3) including inaccurate documentation for medications for mood disorders and schizophrenia (#1), a topical medication for inflammatory skin conditions (#2), a medication for cough and a vitamin supplement for Vitamin D deficiency (#3).<br><br>The findings are:<br><br>Review of the facility's undated Instructions for Medication Aides (MAs) form maintained in the medication administration record (MAR) notebook revealed:<br>-Check your holes (omissions) daily.<br>-Make sure all documentation was done daily. | D 367 | All Charts audits have been done; All Cart audit has been done by Pharmacy<br><br>Tracking system has been put in place to follow daily to assure that all orders, lab, referral, treatment, and that all medications are in the facility by following the tracking system book that was put in place.<br><br>This is monitored daily by Med Aide, RCC and Administrator monitoring three times a week.<br><br>Med Aide had a retraining class on documentation and following Physician orders, and on Medication Administration Policies and Procedures and continue with ongoing training.<br><br>All Med Aide received hand copies of the tracking system for theirs reference guide, copies placed in the MAR's book for reference too.<br><br>RCC monitor daily and Administrator monitor three times a week and LHPS Nurse (RN) and Pharmacy will monitor on a monthly basis.<br><br>Training date has already established are; June 13,2023, next scheduled is for June 23 and July 12, & 13,2023 along with the Med Aide 15 hours Training | completed 06/28/2023<br><br>completed 06/30/2023<br><br>training completed 06/13/2023 and 06/23/2023 for retraining<br><br>completed 06/30/2023 |

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| D 367 | Continued From page 36<br>-Please initial and date all medication cards upon administration of medication.<br><br>1. Review of Resident #3's current FL-2 dated 05/23/23 revealed diagnoses included history of brain tumor, history of squamous cell carcinoma, chronic pain syndrome, type 2 diabetes, and hypothyroidism.<br><br>a. Review of Resident #3's previous FL-2 dated 05/10/23 revealed an order to continue Benzonatate 100mg 1 capsule 3 times a day as needed (prn) for cough. (Benzonatate is used to treat cough.)<br><br>Review of Resident #3's medication clarification orders dated 05/15/23 revealed an order to continue taking Benzonatate 100mg 1 capsule 3 times a day prn for cough.<br><br>Review of Resident #3's current FL-2 dated 05/23/23 revealed an order for Benzonatate 100mg 3 times a day prn.<br><br>Review of Resident #3's April 2023 medication administration record (MAR) revealed:<br>-There was an entry for Benzonatate 100mg 1 capsule 3 times a day prn for cough.<br>-Benzonatate was documented as administered once daily each day from 04/01/23 - 04/30/23.<br>-The prn documentation for Benzonatate was not documented on the back of the MAR on 8 of 30 days.<br>-There was no documentation of the time of administration, the reason of administration, or the resulting effect of the administration on those 8 occasions.<br><br>Review of Resident #3's May 2023 MAR revealed: | D 367 | | |

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| D 367 | Continued From page 37<br><br>-There was an entry for Benzonatate 100mg 1 capsule 3 times a day prn for cough.<br>-There was one prn dose documented as administered on 05/18/23.<br>-There were no other documented doses of Benzonatate being administered on the May 2023 MAR.<br><br>Review of Resident #3's June 2023 MAR revealed:<br>-There was an entry for Benzonatate 100mg 1 capsule 3 times a day prn for cough.<br>-There was one prn dose documented as administered on 06/06/23.<br>-There were no other documented doses of Benzonatate being administered on the June 2023 MAR.<br><br>Review of Resident #3's medications on hand on 06/15/23 at 9:07 revealed:<br>-There was a supply of Benzonatate 100mg capsules dispensed on 05/01/23 with 20 capsules dispensed in the package.<br>-There were 15 of 20 capsules remaining in the package.<br>-Staff initialed and dated beside the first used bubble on 05/18/23.<br>-The second, fourth and fifth used bubbles were not dated or initialed.<br>-The third used bubble was dated 06/06/23.<br><br>Based on observations and record reviews, there were 3 Benzonatate 100mg capsules used between 05/18/23 and 06/15/23 that were not documented on Resident #3's MARs, rendering the MARs inaccurate.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-Resident #3's prn Benzonatate was administered | D 367 | | |

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| D 367 | Continued From page 38<br>every day in April 2023 because the resident was coughing every day.<br>-Documentation for administration of the prn Benzonatate should be on the back of the MAR each time it was administered.<br>-The MAs were supposed to initial the front of the MARs each time any medication was administered.<br>-She was not sure why prn documentation for Benzonatate was not recorded on the front and back of the MARs each time it was administered.<br><br>Interviews with the Administrator on 06/14/23 at 4:38pm and 06/15/23 at 9:43am revealed:<br>-The MAs were supposed to document on the MAR each time they administered medication.<br>-The prn documentation for Resident #3's Benzonatate should be completed and documented each time on the back of the MARs.<br><br>Attempted telephone interview with the RCC on 06/15/23 at 10:00am was unsuccessful.<br><br>Refer to interview with the Administrator on 06/14/23 at 4:45pm.<br><br>b. Review of Resident #3's previous FL-2 dated 01/17/23 revealed an order for Vitamin D2 1.25mg take 1 tablet once a week. (Vitamin D is a supplement used to treat Vitamin D deficiency.)<br><br>Review of Resident #3's previous FL-2 dated 05/10/23 revealed an order to stop taking Vitamin D2 1.25mg capsule.<br><br>Review of Resident #3's medication clarification orders dated 05/15/23 revealed an order to continue taking Vitamin D2 1.25mg 1 capsule once a week in the morning. | D 367 | | |

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| D 367 | Continued From page 39<br><br>Review of Resident #3's current FL-2 dated 05/23/23 revealed an order for Vitamin D2 1.25mg take 1 tablet once a week.<br><br>Review of Resident #3's March 2023 medication administration record (MAR) revealed:<br>-There was an entry for Vitamin D2 1.25mg (50,000 units) take 1 capsule once a week in the morning scheduled at 8:00am.<br>-Documentation for the administration of Vitamin D2 was highlighted for weekly administration on 03/01/23, 03/08/23, 03/14/23 (should be 03/15/23), 03/22/23, and 03/29/23.<br>-Vitamin D2 was documented as administered daily from 03/01/23 - 03/22/23, instead of weekly as ordered.<br>-There was a horizontal line drawn through staff's initials on the days between the weekly highlighted blocks.<br><br>Review of Resident #3's April 2023 MAR revealed:<br>-There was an entry for Vitamin D2 1.25mg (50,000 units) take 1 capsule once a week in the morning scheduled at 8:00am.<br>-Documentation for the administration of Vitamin D2 was highlighted for weekly administration on 04/05/23, 04/12/23, 04/19/23 and 04/26/23.<br>-Vitamin D2 was documented as administered daily from 04/28/23 - 04/30/23, instead of weekly as ordered.<br>-There was a horizontal line drawn through staff's initials from 04/28/23 - 04/30/23.<br><br>Review of Resident #3's May 2023 MAR revealed:<br>-There was an entry for Vitamin D2 1.25mg (50,000 units) take 1 capsule once a week in the morning scheduled at 8:00am.<br>-Documentation for the administration of Vitamin | D 367 | | |

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| D 367 | Continued From page 40<br>D2 was not highlighted for weekly administration.<br>-Vitamin D2 was documented as administered daily from 05/01/23 - 05/04/23, instead of weekly as ordered.<br>-Vitamin D2 was documented with circled initials from 05/05/23 - 05/10/23 and noted the resident was out of the facility.<br><br>Review of Resident #3's pharmacy dispensing records dated 01/01/23 - 06/15/23 revealed there were 4 capsules of Vitamin D2 1.25mg dispensed on 01/18/23, 02/28/23 04/07/23, 05/01/23, and 05/31/23.<br><br>Interview with Resident #3 on 06/14/23 at 4:35pm revealed she was not sure if she received Vitamin D or how often.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-She administered Vitamin D weekly to Resident #3.<br>-She was unsure why it was documented daily on some occasions.<br>-The MAR documentation was not correct, Vitamin D2 was administered once a week only.<br><br>Interviews with the Administrator on 06/14/23 at 4:38pm and 06/15/23 at 9:43am revealed:<br>-She did not realize Resident #3's Vitamin D was documented incorrectly on the MARs.<br>-They usually received 4 capsules of Vitamin D2 each month so there would not be enough Vitamin D to administer it daily.<br>-Staff marked through the daily initials because they realized it was documented incorrectly.<br><br>Attempted telephone interview with the Resident Care Coordinator (RCC) on 06/15/23 at 10:00am was unsuccessful. | D 367 | | |

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| D 367 | Continued From page 41<br><br>Refer to interview with the Administrator on 06/14/23 at 4:45pm.<br><br>2. Review of Resident #1's current FL-2 dated 05/30/23 revealed diagnoses included chronic obstructive pulmonary disease, schizoaffective disorder bipolar type, hypertension, vitamin B12 deficiency, and vitamin D deficiency.<br><br>a. Review of physician orders for Resident #1 dated 05/10/23 revealed there was an order for Perphenazine (used to treat agitation) 8mg tablet three times a day.<br><br>Review of Resident #1's May 2023 medication administration records (MARs) revealed:<br>-There was a printed entry for Perphenazine 8mg tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.<br>-Documentation for the Perphenazine was blank on 3 occasions for the 2:00pm scheduled medication time on 05/28/23, 05/29/23, and 05/30/23.<br>-Documentation for the Perphenazine was blank on 13 occasions for the 8:00pm scheduled medication time on 05/18/23 through 05/30/23.<br><br>Review of the medication notes on the back of the MARs revealed:<br>-There was staff documentation that Resident #1 was out of the facility for all morning medications on 05/16/23 - 05/25/23 and 05/27/23 through 05/30/23. There was no documentation to explain the omission of documentation for administration of the scheduled doses of Perphenazine at 8:00am on 05/26/23, and 05/31/23.<br>-There was staff documentation that Resident #1 was out of the facility for afternoon medications | D 367 | | |

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| D 367 | Continued From page 42<br>on 05/18/23, 05/20/23, 05/25/23, and 05/27/23 through 05/30/23. There was no documentation to explain the omission of documentation for administration of the scheduled doses of Perphenazine at 2:00pm on 05/19/23, 05/21/23 through 05/24/23, and 05/31/23.<br>-There was staff documentation that Resident #1 was out of the facility for evening medications on 05/15/23 through 05/17/23, and 05/27/23 through 05/30/23. There was no documentation to explain the omission of documentation for administration of the scheduled doses of Perphenazine at 8:00pm on 05/18/23 through 05/26/23, and 05/31/23.<br>-There were no staff signatures or initials for the medication notes dated 05/16/23, 05/19/23, 05/20/23, or 05/21/23.<br><br>Interview with a medication aide on 06/14/23 at 3:35pm revealed:<br>-When the resident refused medications, was out of the facility, or the medication was not available in the facility, she circled her initials on the medication administration record.<br>-She documented a note on the back of the MAR when she circled her initials on the front of the MAR where she documented the administration of medications.<br>-She was not sure what the blank spaces on Resident #1's MARs meant.<br><br>Interview with a second MA on 06/15/23 at 9:15am revealed:<br>-Resident #1 was out of the facility from 05/17/23 through 05/30/23.<br>-Documentation on the MARs for medications not administered 05/17/23 through 05/30/23 should have included circled medication aide initials.<br>-The MA documented a reason on the resident's MAR of either medication refused, on order, | D 367 | | |

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| D 367 | Continued From page 43<br>unavailable, or out of the facility when the medication was not administered.<br><br>Refer to interview with the Administrator on 06/14/23 at 4:45pm.<br><br>b. Review of a physician's order for Resident #1 dated 05/12/23 revealed there was an order for Oxcarbazepine (used to treat behavior) 150mg tablet two times a day.<br><br>Review of Resident #1's May 2023 MARs revealed:<br>-There was a handwritten entry for Oxcarbazepine 150mg tablet two times a day scheduled at 8:00am and 8:00pm.<br>-Documentation for the Oxcarbazepine was blank on 14 occasions for the 8:00pm scheduled medication time on 05/17/23 through 05/30/23.<br><br>Review of the medication notes on the back of the MARs revealed:<br>-There was staff documentation that Resident #1out of the facility for evening medications on 05/15/23 through 05/17/23, and 05/27/23 through 05/30/23. There was no documentation to explain the omission of documentation for administration of the scheduled doses of Oxcarbazepine at 8:00pm on 05/18/23 through 05/26/23.<br>-There were no staff signatures or initials for the medication notes dated 05/19/23, 05/20/23, or 05/21/23.<br><br>Interview with a medication aide on 06/14/23 at 3:35pm revealed:<br>-When the resident refused medications, was out of the facility, or the medication was not available in the facility, she circled her initials on the medication administration record. | D 367 | | |

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| D 367 | Continued From page 44<br>-She documented a note on the back of the MAR when she circled her initials on the front of the MAR where she documented the administration of medications.<br>-She was not sure what the blank spaces on Resident #1's MARs meant.<br><br>Interview with a second MA on 06/15/23 at 9:15am revealed:<br>-Resident #1 was out of the facility from 05/17/23 through 05/30/23.<br>-Documentation on the MARs for medications not administered 05/17/23 through 05/30/23 should have included circled medication aide initials.<br>-The MA documented a reason on the resident's MAR of either medication refused, on order, unavailable, or out of the facility when the medication was not administered.<br><br>Refer to interview with the Administrator on 06/14/23 at 4:45pm.<br><br>3. Review of Resident #2's current FL-2 dated 01/31/23 revealed diagnoses included major vascular neurodegenerative intracerebral hemorrhage, asthma, and gastroesophageal reflux disease.<br><br>Review of Resident #2's physician's order dated 5/24/23 revealed an order to discontinue Clobetasol Propionate 0.05% cream. (Clobetasol Propionate is a topical medication used to treat inflammatory skin conditions.)<br><br>Review of Resident #2's June 2023 medication administration record (MAR) revealed:<br>-There was an entry for Clobetasol Propionate 0.05% cream apply topically to skin twice a day for 14 days then twice daily two days on and two days off at 8:00am and 8:00pm. | D 367 | | |

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|---|---|---|---|
| | HAL051062 | A. BUILDING: _____ B. WING _____ | C 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLASSIC CARE HOMES # 1 | 101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577 |

| (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 |
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| D 367 | Continued From page 45<br>-Clobetasol Propionate was documented as administered 10 times from 06/01/23 to 06/14/23 at 8:00am.<br>-Clobetasol Propionate was documented as administered 4 times from 06/01/23 to 06/04/23 at 8:00pm.<br><br>Observation of medications on hand for Resident #2 on 06/14/23 revealed there was no Clobetasol Propionate cream available for administration.<br><br>Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.<br><br>Interview with a medication aide (MA) on 06/14/23 at 1:12pm revealed:<br>-She administered medications to Resident #2.<br>-She put her initials beside each medication entry when she administered the medication.<br>-She administered Ammonium Lactate 12% cream (for dry skin) to Resident #2 during medication pass this morning.<br>-She did not realize she had initialed the wrong medication.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/14/23 at 1:22pm revealed:<br>-She was aware the Clobetasol Propionate for Resident #2 had been discontinued.<br>-She did not realize the entry for the medication had not been discontinued and marked off on the MAR.<br>-She was responsible for reviewing the MARs at the beginning of the month to make sure they were correct.<br><br>Interview with Administrator on 06/14/23 at 2:55pm revealed:<br>-The RCC was responsible for reviewing the | D 367 | | |

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| D 367 | Continued From page 46<br>MARs at the beginning of the month to make sure discontinued medications were marked off.<br>-She did not realize the MAs had been documenting the Clobetasol Propionate cream was being administered to Resident #2 after it was discontinued and no longer available for administration.<br><br>Refer to interview with the Administrator on 06/14/23 at 4:45pm.<br><br>Interview with the Administrator on 06/14/23 at 4:45pm revealed:<br>-MARs were checked daily by the Resident Care Coordinator.<br>-If the RCC was not in the facility, she checked the MARs.<br>-She tried to check the MARs for accuracy daily but she did not usually have enough time to do it every day with all of her other duties.<br>-If she did not check MARs, the Business Office Manager checked the MARs.<br>-When MARs were checked, the staff looked for missed documentation (holes), and effectiveness documentation for as needed medication administration.<br>-Daily checks of the MARs were started in May 2023. | D 367 | | |
| D 392 | 10A NCAC 13F .1008 (a) Controlled Substances<br><br>10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. | D 392 | All control substance sheets are now to be staple to the current MAR so that all documentation will be in the resident charts. Med Aide, RCC,Administrator, and pharmacy will monitor on a monthly basis. | Completed by 6/30/2023 |

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| D 392 | Continued From page 47<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 1 resident (#3) sampled with orders for a controlled substance used to treat moderate to severe pain.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 05/23/23 revealed diagnoses included history of brain tumor, history of squamous cell carcinoma, chronic pain syndrome, type 2 diabetes, and hypothyroidism.<br><br>Review of Resident #3's oncology provider visit note dated 03/16/23 revealed:<br>-The resident was administered an immunotherapy infusion for lung cancer.<br>-There was an order to start Fentanyl 12mcg/hr patch, place 1 patch on skin every third day. (Fentanyl is a controlled substance used to treat moderate to severe pain.)<br><br>Review of Resident #3's physician's order dated 04/17/23 revealed an order for Fentanyl 25mcg/hr patch, place 1 patch on the skin every third day.<br><br>Review of Resident #3's prescription from the oncology provider dated 05/02/23 revealed an order for Fentanyl 12mcg/hr patch, place 1 patch on the skin every third day.<br><br>Review of a clarification request faxed to Resident #3's oncology provider on 05/02/23 revealed:<br>-The facility staff requested to clarify if the | D 392 | | |

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| D 392 | Continued From page 48<br>resident was to receive Fentanyl 12mcg/hr patch or Fentanyl 25mcg/hr patch.<br>-The oncology provider signed the clarification on 05/09/23 to discontinue Fentanyl 25mcg/hr patch and to start Fentanyl 12mcg/hr patch, apply 1 patch to skin every 3 days.<br><br>Review of Resident #3's hospital discharge summary dated 05/10/23 revealed:<br>-The resident's discharge diagnoses included squamous cell lung cancer, hypoxia (low levels of oxygen in the body), pericardial effusion (build up of too much fluid in the sac around the heart), fever, and hypotension (low blood pressure).<br>-There was an order to continue Fentanyl 12mcg/hr patch apply 1 patch to skin every 3 days.<br><br>Review of Resident #3's March 2023 medication administration record (MAR) revealed:<br>-There was a handwritten entry for Fentanyl 12mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm.<br>-Fentanyl 12mcg/hr patch was documented as administered on 03/20/23, 03/24/23, and 03/28/23.<br>-There was a total of 3 Fentanyl 12mcg/hr patches documented as administered in March 2023.<br><br>Review of Resident #3's controlled substance (CS) count sheets for Fentanyl revealed there was no CS count sheet available for any doses administered in March 2023.<br><br>Review of Resident #3's April 2023 MAR revealed:<br>-There was an entry for Fentanyl 12mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm. | D 392 | | |

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| D 392 | Continued From page 49<br>-Fentanyl 12mcg/hr patch was documented as administered on 04/01/23, 04/05/23, 04/09/23, 04/14/23, 0417/21, 04/21/23, 04/25/23, and 04/29/23.<br>-There was a total of 8 Fentanyl 12mcg/hr patches documented as administered in April 2023.<br>-There was no entry for Fentanyl 25mcg/hr patch and none documented as administered.<br><br>Review of Resident #3's CS count sheets for Fentanyl 12mcg/hr patch dated 04/12/23 revealed:<br>-There were 2 CS count sheets dated 04/12/23.<br>-The first sheet had a quantity received of 4 Fentanyl 12mcg/hr patches.<br>-There were 4 patches documented as administered: 04/14/23, 04/17/23, 04/21/23, and 04/26/23 (instead of 04/25/23 as documented on the MAR), leaving a balance of 0.<br>-The second sheet had a quantity received of 6 Fentanyl 12mcg/hr patches.<br>-None of the 6 patches were documented as administered, leaving a balance of 6 patches.<br>-There was no CS count sheet for Fentanyl patches administered from 04/01/23 - 04/13/23.<br><br>Review of Resident #3's CS count sheets for Fentanyl revealed there was no CS count sheet available for Fentanyl 25mcg/hr.<br><br>Review of Resident #3's May 2023 MAR revealed:<br>-There was a computer printed entry for Fentanyl 25mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm.<br>-Staff initialed 05/01/23 and 05/03/23 as administered.<br>-Staff initials were circled on 05/02/23 with no reason documented. | D 392 | | |

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| D 392 | Continued From page 50<br>-Staff initials were circled on 05/04/23 due to the resident being out of the facility (in hospital from 05/04/23 - 05/10/23).<br>-There was a handwritten note indicating the order changed on 05/10/23.<br>-There was a handwritten entry for Fentanyl 12mcg/hr patch, apply 1 patch to dry, clean skin once every 3 days.<br>-There was a handwritten note that the hospital put on Fentanyl patch on 05/09/23.<br>-Fentanyl 12mcg/hr was documented as administered on 05/15/23 and 05/25/23.<br><br>Review of Resident #3's CS count sheet for Fentanyl 12mcg/hr patch dated 03/17/23 revealed:<br>-The quantity received was documented as 6 Fentanyl 12mcg/hr patches.<br>-There were 6 patches documented as administered: 05/03/23, 05/15/23, 05/19/23, 05/25/23, 05/31/23, and 06/04/23, leaving a balance of 0.<br>-The dates documented as administered on the CS count sheet did not accurately reconcile with documentation on the MAR.<br><br>Review of Resident #3's June 2023 MAR revealed:<br>-There was a computer printed entry for Fentanyl 12mcg/hr patch, apply 1 patch topically to clean, dry skin once every 3 days scheduled at 8:00pm.<br>-Fentanyl 12mcg/hr patch was documented as administered on 06/04/23, 06/07/23, 06/09/23, and 06/12/23.<br>-There was a total of 4 Fentanyl 12mcg/hr patches documented as administered in June 2023.<br><br>Review of Resident #3's CS count sheet for Fentanyl 12mcg/hr patch dated 05/02/23 | D 392 | | |

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| D 392 | Continued From page 51<br>revealed:<br>-There were 2 CS count sheets dated 05/02/23.<br>-The first sheet had a quantity received of 6 Fentanyl 12mcg/hr patches.<br>-There were 2 patches documented as administered: 06/09/23 and 06/12/23, leaving a balance of 4 patches.<br>-There was no patch documented as administered on the 06/07/23 as indicated no the MAR.<br>-The second sheet had a quantity received of 4 Fentanyl 12mcg/hr patches.<br>-None of the 4 patches were documented as administered, leaving a balance of 4 patches.<br><br>Review of Resident #3's medications on hand on 06/15/23 at 9:08am and 9:56am revealed:<br>-There was a supply of Fentanyl 12mcg/hr patches dispensed on 04/12/23 with 6 patches remaining.<br>-There was a supply of Fentanyl 12mcg/hr patches dispensed on 05/02/23 with 8 patches remaining.<br>-There was a total supply of 14 Fentanyl 12mcg/hr patches remaining.<br>-There was no Fentanyl 25mcg/hr patches on hand.<br><br>Review of the facility's pharmacy return sheets revealed 10 of 10 Fentanyl 25mcg/hr patches dispensed on 04/17/23 were returned to the pharmacy on 05/09/23.<br><br>Interview with Resident #3 on 06/14/23 at 4:35pm revealed:<br>-She had pain sometimes as high as 10 on a scale of 1 - 10 (with 10 being the most severe pain).<br>-The pain was usually in her mid-back area.<br>-Staff applied a pain patch to her skin but she | D 392 | | |

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| D 392 | Continued From page 52<br>was not sure how often it was changed.<br><br>Interview with a medication aide (MA) on 06/14/23 at 3:33pm revealed:<br>-She administered Resident #3's Fentanyl patch according to the marked off blocks on the MAR.<br>-The MAs were supposed to document on the MAR and the CS count sheet each time a controlled substance was administered.<br>-She did not know why Resident #3's CS count sheet did not accurately reconcile with the documentation for administration of the Fentanyl patch on the MAR.<br><br>Interview with the Administrator on 06/15/23 at 9:43pm revealed:<br>-The MAs should document the administration of controlled substances on the MAR and the CS count sheets.<br>-The Resident Care Coordinator (RCC) was responsible for checking the CS count sheets and comparing them to the MARs daily.<br>-She tried to check behind the RCC but there had not been enough time to do this with her other job responsibilities.<br>-She was not aware Resident #3's CS count sheets for Fentanyl did not accurately reconcile with the documentation on the MARs.<br>-There should be a CS count sheet for all of Resident #3's Fentanyl since it was ordered in March 2023.<br>-She could not locate any other CS count sheets for Resident #3's Fentanyl patches.<br><br>Attempted telephone interview with the RCC on 06/15/23 at 10:00am was unsuccessful. | D 392 | | |

## Forte, Hope

**From:** Angie Peedin <angiepeedin@gmail.com>
**Sent:** Friday, July 28, 2023 9:12 PM
**To:** Forte, Hope; Vish Patel; Punam Gandhi; Ritesh Patel; Angie Peedin
**Subject:** [External] Revised 07/28/2023 Correction Plan for B#1 Classic Care
**Attachments:** Revised Correction Plan for B#1 07-28-2023.pdf



Hope, Here's the updated plan for Building #1. If there's any question please let me know.

Have a great day,
*Angie Peedin,*
*Administrator*
*Classic Care*
*101 Annie Parker Cir.*
*Smithfield, NC 27577*
*Phone: 919-726-9447*
*angiepeedin@gmail.com*