Division of Health Service Regulation

PRINTED: 12/08/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054042	A. BUILDING: ______ B. WING ______	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBBS HELPING HANDS	2504 TOWERHILL ROAD KINSTON, NC 28501

(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 000	**Initial Comments** The Adult Care Licensure Section conducted an annual survey on November 30, 2023.	C 000	Plans of Corrections for the findings conducted by the Adult Care Licensure Section during their Annual Survey conducted on 11/30/2023.	
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 2 of 3 sampled residents (#2, #3) including a medication used to treat urinary retention. The findings are: 1. Review of Resident #2's current FL-2 dated 01/30/23 revealed: -Diagnosis included enlarged prostate. -There was an order for tamsulosin (used to treat urinary retention) 0.4mg daily. Review of Resident #2's report of health services to resident sheet revealed: -There was an entry dated 11/02/23 which read will discontinue tamsulosin and start alfuzosin (used to treat urinary retention). -The entry was signed by Resident #2's primary care provider (PCP).	C 330 C330	10A NCAC 13G.1004(a) Medication Administration. (a) Based on the findings of the Survey team on 11/30/23, the following Corrections will be made immediately: 1) The Batch meds are delivered by Southern Pharmacy Svcs every 28 days. when the Batch is delivered to the facility, all medications will be checked by two Staff members. There will be a log of signatures each time the Batch meds are checked & dated. 2) The meds in the Batch will be checked for accuracy against the current medical records of each resident to ensure if any medications delivered has been discontinued or if any medication(s) that	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: Jan 03 2023

STATE FORM 6899 FQN511

Reviewed and Acknowledged [initials] 01/05/24

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C 330	Continued From page 1 Review of Resident #2's after visit summary dated 11/02/23 revealed: -Under today's medication changes it read start taking alfuzosin. -Under medication list it read alfuzosin 10mg daily. -Tamsulosin was not listed on the medication list. Review of Resident #2's record revealed there was a prescription for alfuzosin 10mg daily dated 11/06/23. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an entry for alfuzosin 10mg every day scheduled for administration at 8:00am. -Alfuzosin 10mg was documented as administered at 8:00am on 11/03/23 to 11/30/23. Observation of Resident #2's medications on hand on 11/30/23 at 1:40pm revealed there was no alfuzosin 10mg. Interview with a pharmacist at the facility's contracted pharmacy on 11/30/23 at 2:07pm revealed: -Twenty-two tablets of alfuzosin 10mg was dispensed for Resident #2 on 11/02/23. -The facility's contracted pharmacy only dispensed 22 tablets of alfuzosin on 11/02/23 because the resident's medications were on a cycle fill and the 22 tablets would be enough for him until the next batch of medications were delivered to the facility. -Resident #2's alfuzosin 10mg had been canceled by the Registered Nurse (RN) at the resident's primary care provider's (PCP) office on 11/06/23. -Since they received the cancellation for Resident #2's alfuzosin on 11/06/23 they did not send any	C 330	continuation from page 1 of 9 was added was not sent. This will also be done by two staff members for accuracy. B. The medication check against the current medical record will also be done to check for any discrepancies (ex. orders discontinued, or orders added). Make a list of all discrepancies and call the following morning to the primary physician's office and also to the pharmacy for clarification. C. The medication checks will be done the following Wednesday morning by 2 staff, using the following steps to ensure accuracy: (1) Check batch meds with current medical record. (2) Check for any discontinued medication, so that this medication is taken out of Batch.	

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C 330	Continued From page 2 to the facility on the next cycle fill. Interview with Resident #2 on 11/30/23 at 3:24pm revealed he had not had any problems urinating over the past week or so. Interview with the Administrator on 11/30/23 at 2:15pm revealed: -She had called Resident #2's PCP office and spoke to the RN on 11/06/23 and requested a hard copy of his prescription for alfuzosin so she could place it in his record. -The PCP's office usually provided a hard copy of resident's prescriptions at the appointment but they did not do so at Resident #2's appointment on 11/02/23. -When the PCP's office sent the hard copy of the prescription to her it had the date of 11/06/23 on it instead of the date it was ordered. -When she received batch medications from the facility's contracted pharmacy, she would compare the medications she received with the medications on the resident's MAR. -She thought she saw Resident #2's alfuzosin in the batch medication last received from the facility's contracted pharmacy. -She should have noticed that Resident #2 did not receive alfuzosin with the last batch of medications that were delivered by the facility's contracted pharmacy. -If she had noticed that Resident #2 did not receive alfuzosin with the last batch of medications he received she would have called the facility's contracted pharmacy to see why he did not receive it. Telephone interview with the RN at Resident #2's PCP's office on 11/30/23 at 2:11pm revealed: -Alfuzosin was ordered for Resident #2 on 11/02/23.	C 330	Continuation from page 2 of 9 and not put in the medication cart with other medications that are currently accurate.. for administration. (3) Check for medications that were added since last batch delivery to ensure they are in the batch. If not Contact the Contracted pharmacy for delivery of medication not in the batch. Ensure that the medication has been transcribed on the medical record Correctly. (4) Check for all medications Signed for and make sure that all those medications are on hand. If not, do not Sign the medical record that the med was administered. (5) Check to make sure that discontinued medications are not being signed or initialed for administration. (6) Check bubble pack (med card) to ensure medications are in all	

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C 330	Continued From page 3 -She received a call from the Administrator on 11/06/23 requesting a prescription for Resident #2's Alfuzosin. -Resident #2's alfuzosin was still an active medication and had not been discontinued. -She did not call Resident #2's facility's contracted pharmacy and discontinue his alfuzosin. -Alfuzosin was used to treat urinary retention. -Resident #2 not receiving alfuzosin could cause him to have problems urinating. Attempted telephone interview with Resident #2's PCP on 11/30/23 at 2:11pm was unsuccessful. 2. Review of Resident #3's FL-2 dated 01/30/23 revealed diagnoses included adaptive deficit. Review of Resident #3's medication orders revealed there was an order dated 11/02/23, for Afluzosin (a medication used to treat the symptoms of an enlarged prostate) 10mg once daily. Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an entry for Afluzosin 10mg every day scheduled for administration at 8:00am. -Alfuzosin was documented as administered at 8:00am daily 11/03/23 through 11/29/23. Observation of Resident #3's medications on hand on 11/30/23 at 2:35pm revealed there was no Afluzosin 10mg available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/30/23 at 2:07pm revealed: -The pharmacy received the order for Alfuzosin on 11/02/23.	C 330	Continuation from page 3 of 4 each bubble to cover that particular Cycle. If not contact the Contracted pharmacy to let them be aware of what number it is on the medication card that is empty, order that empty bubble medication. (H) Please ask for hard copies of new medications at the primary physicians office while you are their. D. The following Plan of Correction will be put into place immediatly and will be on going with dates and signatures of following through the plan	01/03/24 to ongoing

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C 330	Continued From page 4 -The current dispensing records showed 22 tablets of Alfuzosin were dispensed on 11/02/23. -The order for Alfuzosin was "canceled" by the primary care provider's (PCP) office on 11/06/23. -Alfuzosin had not been dispensed since 11/02/23. Interview with the Administrator on 11/30/23 at 2:25pm revealed: -She was not aware Alfuzosin was not on hand. -Afluzosin was not administered to Resident #3 11/25/23 through 11/29/23. -She had documented Alfuzosin was administered to Resident #3 11/25/23 through 11/29/23 on the MAR in error. Telephone interview with a Registered Nurse (RN) at Resident #3's PCP office on 11/30/23 at 2:11pm revealed: -Alfuzosin 10mg was still active on Resident #3's medication list. -Alfuzosin should have never been discontinued at the facility's contracted pharmacy. -She did not know how Resident #3's alfuzosin got canceled at the facility's contracted pharmacy. -She would call the facilty's contracted pharmacy and have Resident #3's alfuzosin restarted. -Alfuzosin was used to treat urinary retention. -Resident #3 not receiving his alfuzosin as ordered could cause him to have problems urinating. Interview with Resident #3 on 11/30/23 at 3:05pm revealed he had not noticed any symptoms or concerns related to not taking Alfuzosin 11/25/23 through 11/29/23.	C 330 C342	10A NCAC 13G. 1004(j) Medication Administration Accuracy of medication Records A. Plan for accuracy of medical Record during the administration of meds 1) Check each medication for accuracy. Check the med card with the medical record making sure that the med card in hand is ~~the~~ same as the medication on the medical records. If their is no medication, the should not be any Signatures on the medical record. If the medication is current but was not delivered by the Contracted pharmacy	
C 342	10A NCAC 13G .1004(j) Medication Administration	C 342		

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STATE FORM

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C 342	Continued From page 5 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 2 of 3 sampled residents (#2, #3) including inaccurate documentation for medications used to treat urinary retention. The findings are: 1. Review of Resident #2's current FL-2 dated 01/30/23 revealed: -Diagnosis included enlarged prostate. -There was an order for tamsulosin (used to treat urinary retention) 0.4mg daily.	C 342	Continuation of page 5 of 9 Contact the pharmacy to let them know what medication are not came with the batch and that it is needed, in other words order the medication. (2) Question to see if the medication has been discontinued why it wasnt delivered. You can never be too sure. (3) If medication was discontinued call primary physicians office to obtain a d.c. order for that med. (4) If there is a new medication in the batch and the facility does not have the new order contact the pcp and the contracted pharmacy to get a copy of the new medications. B. Completion Date	Jan 03 2023 → ongoing

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C 342	Continued From page 6 Review of Resident #2's report of health services to resident sheet revealed: -There was an entry dated 11/02/23 which read will discontinue tamsulosin and start alfuzosin (used to treat urinary retention). -The entry was signed by Resident #2's primary care provider (PCP). Review of Resident #2's after visit summary dated 11/02/23 revealed: -Under today's medication changes it read start taking alfuzosin. -Under medication list it read alfuzosin 10mg daily. -Tamsulosin was not listed on the medication list. Review of Resident #2's record revealed there was a prescription for alfuzosin 10mg daily dated 11/06/23. Review of Resident #2's November 2023. medication administration record (MAR) revealed: -There was an entry for alfuzosin 10mg every day scheduled for administration at 8:00am. -Alfuzosin 10mg was documented as administered at 8:00am on 11/03/23 to 11/30/23. Observation of Resident #2's medications on hand on 11/30/23 at 1:40pm revealed there was no alfuzosin 10mg. Interview with a pharmacist at the facility's contracted pharmacy on 11/30/23 at 2:07pm revealed: -Twenty-two tablets of alfuzosin 10mg was dispensed for Resident #2 on 11/02/23. -The facility's contracted pharmacy only dispensed 22 tablets of alfuzosin on 11/02/23 because the resident's medications were on a cycle fill and the 22 tablets would be enough for	C 342	Continuation of page left Facilities Plan for Inaccurate documentation of medications on medical records: -1) All medications will be Checked three times for Administered, making Sure that the medication being administered are On hand. (1) Check the med card when you take it out of the medication Cart - (2) Make sure you have the right resident - (3) Right name of med. - (4) Right dose & strength of medication - (5) Instructions for administration of med. - (6) Date and time of administration of med. - (7) documentation of any omission of medications or treatments and reason - (8) Name and initials of person	

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C 342	Continued From page 7 him until the next batch of medications were delivered to the facility. -Resident #2's alfuzosin 10mg had been canceled by the Registered Nurse (RN) at the resident's primary care provider's (PCP) office on 11/06/23. -Since they received the cancellation for Resident #2's alfuzosin on 11/06/23 they did not send any to the facility on the next cycle fill. Interview with the Administrator on 11/30/23 at 2:15pm revealed: -When she received batch medications from the facility's contracted pharmacy, she would compare the medications she received with the medications on the resident's MAR. -She thought she saw Resident #2's alfuzosin in the last batch medication received from the facility's contracted pharmacy. -She should have noticed that Resident #2 did not receive alfuzosin with the last batch of medications that were delivered by the facility's contracted pharmacy. -She documented in error that she administered alfuzosin to Resident #3 on 11/25/23 to 11/30/23. 2. Review of Resident #3's FL-2 dated 01/30/2023 revealed diagnoses included adaptive deficit. Review of Resident #3's medication orders revealed there was an order dated 11/02/23, for Afluzosin (a medication used to treat the symptoms urinary retention)10mg to be taken once a day. Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an entry for Afluzosin 10mg every day scheduled for administration at 8:00am.	C 342	Continuation of page 7 of 9 administering the med. D. If a medication is not in the facility and it is a Current medication prescribed on a daily basis or if it is a new medication, always make sure your orders for that medication are accurate, if not, Call the residents' primary Care Physician and the Contracted pharmacy for Clarification as to reduce any and all errors when possible during medication administration. E. Date of Completion	Jan 03 2023 ≥ Ongoing

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C 342	Continued From page 8 -Alfuzosin was documented as administered at 8:00am daily 11/03/23 through 11/29/23. Observation of Resident #3's medications on hand on 11/30/23 at 2:35pm revealed there was no Alfuzosin available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/30/23 at 2:07pm revealed: -The pharmacy received the order for Alfuzosin on 11/02/23. -The current dispensing records showed 22 tablets of Alfuzosin were dispensed on 11/02/23. -The order for Alfuzosin was "canceled" by the primary care provider's office on 11/06/23. -Alfuzosin had not been dispensed since 11/02/23. Interview with the Administrator on 11/30/23 at 2:25pm revealed: -She confirmed Alfuzosin was not on hand. -Afluzosin was not administered to Resident #3 11/25/23 through 11/29/23. -She had documented Alfuzosin was administered to Resident #3 on 11/25/23 through 11/29/23 on the MAR in error.	C 342	Continuation of page 8 of 9 The administrator will be in charge of making sure that all of the plans of corrections are enforced.	Jan-03 2023 Ongoing