| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {C 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey on 09/12/23 to 09/13/23 with an exit via telephone on 09/13/23. | {C 000} | | |
| C 246 | 10A NCAC 13G .0902(b) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to notify the primary care provider for 1 of 3 sampled residents (#1) an inhalation medication, and a transdermal pain patch were not available for administration to the resident.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 04/13/23 revealed diagnoses included hypoxia and chronic abdominal pain.<br><br>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 05/08/23.<br><br>a. Review of Resident #1's hospital discharge notes dated 05/08/23 revealed:<br>-Resident #1 had been admitted to the hospital for hypoxia.<br>-Resident #1's primary diagnoses included chronic obstructive pulmonary disease (COPD).<br><br>Review of Resident #1's primary care provider | C 246 | | |

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(PCP) after visit notes dated 08/03/23 revealed there was an order for albuterol sulfate (used to treat breathing issues) 2.5/.0.5ml solution via nebulizer twice daily.

Review of Resident #1's August 2023 medication administration record (MAR) revealed:
-There was no entry for albuterol sulfate 2.5/0.5mL via nebulizer twice daily as ordered on 08/03/23.
-There was no documentation albuterol sulfate via nebulizer was administered from 08/03/23 to 08/31/23.

Review of Resident #1's MAR dated 09/01/23 to 09/12/23 revealed:
-There was an entry for albuterol sulfate 2.5mg/3ml nebulizer 0.083 percent use one vial via nebulizer twice daily scheduled at 8:00am and 8:00pm.
-There was documentation albuterol sulfate was administered via nebulizer twice daily on 09/01/23 to 09/08/23.
-There was no documentation of administration for albuterol sulfate on 09/09/23 to 09/12/23.

Review of Resident #1's record revealed there was no documentation of contact with Resident #1's primary care provider (PCP) regarding his order for albuterol sulfate via a nebulizer.

Observation of Resident #1's medications on hand on 09/12/23 at 10:44am revealed:
-There was an opened foil package of albuterol sulfate 2.5mg/3ml with 29 unopened albuterol sulfate vials.
-The foil package was not dated with an open date and it was not in a box or resealable bag.
-There was no medication label indicating the resident's name, the dosage, the frequency, the

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amount dispensed or the dispensed date on the foil package.
-There was no nebulizer stored with the medication.

Observation of Resident #1's room on 09/12/23 at 8:28am revealed there was no nebulizer in his room.

Interviews with Resident #1 on 09/13/23 at 8:28am and 1:38pm revealed:
-He had COPD and had a nebulizer machine at another facility, but had not had one since he was admitted to the current facility.
-His PCP had told him at his last appointment he needed a nebulizer for his breathing, but he had not gotten one yet.
-He really needed the albuterol sulfate via nebulizer before bedtime, because he was experiencing increased difficulty breathing at night.
-He tossed and turned at night when he tried to sleep because it felt like his lungs were "closed".
- "I really need that nebulizer machine bad".
-He asked about the nebulizer machine and complained about not being able to breath to the facility staff since he was admitted to the facility.
-He was told the Administrator was checking on a nebulizer, but there was an insurance problem.
-He had stopped asking and complaining; "I have given up and just try not to worry about it too much" because he did not think he was going to get the machine.
-He said if he could only get the nebulizer machine to inhale his albuterol at night or at least as needed (PRN) it would help his breathing.

Telephone interview with the facility's contracted oxygen supply company on 09/12/23 at 4:39pm revealed:

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| C 246 | Continued From page 3<br>-Resident #1 was issued a nebulizer on 05/31/22 at the address of his previous facility.<br>-The previous nebulizer was fully covered by his insurance provider; insurance typically only covered the cost of one nebulizer per five years.<br>-There had not been any inquiries about a nebulizer or a request for a nebulizer for Resident #1 from the current facility.<br>-A new nebulizer could be requested with new physician's orders and could be purchase out of pocket if the insurance did not cover the cost.<br><br>Telephone interview with Resident #1's PCP on 09/13/23 at 1:16pm revealed:<br>-Resident #1 had a diagnosis of COPD.<br>-She observed the resident wheezing during his exam on 08/03/23.<br>-He was administered 3ml of albuterol sulfate via nebulizer while in the office on 08/03/23.<br>-Resident #1 complained of shortness of breath and complained of not having medication for his COPD; including a nebulizer.<br>-She ordered albuterol sulfate 2.5mg/3ml nebulizer administer one vial via nebulizer twice daily.<br>-She had ordered the albuterol to be administered via nebulizer because the nebulizer made the albuterol into a finer mist and was a longer treatment than an inhaler.<br>-She also ordered the albuterol via nebulizer because Resident #1 would be more compliant with a nebulizer than an inhaler.<br>-The order she wrote should have covered the obtaining of a nebulizer and the albuterol.<br>-The facility was responsible for securing a nebulizer for Resident #1 through a medical supply company.<br>-She had not been notified by the facility about not being able to obtain a nebulizer for Resident #1. | C 246 | | |

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-She expected the facility to notify her anytime there was a problem with an order she wrote.
-She expected the facility to call her immediately when they had difficulty getting a nebulizer for Resident #1 because he needed the nebulizer for the albuterol sulfate to be administered.
-She would have done everything she could to get Resident #1 the nebulizer.
-She thought his albuterol sulfate was administered all this time and it was not.
-She could have called the equipment supply company herself to find out what needed to be done to get a nebulizer for Resident #1 if she had known.

Interviews with the Medication Aide (MA) on 09/13/23 at 10:56am and 1:03pm revealed:
-She had not administered Resident #1 his albuterol sulfate via nebulizer because he did not have a nebulizer machine.
-Resident #1 had not had a nebulizer since he was admitted to the facility.
-The Administrator had called the PCP about the nebulizer sometime in July 2023.
-The Administrator was responsible for calling the PCP.

Interview with the Administrator on 09/12/23 at 3:52pm revealed:
-She had attempted to get Resident #1 a nebulizer so he could take his albuterol; she had called the PCP and a named oxygen equipment supply company in July 2023.
-She thought the named equipment supply company told her there was an issue with insurance coverage.
-The PCP needed more information so Resident #1 went to an appointment with the PCP on 08/03/23.
-The PCP had written new orders for albuterol via

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nebulizer and she faxed them to the pharmacy.
-She did not know Resident #1 had not been administered his albuterol sulfate via nebulizer; she did not know he did not have the nebulizer to administer the albuterol.
-She did not contact the PCP about the nebulizer after 08/03/23 because she did not know Resident #1 never received a nebulizer.

b. Review of a physician's order dated 05/05/23 revealed there was an order for lidocaine 5 percent patch (used to relieve pain) apply one patch to the affected area only for 12 hours daily and then remove patch.

Review of Resident #1's August 2023 medication administration record (MAR) revealed:
-The first entry on the MAR was an entry for lidocaine pad 5 % patch place 1 patch on skin once daily apply to affected area for 12 hours each day then remove scheduled at 8:00am.; not covered by insurance in quotations marks was also in the entry.
-There was no documentation Resident #1's lidocaine patch was applied from 08/01/23 to 08/31/23.
-There was a second entry for lidocaine patch apply 1 patch topically once daily to affected area, on for 12 hours off for 12 hours scheduled to apply at 8:00am and remove at 8:00pm.
-There was no documentation Resident #1's lidocaine patch was applied from 08/01/23 to 08/31/23 on the second entry.

Review of Resident #1's MAR from 09/01/23 to 09/12/23 revealed:
-The first entry on the MAR was an entry for lidocaine pad 5 % place 1 patch on skin once daily apply to affected area for 12 hours each day then remove scheduled at 8:00am.; not covered

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| C 246 | Continued From page 6 | C 246 | | |

by insurance in quotations marks was also in the entry.
-There was no documentation Resident #1's lidocaine patch was applied from 09/01/23 to 09/12/23.
-There was a second entry for lidocaine patch apply 1 patch topically once daily to affected area, on for 12 hours off for 12 hours scheduled to apply at 8:00am and remove at 8:00pm.
-There was no documentation Resident #1's lidocaine patch was applied from 09/01/23 to 09/12/23 on the second entry.

Review of Resident #1's record on 09/12/23 revealed there was no documentation of contact with Resident #1's primary care provider (PCP) regarding his lidocaine patch order.

Observation of Resident #1's medication on hand on 09/12/23 at 10:44am revealed there were no lidocaine 5% patches available for application.

Interview with Resident #1 on 09/12/23 at 8:23am revealed:
-He had severe and continuous pain in his hip.
-He used a walker and a cane to walk, because of the hip pain.
-He did not know he had an order for a lidocaine patch.
-He would have used the lidocaine patch if he had known about it; it would have helped his hip pain.

Telephone interview with the pharmacist from Resident #1's contracted pharmacy on 09/12/23 at 11:40am revealed:
-Resident #1 had an order for lidocaine 5% patch dated 05/05/23.
-The order was not initially filled because the insurance would not cover it.
-The pharmacy spoke to staff at the facility by

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telephone on or around 05/18/23 and notified staff of the insurance issue so the facility could reach out to the physician.
-The pharmacy never had a response from the facility.
-The pharmacy printed the MARs and included the note "not covered by insurance" on the lidocaine entry.
-Lidocaine patches were a topical pain reliever applied to a specific area for muscle or arthritis joint pain relief.
-If the lidocaine patch was not applied as ordered the resident would not have relief from his pain and would have continued discomfort in the area.

Telephone interview with Resident #1's PCP on 09/13/23 at 1:22pm revealed:
-Resident #1 had severe joint pain in a hip or knee and needed a replacement.
-Resident #1 relied on a cane for ambulation due to the joint pain.
-Resident #1 was on blood thinners so there was a limit to the oral pain medications he could take.
-A topical lidocaine patch would have provided some pain relief if it was administered as ordered.
-It was extremely important for her to be notified anytime there was an issue with Resident #1's medication.
-The facility should have contacted her as soon as the pharmacy told them there was an insurance issue with his medications.
-She expected the facility to reach out to her if Resident #1 had continued pain or couldn't get medication for any reason; all the facility had to do was call her because she could have figured something else out for Resident #1.

Interviews with the medication aide (MA) on 09/12/23 at 1:03pm and 3:51pm revealed:
-The pharmacy called her and told her insurance

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| C 246 | Continued From page 8<br>would not cover Resident #1's order for a lidocaine patch when it was first ordered.<br>-She did not contact the PCP about the lidocaine patch; the Administrator was responsible for contacting the PCP.<br>-She told the Administrator when the pharmacy told her.<br>-She did not know if the PCP knew the lidocaine patches were not dispensed.<br><br>Interview with the Administrator on 09/12/23 at 3:39pm revealed:<br>-She was not aware Resident #1 did not have his lidocaine patch, because she did not know he had an order for it.<br>-The order for the lidocaine patch must been have from when he was discharged from the hospital.<br>-She had not noticed the order for the lidocaine patch on the MAR.<br>-The pharmacy usually contacted her when there was an issue with getting a medication order filled.<br>-The MA should have let her know about the insurance issue with the lidocaine patch and not just ignored it.<br>-She did not contact Resident #1's PCP about the lidocaine patch issue, because she did not know about it.<br>-If she had been made aware, she would have contacted the PCP.<br><br>_____<br>The facility failed to notify Resident #1's primary care provider when there were issues with orders for a nebulizer which resulted in the resident experiencing shortness of breath and difficulty breathing and lidocaine patches not dispensed due to insurance coverage which resulted in the resident experiencing increased back and knee pain. This failure was detrimental to the health, | C 246 | | |

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| C 246 | Continued From page 9<br>safety and welfare of the residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/12/23 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 28, 2023. | C 246 | | |
| {C 330} | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<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 A2 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents including a inhaler nebulizer medication and a topical pain patch medication (#1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 04/13/23 revealed diagnoses included hypoxia and chronic abdominal pain. | {C 330} | | |

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| {C 330} | Continued From page 10 | {C 330} | | |

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 05/08/23.

a. Review of Resident #1's hospital discharge notes dated 05/08/23 revealed:
-Resident #1 had been admitted to the hospital for hypoxia (the absence of enough oxygen in the tissues to sustain body functions)
-Resident #1's primary diagnoses included chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD) and hypertension.
-Resident #1 had an order for albuterol (used to treat COPD) 2.5mg mg/3mL nebulizer (a small machine that turns liquid medication into a mist that can be inhaled) inhale 3mL every four hours as needed for shortness of breath.
-There was an end date of 06/04/23 for the albuterol.

Review of Resident #1's primary care provider (PCP) after visit notes dated 08/03/23 revealed:
-The resident had a diagnose of COPD.
-There was an order for albuterol sulfate 2.5/.05ml solution via nebulizer twice daily with no end date.

Review of Resident #1's August 2023 medication administration record (MAR) revealed:
-There was no entry for albuterol sulfate 2.5/0.5mL via nebulizer twice daily as ordered on 08/03/23.
-There was no documentation albuterol sulfate via nebulizer was administered from 08/03/23 to 08/31/23.

Review of Resident #1's September 2023 MAR from 09/01/23 to 09/12/23 revealed:
-There was an entry for albuterol sulfate

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| {C 330} | Continued From page 11<br><br>2.5mg/3mL nebulizer 0.083percent use one vial via nebulizer twice daily scheduled at 8:00am and 8:00pm.<br>-There was documentation albuterol sulfate was administered via nebulizer twice daily on 09/01/23 to 09/08/23.<br>-There was no documentation of administration for albuterol sulfate from 09/09/23 to 09/12/23.<br><br>Observation of Resident #1's medications on hand on 09/12/23 at 10:44am revealed:<br>-There was an opened foil package of albuterol sulfate 2.5mg/3mL.<br>-There were 29 unopened albuterol sulfate vials in the foil package.<br>-The foil package was not dated with an open date and it was not in a box or resealable bag.<br>-There was no medication label indicating the resident's name, the dosage, the frequency, the amount dispensed or the dispensed date on the foil package.<br>-There was no nebulizer stored with the medication for administering the albuterol sulfate.<br><br>Observation of Resident #1's room on 09/12/23 at 8:28am revealed there was no nebulizer machine stored in the room.<br><br>Interviews with Resident #1 on 09/13/23 at 8:28am and 1:38pm revealed:<br>-He had COPD and had a nebulizer machine at another facility, but had not had one since he was admitted to the current facility.<br>-He used his nebulizer twice a day when he was at the previous facility.<br>-His PCP had told him at his last appointment he needed a nebulizer for his breathing, but he had not gotten one yet.<br>-He really needed the albuterol sulfate via nebulizer before bedtime because he was | {C 330} | | |

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experiencing increased difficulty breathing at night.
-He tossed and turned at night when he tried to sleep because it felt like his lungs were "closed".
-He had an emergency inhaler he used when he had difficulty breathing but it only helped a little bit; the nebulizer treatment did more to help him breath better.
-When he used a nebulizer at the previous facility and at the PCP's office he could feel his lungs "open up" as he used a nebulizer to inhale his albuterol.
-He had used a nebulizer when he was in the PCP office about a month ago and it helped him breathe better.
- "I really need that nebulizer machine bad".
-He asked about the nebulizer machine and complained about not being able to breath to the facility staff since he was admitted to the facility.
-He was told the Administrator was checking on a nebulizer but there was an insurance problem.
-He had stopped asking and complaining; "I have given up and just try not to worry about it too much", because he did not think he was going to get the machine.
-He said if he could only get the nebulizer machine to inhale his albuterol at night or at least as needed (PRN) it would help his breathing.

Telephone interview with a pharmacist from Resident #1's contracted pharmacy on 09/12/23 at 11:40am revealed:
-Resident #1 had an order for albuterol sulfate 2.5mg/3mL inhale one 3mL vial via nebulizer twice daily dated 08/03/23.
-The order was received via facsimile from the facility on 08/03/23.
-A thirty-day supply, sixty vials, of albuterol sulfate were dispensed on 08/03/23.
-The pharmacy did not provide the nebulizer

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machine, only the medication.
-The facility would have ordered a nebulizer machine from another source for Resident #1.
-Albuterol sulfate was a bronchodilator used to treat breathing issues caused by shortness of breath associated with COPD by dilating the bronchi so the resident can breathe easier.
-An expected outcome of albuterol sulfate not administered correctly could be shortness of breath and difficulty breathing.

Telephone interview with the facility's contracted oxygen supply company on 09/12/23 at 4:39pm revealed:
-Resident #1 was issued a nebulizer on 05/31/22 at the address of his previous facility.
-The nebulizer was fully covered by his insurance provider.
-Insurance typically only covered the cost of one nebulizer per five years.
-The nebulizer became the property of the Resident once it was purchased and paid in full by the insurance provider.
-There had not been any inquiries about a nebulizer or a request for a nebulizer for Resident #1 from the current facility.
-A new nebulizer could be requested with new physician's orders and could be purchased out of pocket if the insurance did not cover the cost.

Telephone interview with a representative from Resident #1's dialysis clinic on 09/13/23 at 8:46am revealed:
-Resident #1 was seen at the dialysis clinic three times a week for dialysis treatment.
-Resident #1 had consistently complained of shortness of breath and difficulty breathing.
-The staff had witnessed Resident #1 experience shortness of breath while on dialysis.
-He contacted the Administrator via telephone in

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August 2023 and requested she send Resident #1's medications related to his breathing, including his inhalers with him to the clinic for review.
-The facility sent tablets, but did not send inhalers or vials for a nebulizer and did not send the MAR.
-On 07/17/23, he contacted a pulmonary physician and scheduled an appointment for 09/26/23 for Resident #1 due to his difficulty breathing.

Telephone interview with Resident #1's PCP on 09/13/23 at 1:16pm revealed:
-Resident #1 was seen in her office on 08/03/23.
-He had a diagnosis of COPD.
-He was observed wheezing during his exam on 08/03/23.
-He was administered 3mL of albuterol sulfate via nebulizer while in the office on 08/03/23.
-Resident #1 complained of shortness of breath and complained of not having medication for his COPD; including a nebulizer.
-Resident #1 told her he had a previous order for albuterol via nebulizer PRN for shortness of breath and difficulty breathing.
-She ordered a new inhaler scheduled once daily, an emergency inhaler and albuterol sulfate 2.5mg/3mL nebulizer administer one vial via nebulizer twice daily.
-She had ordered the albuterol to be administered via nebulizer because the nebulizer made the albuterol into a finer mist and was a longer treatment than an inhaler.
-She also ordered the albuterol via nebulizer because Resident #1 would be more compliant with a nebulizer than an inhaler.
-She was doing all she could do to keep Resident #1 from having exacerbation of his COPD and keeping him out of the hospital.
-She expected the facility to follow the orders she

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| {C 330} | Continued From page 15<br>wrote for Resident #1 for his albuterol via nebulizer.<br><br>Interviews with the medication aide (MA) on 09/13/23 at 10:56am and 1:03pm revealed:<br>-She did not know why the albuterol sulfate was not in a box and was not labeled; she did not know where the label went.<br>-She did not know when or how many albuterol sulfate vials had been dispensed.<br>-She had not administered Resident #1 his albuterol sulfate via nebulizer because he did not have a nebulizer machine.<br>-She did not know how many vials of albuterol sulfate the pharmacy had dispensed for Resident #1.<br>-Resident #1 had not had a nebulizer since he was admitted to the facility.<br>-Resident #1 had asked about a nebulizer.<br>-The Administrator was responsible for ordering the nebulizer.<br>-The Administrator had called the PCP about the nebulizer sometime in July 2023.<br>-She knew the nebulizer would be supplied by an oxygen supply company, but she did not know which one.<br>-The PCP faxed new orders to the pharmacy.<br>-She knew the PCP had written a new order for albuterol sulfate because she saw the after-visit report.<br>-She did not know what happened to Resident #1's other 31 albuterol sulfate vials.<br>-She had administered Resident #1 an albuterol via hand held inhaler but not via the nebulizer because he did not have one.<br>-Resident #1 took his inhaler with him to dialysis because he had difficulty breathing while at dialysis and he said the clinic told him to bring his emergency inhaler.<br>-Resident #1 had not complained to her about not | {C 330} | | |

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being able to sleep at night; he slept most of the day.

Interview with the Administrator on 09/12/23 at 3:52pm revealed:
-She had attempted to get Resident #1 a nebulizer so he could take his albuterol; she had called the PCP and an oxygen equipment supply company in July 2023.
-She thought the oxygen equipment supply company told her there was an issue with insurance coverage.
-The PCP needed more information so Resident #1 went to an appointment with the PCP on 08/03/23.
-She did not go to the appointment with Resident #1 was she did not know if he was administered albuterol via a nebulizer at the 08/03/23 visit.
-The PCP had written new orders for albuterol via nebulizer and she faxed them to the pharmacy.
-She did not know Resident #1 had not been administered his albuterol sulfate via nebulizer; she did not know he did not have the nebulizer to administer the albuterol.
-She had not contacted the oxygen supply company after the 08/03/23 appointment to order a nebulizer for Resident #1 because the MA was responsible for ordering it when the Administrator was not at the facility.
-She had not called the named supply company since July 2023.
-The facility should have followed up with the oxygen supply company and the PCP because the nebulizer never came.
-If the insurance would not have paid for a nebulizer machine for Resident #1 then the facility would have covered the cost.
-She was not aware he was having shortness of breath while at dialysis; the dialysis clinic had requested a copy of his MAR not his albuterol

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inhaler.
-Resident #1 had not complained of difficulty breathing or shortness of breath and he had not complained about not being able to sleep at night.

b. Review of Resident #1's hospital discharge notes dated 05/08/23 revealed:
-Resident #1's diagnoses included hypoxia, chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD) and hypertension.
-Resident #1 had an order for lidocaine 5% patch (used to treat) apply one patch to the affected area only for 12 hours daily and then remove patch.

Review of a physician's order dated 05/05/23 revealed there was an order for lidocaine 5% patch apply one patch to the affected area only for 12 hours daily and then remove patch.

Review of Resident #1's August 2023 medication administration record (MAR) revealed:
-The first entry on the MAR was an entry for lidocaine pad 5% place 1 patch on skin once daily apply to affected area for 12 hours each day then remove scheduled at 8:00am.; not covered by insurance in quotations marks was also in the entry.
-There was no documentation Resident #1's lidocaine patch was applied from 08/01/23 to 08/31/23.
-There was a second entry for lidocaine patch apply 1 patch topically once daily to affected area, on for 12 hours off for 12 hours scheduled to apply at 8:00am and remove at 8:00pm.
-There was no documentation Resident #1's lidocaine patch was applied from 08/01/23 to 08/31/23 on the second entry.

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| {C 330} | Continued From page 18<br><br>Observation of Resident #1's medication on hand on 09/12/23 at 10:44am revealed there were no lidocaine 5% patches available for application.<br><br>Interview with Resident #1 on 09/12/23 at 8:23am revealed:<br>-He had severe and continuous pain in his hip.<br>-He used a walker or a cane to walk because of the hip pain.<br>-He took acetaminophen for the pain and had once used a cream on his hip for relief.<br>-He complained of pain to the MA and she would administer acetaminophen to him.<br>-He did not know he had an order for a lidocaine patch.<br>-He would have used the lidocaine patch if he had known about it; it would have helped his hip pain.<br><br>Telephone interview with the harmacist from Resident #1's contracted pharmacy on 09/12/23 at 11:40am revealed:<br>-Resident #1 had an order for lidocaine 5% patch dated 05/05/23.<br>-The order was not initially filled the order because the insurance would not cover it.<br>-The pharmacy had attempted to reach out to the ordering physician to reduce the dosage to 4% so the resident could purchase an over the counter patch but was unsuccessful with an approval.<br>-The pharmacy contacted the facility on or around 05/18/23 and notified facility staff of the insurance issue so the facility could reach out to the physician.<br>-The pharmacy never had a response from the physician or the facility.<br>-The pharmacy printed the MARs and included the note "not covered by insurance" on the lidocaine entry.<br>-He was not sure what the facility did to provide the lidocaine patch for the resident; the pharmacy | {C 330} | | |

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continued to put it on the MAR.
-Lidocaine patches were a topical pain reliever applied to a specific area for extended muscle or arthritis joint pain relief.
-If the lidocaine patch was not applied as ordered the resident would not have relief from his pain and would have continued discomfort in the area.

Telephone interview with Resident #1's primary care provider (PCP) on 09/13/23 at 1:22pm revealed:
-She did not know Resident #1 had a discharge order from the hospital for a lidocaine 5% patch apply for 12 hours; she had not been provided with hospital notes.
-She knew he had severe joint pain in a hip or knee and needed a replacement.
-Resident #1 relied on a cane for ambulation due to the joint pain.
-Resident #1 was on blood thinners so there was a limit to the oral pain medications he could take.
-He had an order for acetaminophen 1000mg four times a day for pain, but still complained of joint pain.
-A topical lidocaine patch would provide some pain relief if it was administered as ordered.

Interviews with the medication aide (MA) on 09/12/23 at 1:03pm and 3:51pm revealed:
-Resident #1 frequently complained of hip pain.
-He had an order for acetaminophen (used to treat mild pain) as needed (PRN) and often requested it when he complained of pain.
-She had not noticed the entries for the lidocaine patch on the MAR or the note about the insurance coverage.
-She referenced the MAR when she administered medications.

Interview with the Administrator on 09/12/23 at

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| {C 330} | Continued From page 20<br><br>3:39pm revealed:<br>-She was not aware Resident #1 did not have his lidocaine patch because she did not know he had an order for it.<br>-The order for the lidocaine patch must been from when he was discharged from the hospital.<br>-If she had seen it on the MAR, she would have made sure he had the medication.<br>-The pharmacy usually contacted her when there was an issue with getting a medication order filled.<br>-When a resident had a medication that was not covered by their insurance, the facility usually paid for it.<br>-The MA should have let her know about the lidocaine patch and not just ignored it.<br>-He complained of pain all the time, mostly his head hurt; he requested his PRN pain medication for his pain.<br><br>_____<br>The facility failed to administer medications as ordered. Resident #1's who had an order for a bronchodilator administered via nebulizer causing the resident to experience shortness of breath which required him to use his emergency inhaler more frequently and prevented him from sleeping at night and a medicated patch resulting in the resident continuing to experience hip pain and discomfort. This failure placed the residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/12/23 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 13, 2023. | {C 330} | | |

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| C 342 | Continued From page 21 | C 342 | | |
| C 342 | 10A NCAC 13G .1004(j) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the 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 1 of 3 sampled residents (#1,) including a chronic obstructive pulmonary disease (COPD).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 04/13/23 revealed diagnoses included hypoxia and chronic abdominal pain. | C 342 | | |

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| C 342 | Continued From page 22<br><br>Review of Resident #1's primary care provider (PCP) after visit notes dated 08/03/23 revealed:<br>-The resident had a diagnose of COPD.<br>-There was an order for albuterol sulfate 2.5/.05ml solution via nebulizer twice daily.<br><br>Review of Resident #1's August 2023 medication administration record (MAR) revealed:<br>-There was no entry for albuterol sulfate 2.5/0.5mL via nebulizer twice daily as ordered on 08/03/23.<br>-There was no documentation albuterol sulfate via nebulizer was administered from 08/03/23 to 08/31/23.<br><br>Review of Resident #1's MAR dated 09/01/23 to 09/12/23 revealed:<br>-There was an entry for albuterol sulfate 2.5mg/3mL nebulizer 0.083percent use one vial via nebulizer twice daily scheduled at 8:00am and 8:00pm.<br>-There was documentation albuterol sulfate was administered via nebulizer twice daily on 09/01/23 to 09/08/23.<br>-There was nothing documented for albuterol sulfate on 09/09/23 to 09/12/23.<br><br>Observation of Resident #1's medications on hand on 09/12/23 at 10:44am revealed:<br>-There was an opened foil package of albuterol sulfate 2.5mg/3mL.<br>-There were 29 unopened albuterol sulfate vials in the foil package.<br>-The foil package was not dated with an open date and it was not in a box or resealable bag.<br>-There was no medication label indicating the resident's name, the dosage, the frequency, the amount dispensed or the dispense date on the foil package.<br>-There was no nebulizer stored with the | C 342 | | |

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| WE CARE FAMILY CARE | 1718 MORGANTON ROAD BURLINGTON, NC 27217 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 342 | Continued From page 23<br>medication for administering the albuterol sulfate.<br><br>Observation of Resident #1's bedroom on 09/12/23 at 8:28am revealed there was no nebulizer machine stored in the room.<br><br>Interviews with Resident #1 on 09/13/23 at 8:28am and 1:38pm revealed:<br>-He had COPD.<br>-His PCP had told him at his last appointment he needed a nebulizer for his breathing, but he had not gotten one yet.<br>-He had not had a nebulizer or a nebulizer treatment since being admitted to the facility.<br><br>Telephone interview with a Pharmacist from Resident #1's contracted pharmacy on 09/12/23 at 11:40am revealed:<br>-Resident #1 had an order for albuterol sulfate 2.5mg/3mL inhale one 3mL vial via nebulizer twice daily dated 08/03/23.<br>-A thirty-day supply, sixty vials, of albuterol sulfate were dispensed on 08/03/23.<br>-The pharmacy did not provide the nebulizer machine, only the medication.<br><br>Interviews with the Medication Aide (MA) on 09/13/23 at 10:56am and 1:03pm revealed:<br>-She had not administered Resident #1 his albuterol sulfate via nebulizer because he did not have a nebulizer machine.<br>-She had administered Resident #1 an albuterol via hand held inhaler but not via the nebulizer because he did not have one.<br>-She looked at the MAR prior to administering each medication and she administered medication to one resident at a time.<br>-She documented the medication administration after she administered the resident the medication. | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL001113 | A. BUILDING: _____ B. WING _____ | R 09/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WE CARE FAMILY CARE | 1718 MORGANTON ROAD BURLINGTON, NC 27217 |

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|---|---|---|---|---|
| C 342 | Continued From page 24<br>-She thought she had documented the administration of the hand-held inhaler on the MAR; she did not realize she was documenting on the wrong entry.<br><br>Interview with the Administrator on 09/12/23 at 3:39pm revealed:<br>-She had not reviewed the MAR for accuracy in a few weeks.<br>-She and the MA were the only staff who administered medications.<br>-She had not reviewed the MARs for September 2023, so she had not found the error.<br>-The MA should have been more careful when documenting on the MAR. | C 342 | | |