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| HAYMOUNT REHABILITATION & NURSING CENTER, INC | 2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303 |

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| F 000 | INITIAL COMMENTS<br><br>The surveyor entered the facility on 5/21/18 to conduct a complaint survey and exited on 5/22/18. Additional information was obtained on 5/23/18 and 5/29/18. Therefore, the exit date was changed to 5/29/18. | F 000 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interview, and staff interviews for one (Resident # 3) of three sampled residents, the facility failed to monitor for pain medication side effects when the resident had a documented history of side effects | F 757 | 1.Southern Pharmacy will continue to monitors all resident orders based on diagnosis, allergies, and clinical necessity. Pharmacists will use sound judgment and best clinical practice to determine | 6/26/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/15/2018

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| F 757 | Continued From page 1<br>and allergies to pain medication.<br>The findings included:<br><br>Record review revealed Resident # 3 was admitted to the skilled section of the facility on 4/30/18 after undergoing a total left knee replacement secondary to osteoarthritis. Prior to the resident's surgery she had resided on the assisted living unit of the facility.<br><br>Review of the resident's 4/30/18 hospital discharge summary revealed the following information. Following her surgery, the resident had initially been prescribed Dilaudid for pain. On the second post-operative day, the resident had appeared lethargic. There was documentation the lethargy was "likely secondary to pain medication." The Dilaudid was stopped, and within approximately five hours the resident was noted to be more alert and oriented. The resident reported to the physician that she normally took Vicodin for pain, and therefore Vicodin was restarted. (Vicodin is a combination of hydrocodone and acetaminophen). At time of hospital discharge, the resident was documented as alert, oriented, "emotionally appropriate," and cooperative.<br><br>According to hospital discharge summary orders the resident was to receive hydrocodone-acetaminophen 5-300 mg (milligrams) every six hours as needed for pain. The hospital discharge summary also noted, "scheduled Tylenol."<br><br>According to the hospital discharge summary the resident had multiple documented allergies. One of the listed allergies was Oxycontin, which is an extended release form of oxycodone. | F 757 | appropriate therapy while considering risk vs benefit. All resident that have an allergy/side effect to a drug are monitored monthly by the consultant pharmacist. An alert system is and was in place at the time of the survey that alerts facility to specific drug allergies. On 4/30/18, resident was readmitted to the skilled unit of the facility. The alert system did alert the prescribing pharmacist of the drug allergy of Oxycontin. The prescribing consultant made sound judgment and utilized best clinical practice and reviewed medication history. Patient had received Norco in the past and had did not have any true side effects or reactions to the drug, therefore, Oxycodone was prescribed. The prescribing pharmacist will now send out written correspondence to the facility before dispensing the medication for drugs identified in the alert system. The MD will give the approval for the drug and documentation will be placed in the resident's medical record.<br>On 5/4/18, the physician wrote an order to discontinue Percocet, and resident wasn't prescribed Percocet, the facility determined that this was human error.<br>2. a.Educational sessions began on 6/13/18 conducted by the Director of Quality & Education and DON to include documentation and follow-up of pain medications. All licensed nurses and Med Aides/Techs will be trained by 6/20/18 or they will be removed from the schedule until training occurs.<br>b.Southern Pharmacy policies for medication monitoring were reviewed. Facility administrative staff and pharmacy | |

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| F 757 | Continued From page 2<br><br>Review of the resident's facility record revealed on 5/1/18 the resident's pain medication orders were clarified through her facility physician to be hydrocodone-acetaminophen 5-325 mg one tab every six hours as needed for pain and Tylenol Extra Strength two 500 mg tabs every six hours as needed for pain.<br><br>Also, it was noted upon the resident's facility admission orders that the resident had an allergy to Oxycontin. This information appeared on her May, 2018 cumulative physician's order sheet and also on the May, 2018 medication administration record (MAR).<br><br>Review of physician orders revealed the physician's assistant (PA) wrote an order on 5/4/18 to discontinue the resident's Percocet. (Percocet is a combination of oxycodone and acetaminophen). At the time the PA wrote this order, the resident was not receiving Percocet. The PA prescribed oxycodone 5 mg every six hours. When the 5/4/18 oxycodone order was written, there was still documentation on the record the resident had an allergy to Oxycontin.<br><br>According to the May, 2018 MAR the Oxycodone order was transcribed to the digital MAR to be given at 12 AM, 6 AM, 12 PM, and 6 PM. Excluding fourteen doses, the resident was documented as receiving the medication from 6 PM on 5/4/18 through 5/21/18 at 6 PM. This meant she received 55 doses of oxycodone. For fourteen of the doses, a "N" appeared on the digital MAR which indicated it had not been given. These fourteen times were as follows:<br>5/14/18- at 12 PM and 6 PM<br>5/15/18 - at 12 AM; 6 AM; 12 PM; and 6 PM | F 757 | executives met on 6/13/18 to discuss current practice. The pharmacy implemented a plan to communicate any/all drug allergies and sensitivities to the facility before administration of a drug identified in the alert system.<br>c.Monthly pharmacist medication profile audits will ensure appropriate use of medications and compliance within facility.<br>d.The facility will bring copies of all physician's orders to the Morning Meeting daily to ensure accuracy of orders and order clarification will be obtained as necessary.<br><br>3.a.Pharmacist will continue to conduct a monthly chart review to include areas of appropriate use of medications. Drug Regimen Reports will be given to the DON upon exit after monthly pharmacy review and any findings of unnecessary meds will be addressed with the physician.<br>b.Nurses will continue to monitor for negative side effects of medications and will notify the physician as needed. The nurse will also communicate such negative side effects on the 24 Hour report. 24 Hour reports will continue to be reviewed in the morning clinical meeting 5 X's weekly by the clinical nursing team. Any findings of side effects not communicated with the physician will result in disciplinary action or repeat training.<br>c.Weekly audits will be conducted by the DNS and/or designee and findings documented on audit sheet, Weekly Drug Monitoring Audit Tool. Compliance with | |

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| F 757 | Continued From page 3<br>5/16/18-at 12 AM; 6 AM; 12 PM<br>5/17/18 at 12 AM; and 6 AM<br>5/18/18 at 12 AM and 6 AM<br>5/21/18 at 12 PM.<br><br>On 5/14/18 the resident's admission minimum data set assessment was completed. The resident was assessed to be cognitively intact. The resident scored a perfect score of 15 on her brief interview for mental status.<br><br>Review of nursing notes revealed an entry on 5/15/18 at 2:17 AM by Nurse # 2. Nurse # 2 noted the resident stated the oxycodone, "makes me feel crazy."<br><br>On 5/16/18 at 2:39 AM, Nurse # 3 documented the resident was not able to sleep at night.<br><br>On 5/17/18 at 2:19 AM, Nurse # 3 documented the resident had been refusing her oxycodone and had spent more hours sleeping since she had refused it.<br><br>According to the record, the resident went to the orthopedic on 5/15/18 for a follow up visit. The date of 5/15/18 coincided with a date on which the resident did not take the oxycodone. The orthopedic noted on his consultation report that he prescribed the resident to have one to two tablets of Norco 5/325 mg every one to two hours as needed for pain. (Norco is a combination of hydrocodone and acetaminophen, which was originally prescribed for the resident after her surgery).<br><br>According to the record, the resident was also seen by the attending physician on 5/15/18. The physician did not note anything regarding the | F 757 | the audits and changes will be brought to the facility monthly QAPI by DNS/ Designee meeting x 4 months, and as needed going forward, for review of compliance with said plan by the QAPI committee members.<br>d.Outcomes, discussions, and revisions if needed, will be part of the meeting minutes<br>e.Applicable staff will be re-in serviced by SDC/Designee as needed for any revisions to said plan.<br>f.Revisions to said plan will require monitoring to begin again at step 3(a).<br>4.a. The facility DON, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program.<br>b. The facility Executive Director, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the DON's absence | |

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resident's pain medications.

Record review revealed on 5/17/18 the consultant pharmacist reviewed the resident's medication regimen during her monthly audit. The pharmacist noted the resident's Percocet was discontinued on 5/4/18 and the resident was started on scheduled doses of oxycodone. The pharmacist did not question this order or make any recommendations regarding the oxycodone use.

Two interviews were completed with the resident prior to the resident's full chart review being completed which revealed she had a documented history of an Oxycontin allergy. These interviews were on 5/21/18 at 9:17 AM and 3:45 PM while the resident was still on oxycodone. On 5/21/18 at 9:17 AM the resident complained that she had not correctly received her pain medication. She had asked about it but was told by a staff member the medication nurse was "hiding out" somewhere and that was why she did not get it. The resident also reported at this time that she had recently had money stolen from her. She said she kept a key to her locked drawer around her wrist, and someone had removed the key while she slept. On 5/21/18 at 3:45 PM, the resident was interviewed again. The resident stated she had again not gotten her pain medication that day at 12 noon. She stated Nurse # 1 was supposed to have given it to her, and she had been in pain. When asked about details of not getting her pain medication, the resident seemed to have trouble recalling exactly all the details. She also reported Nurse # 1 had told her she was out of pain medication. The resident was worried about what she was going to do regarding her pain since there was no medication. The resident further

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reported the following. She had not wanted to be on oxycodone because she could not take the "full strength of it." She had always taken Norco (hydrocodone) for pain, which she was accustomed to taking without a problem. She had recently gone to her orthopedic and asked him to switch her back to the Norco, and he wrote a prescription and order for it. She brought the order and prescription back to the facility following her orthopedic appointment and gave it to a staff member. She was still not getting the Norco. She had tried to talk to staff about it, and they had told her oxycodone and Norco "were all the same thing." She was not clear regarding to whom she had had discussed this, but was consistent in that she did not like being on the oxycodone because she thought it made her feel different than when she was on the Norco. She also seemed unsure of what needed to be done since the staff had told her the oxycodone was the same thing as the Norco which she had always taken.

Directly following the 3:45 PM interview on 5/21/18, Nurse # 1 was interviewed about the resident not receiving any pain medication and her claims that she was out of medication. According to the nurse, the resident had been asleep at 12 noon when the oxycodone was due to be administered. Therefore per nursing discretion the nurse held the pain medication and did not awaken the resident. The nurse stated she never told the resident she was out of pain medication, and the nurse stated she thought the resident might be confused. The nurse opened the narcotic medication cart to show there was pain medication still in stock for the resident. During the conversation with the nurse, the nurse did not mention that the resident had a

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documented allergy to Oxycontin and the surveyor had not yet completed a chart review. While the surveyor was talking to Nurse # 1, the DON (Director of Nursing) approached. It was shared with the DON that the resident had concerns about her pain medication. The DON was asked if the orthopedic consult could be obtained for the surveyor's review the next day. The DON stated she would obtain it.

On 5/22/18 at 9 AM the resident was observed in her room lying in bed. A nurse aide (NA) was taking away her breakfast tray at this time. The resident had not eaten. The resident stated she was dizzy and nauseous.

Following this interview the review of the resident's chart was completed revealing the resident had the documented allergy to oxycodone. Also, the DON had made an entry on 5/21/18 at 5:39 PM noting she had spoken to the resident. The time of 5:39 PM was following the time the surveyor had spoken to the DON on 5/21/18 letting her know the resident had medication concerns. At 5:39 PM the DON documented the resident told her she did not want to be on oxycodone and wanted to be on the Norco. The DON noted the physician was called and an order was obtained to change the resident to Norco 5-325 mg every six hours for pain, and Norco 5-325 mg every six hours as need for breakthrough pain.

The oxycodone was discontinued on the May, 2018 MAR after the resident received the 6 PM dose on 5/21/18.

On 5/22/18 at 10:20 AM the DON and a corporate consultant were interviewed. They were asked

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about the 5/4/18 Percocet discontinuation order which had been written when the resident was not on Percocet. They did not know why the PA had written the order to discontinue a medication the resident was not receiving or why he had placed the resident on oxycodone when she had an allergy to Oxycontin.

The PA was interviewed on 5/22/18 at 12:15 PM and reported the following. On 5/4/18 he was trying to lessen the potential of liver damage by placing the resident on a pain medication that did not include acetaminophen. In retrospect, he realized he should have written to discontinue hydrocodone rather than discontinue Percocet. The PA stated usually a resident, who could take hydrocodone, could also take oxycodone. For residents who have listed allergies to one of the medications, it might mean an intolerance but not a true allergy to the medication. Since Resident # 3 had been taking hydrocodone without a problem, he had felt she could tolerate the oxycodone.

A pharmacy manger was interviewed on 5/22/18 at 1:10 PM. The pharmacy manager stated they had not questioned the order for the oxycodone on 5/4/18 before filling it and dispensing it to the facility. According to the pharmacist both hydrocodone and oxycodone are in the same drug class, and therefore if a resident was allergic to one then they should be allergic to the other. According to the pharmacist side effects could vary from one of these medications compared to the other, and were "patient specific."

Interviews were conducted with direct care staff who had cared for Resident # 3 while she was on the oxycodone. They are as follows.

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Medication Aide (MA) # 1 had been responsible for two of the fourteen oxycodone doses which had been held. MA # 1 was interviewed on 5/22/18 at 2:10 PM. The MA stated the resident had reported the oxycodone made her dizzy and she had told Nurse # 1.

Nurse # 1 had been responsible for four of the fourteen oxycodone doses which had been held. Nurse # 1 was interviewed on 5/22/18 at 2:17 PM. Nurse # 1 reported sometimes the resident would be asleep and she did not awaken sleeping residents for pain medication. Nurse # 1 also stated MA # 1 had not told her the medication was making the resident dizzy or she would have talked to the physician about it.

Nurse # 2 had been responsible for two of the fourteen oxycodone doses which had been held. These held doses were on 5/14/18. This date was before the resident discussed her medications with the orthopedic and returned to the facility to be told by staff that oxycodone and hydrocodone were the same thing. Nurse # 2 was interviewed on 5/22/18 at 3:30 PM and reported the following. She had held the doses of oxycodone on the 14th because the resident had told her it "made her feel loopy." The resident only wanted Tylenol. The doses she had held were on the same shift. She had placed the resident's concern on the 24 hour report and thought it would be addressed. She did not return to work until the night of 5/18/18 and was surprised when she saw the oxycodone was still ordered. She asked the resident about it, and the resident told her she would take it because she had decided it might be the Tylenol which was affecting her. Therefore, she gave the oxycodone.

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Nurse # 3 had been responsible for six of the fourteen oxycodone doses which had been held. Nurse # 3 was interviewed on 5/22/18 at 10:30 PM. Nurse # 3 reported the following. The resident had refused the oxycodone because she did not like the way it made her feel. She had said she did not want to take any more narcotics, and Tylenol helped her at night when the nurse worked. Therefore, she gave the resident Tylenol instead for pain. She had put the resident's concerns about oxycodone on the 24 hour report to be addressed.

NA (Nurse Aide) # 1 was interviewed on 5/22/18 at 2:15 PM. NA # 1 reported the following. She took care of the resident approximately two days per week. The resident had complained of dizzy spells and feeling sick on her stomach at times when she cared for her. She told the medication aide on the hall when this occurred.

NA # 2 was interviewed on 5/22/18 at 2:20 PM. NA # 2 stated she had cared for the resident on 5/20/18. The NA reported the following. The resident appeared confused on 5/20/18. The resident had claimed someone had stolen money from her and reported problems with the key to her personal locked storage. The NA reported the resident's story regarding the stolen money did not seem to make sense.

Interview with the administrator on 5/23/18 at 4:43 PM revealed the consultant pharmacist would be available for interview on 5/29/18.

The consultant pharmacist was interviewed on 5/29/18 at 12:18 PM and reported the following information. She had not questioned the 5/4/18

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order to discontinue Percocet and start oxycodone. Both hydrocodone and oxycodone are codeine derivatives and therefore typically an individual with an allergy to one would have an allergy to the other. The pharmacist had thought, since the resident had been taking the hydrocodone without problems, there was no need to question the oxycodone order. During her 5/17/18 review, the pharmacist had identified the resident was starting to refuse a few doses of the oxycodone, but thought it was attributed either to the resident not having pain or an effort to decrease her Opioid use. She had not talked to the resident, and staff had not alerted her that the resident could be having some side effects. According to the pharmacist, in general some residents tolerate one of the medications better than the other, and some residents report less side effects while taking one of the medications versus the other. The better tolerated medication varied between different individuals. It would have been her expectation that if the nurses knew the resident was complaining of dizziness, did not like how she felt on the oxycodone, or felt it might be contributing to confusion that they would have reported this to the physician so it could be addressed.

Interview with the physician on 5/22/18 at 1:45 PM revealed he had not been aware the resident was having any possible side effects to the oxycodone. The physician did not feel the resident had a true allergy to oxycodone or that she had been harmed by receiving it. The physician was not sure what the documented allergy to oxycodone entailed. According to the physician the resident might tolerate the hydrocodone better and with less side effects than the oxycodone, and it was his plan to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345414 | A. BUILDING _____ B. WING _____ | C 05/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HAYMOUNT REHABILITATION & NURSING CENTER, INC** | **2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303** |

| (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) COMPLETION DATE |
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| F 757 | Continued From page 11<br>discuss it with the resident. | F 757 | | |