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	NH0435	A. BUILDING: _____ B. WING _____	C 02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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D 000	Initial Comments An unannounced onsite complaint investigation was conducted from 01/22/24 through 01/26/24 with additional information obtained on 02/01/24. Therefore, the exit date was 02/01/24. Event ID #2GIM11. Intake# NC00206545 was investigated. One (1) of 1 allegation resulted in deficiency.	D 000		
D 410	10A NCAC 13F .1010(c) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis. This Rule is not met as evidenced by: Based on record reviews, staff, Resident, Pharmacist and Physician Assistant interviews the facility failed to obtain a medication prescribed for chronic pain from the pharmacy resulting in the resident not receiving 3 doses of the medication for 1 of 1 resident (Resident #211) reviewed for pharmacy services. The finding included: Resident #211 was admitted to the assisted living facility on 04/25/22 with diagnoses that included chronic obstructive pulmonary disease. A review of a Neurological Assessment dated 12/07/23 from 4:30 PM to 6:15 PM and documented by Nurse #2 revealed Resident #211	D 410	D410 Resident #211 received his medication on January 22, 2024, per physician order. Current residents in the Assisted Living are at risk for this deficit practice. On February 23, 2024, The Director of Nursing completed an audit Residents on Assisted Living pain medications to ensure availability. All Residents pain medications were available. On January 24, 2024, The Director of Nursing/Staff Development Coordinator began educating all current licensed nurses, medication aides/techs on	3/4/24

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D 410	Continued From page 1 was alert. A review of Resident #211's physician orders revealed an order dated 04/25/23 for Oxycodone-Acetaminophen Tablet 10-325 milligrams (mg) (a narcotic analgesic) take one tablet by mouth four times a day for chronic pain. A review of Resident #211's Medication Monitoring/Control Record for Oxycodone-Acetaminophen Tablets 10-325 mg tablets revealed the last dose was given on 01/22/24 at 1:36 AM by Medication Aide (MA) #5. The remaining count was 0. Review of Resident #211's 01/2024 Medication Administration Record (MAR) revealed the Oxycodone-Acetaminophen was scheduled to be given at 1:00 AM, 8:00 AM, 2:00 PM and 8:00 PM. The MAR further revealed the Oxycodone-Acetaminophen was not given on 01/22/24 at 8:00 AM, 2:00 PM and 8:00 PM. The documentation indicated to see the Progress Notes for details written by Medication Aide (MA) #3. A review of Resident #211's progress notes written by MA #3 on 01/22/24 at 9:52 AM, 01/22/24 at 1:06 PM and 01/22/24 at 8:45 PM. The notes stated, "waiting on pharmacy". An interview was conducted with Resident #211 on 01/23/24 at 1:35 PM. The Resident was sitting on the side of his bed, neatly groomed, alert and oriented and well versed in conversation. Resident #211 explained that he had a problem with the facility running out of his oxycodone and it happened again yesterday (01/22/24). He stated when MA #3 gave him his 8:00 AM medications on 01/22/24 the MA informed him	D 410	medication availability and following physician orders. The Director of Nursing/Staff Development Coordinator will ensure all current licensed nurses and medication aides/techs who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator will ensure newly hired licensed nurses and medication aides/techs, to include agency staff, will receive education during facility orientation in-person or via telephone prior to working. The Director of Nursing/Staff Develop Coordinator will monitor using a Quality Assurance tool for pain medication availability. The monitoring will include inspection of medication carts for pain medication availability. The QA monitoring will be conducted weekly x 12 weeks. The Director of Nursing/Staff Development Coordinator will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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that he was out of his oxycodone, and she had already called the pharmacy to check on when the medication would be delivered and the pharmacy informed MA #3 that it would be delivered between 4-5 pm on 01/22/24. The Resident stated the oxycodone did not come at that time and it was not delivered until around midnight which was when Resident #211 finally got a dose of oxycodone. The Resident stated he had to suffer because he had to go about 23 hours without his narcotic pain medication that he needed for his chronic pain. He stated that he should not have to go without his pain medication to the point of going through withdrawals.

During an interview with MA #3 on 01/23/24 at 2:41 PM the MA explained that it was reported to her on 01/22/24 by the third shift MA #5 that Resident #211 did not have any more oxycodone left in his card and MA #3 had already called the pharmacy to see when they could deliver the medication to the facility. The pharmacy told MA #3 that the oxycodone would be delivered to the facility in the mid-day delivery between 4-5 pm. The MA stated she informed the Resident of that, and he said "okay" and thanked me for doing that. The MA continued to explain that when the midday pharmacy delivery came, she went to get the Resident's oxycodone and it was not in the delivery so she called the pharmacy back and the pharmacy stated it would be in the late run between 11-12 PM and by that time she would be going home. The MA explained that when she needed to reorder narcotics, she let the supervisor or unit manager know and they would print the prescription and she would take it to the provider to sign it and then fax it to the pharmacy for refill. When asked why the MA did not let a nurse know that the Resident was out of the oxycodone the MA indicated she knew Resident

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#211's oxycodone had already been requested from the pharmacy and that was why she kept calling the pharmacy to check on the medication.

An interview was conducted with MA #2 on 01/24/24 t 6:17 PM and who explained that she often worked with Resident #211 and the last time she worked with the Resident he had at least a 2-3 day supply of oxycodone left in his card because she did not have to request a prescription for a refill.

An interview was conducted with MA #7 on 01/24/24 at 6:30 PM who confirmed she worked with Resident #211 on 01/21/24 on 3 PM - 11 PM shift and had to administer the Resident's oxycodone during her shift (8:00 PM). The MA indicated she did not recall Resident #211 being low on oxycodone or she would have notified the supervisor for a refill.

During an interview with Nurse #2 on 01/24/24 at 6:49 PM and 01/26/24 at 4:26 PM the Nurse reported she occasionally worked with Resident #211 when she worked the unit he lived on. The Nurse described the Resident to be alert and oriented to person, place and time and voiced his wants and needs. Nurse #2 explained that medication aides normally informed her of needed refills from the pharmacy and she would print the prescription and put it in the provider's box for their signature. The Nurse indicated she did not recall recently being asked to print a prescription for Resident #211.

An interview was conducted with MA #8 on 01/24/24 7:00 PM who confirmed that she worked with Resident #211 on 01/19/24 at 1:00 AM and had given him a dose of oxycodone and she noticed the supply was running low. The MA

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explained that she notified Nurse #12 that Resident #211 needed a new prescription for the oxycodone during that shift on 01/19/24 and Nurse #12 confirmed that she had faxed a new prescription to the pharmacy.

During an interview with Nurse #12 on 01/25/24 at 8:00 AM the Nurse confirmed that MA #8 notified her during the shift on 01/19/24 that Resident #211 needed a new prescription for his oxycodone, and she printed off the prescription and put it in the provider's box so they could sign it and fax the prescription to the pharmacy. The Nurse stated she did not know which provider was scheduled to work that day so she could not say which provide signed the prescription.

An interview was conducted with the Pharmacist on 01/25/24 at 10:21 AM. The Pharmacist explained that the pharmacy received a new prescription for Resident #211 on 01/18/24 Oxycodone-Acetaminophen 10/325 mg to be given four times a day for 120 tablets written by the NP and it was delivered to the facility in the early morning of 01/23/24. The Pharmacist continued to explain that the refill was requested too early on 01/18/24 and that was why the medication was not sent from the pharmacy until the evening of 01/22/24. She continued to explain that they also had an issue with the Resident's insurance approving the medication and it was rejected three times and on the fourth time it was accepted which was when the medication was sent to the facility in the delivery on 01/22/24. The Pharmacist was asked why they did not call the facility to find out how much medication they had on hand for the Resident and the Pharmacist stated they could not have the manpower to call the facilities after every rejected claim and sometimes it did take several attempts to get it

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approved. The Pharmacist stated there was no record that anyone from the facility called to notify the pharmacy that they were running out of the medication, because they could have sent a stat dose to the facility until the Resident's insurance approved a refill. The Pharmacist continued to explain that they ask the facilities to request refills 3-5 days before they completely run out of medication in the event the pharmacy had issues with insurances and in this case, they did but no one from the facility called to inform the pharmacy that they were running completely out of Resident #211's pain medication.

On 01/25/24 at 10:45 AM an interview was conducted with MA #4 who confirmed she gave Resident #211 a dose of oxycodone at 12:59 AM on 01/23/24 after receiving the medication from the pharmacy. The MA explained that she has never not had Resident #211's oxycodone to give him and she always made sure she reordered routine medications when they got down to having a 2-3 day supply left in the card.

An interview was conducted with MA #6 on 01/25/24 at 11:45 AM. The MA stated that she sometime worked with Resident #211 and the last time she worked with him was 01/20/24 and 01/21/24 (Saturday and Sunday) from 7:00 AM to 3:00 PM. The MA explained that she usually looked to make sure the residents had enough medications on hand to prevent them from running out of narcotics, but she did not do that over the weekend. The MA explained she should have looked to see if the Resident had enough oxycodone and if he didn't, I would have called the pharmacy to see if they could send some in the delivery and if not, I would have let my supervisor know so that she could get a prescription for it and fax it to the pharmacy.

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D 410	Continued From page 6 During an interview with MA #5 on 01/25/24 at 2:37 PM the MA confirmed she worked third shift on 01/21/24 and gave Resident #211 his last dose of oxycodone around 1:00 AM. She explained that she only worked on the assisted living side of the facility 3-4 times a month and the last time she had worked the Resident had plenty of oxycodone left and did not need to request a refill. The MA continued to explain that when she reported off to MA #3, around 7:00 AM on 01/22/24 she informed her that she used the last pill and had already pulled the empty card from the medication cart. The MA stated she was still new to the process and that was what she did when she needed a medication refilled. On 01/25/24 at 2:44 PM an interview was conducted with Nurse #15 who confirmed that she worked with Resident #211 on the morning of 01/21/24 at 1:00 AM and gave the Resident his oxycodone. The Nurse explained that she usually reordered medication from the pharmacy when the remaining tablets were in the last column, and she did not recall Resident #211's oxycodone being that low or she would have reordered the medication. An interview was conducted with the Nurse Practitioner (NP) on 01/26/24 at 10:47 AM who confirmed he worked in the facility on 01/18/24 and signed a prescription for Resident #211's oxycodone. The NP stated that he was not made aware of the Resident running low on his pain medication and not receiving three doses of the narcotic. He explained that he would have expected the nurses to either call the pharmacy and see if they could stat the Resident down some or they could have called the NP, and he would have ordered something in the place until	D 410		

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the Resident's supply was delivered from the pharmacy. The NP stated Resident #211 should not have had to go without his pain medication.

During an interview with MA #1 on 01/26/24 at 2:45 PM she confirmed that she worked on 01/20/24 at 8:00 PM and gave Resident #211 his dose of oxycodone. The MA explained that she did notice that he was running low on the oxycodone, but MA #8 had already told her that she had notified Nurse #12 that the Resident needed a new prescription for his oxycodone and the Nurse had faxed a new prescription to the pharmacy and they were waiting on the medication to be delivered to the facility.

An interview was conducted with Unit Manager (UM) #2 on 01/26/24 at 10:27 AM. The UM explained that the requests for refills should be made when the medication was in the last column which is indicated in blue on the medication card. She continued to explain that the nurses or medication aides should call the pharmacy and ask for the refill and if needed they should call the provider and ask for something to be used in the place of the medication. The UM stated the residents should not have to go without their pain medication.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:36 AM the DON explained that the medication aides should notify the nurses a few days before the medication runs out that they needed a prescription for the medication so that it could be attained and faxed to the pharmacy. She stated if needed they could get the medication from the backup pharmacy regardless the DON stated someone should have called the pharmacy and checked on the medication for Resident #211.

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D 410	Continued From page 8 An interview was conducted with the Administrator on 02/01/24 at 3:57 PM who explained that there should be no reason for a resident to run out of their medication.	D 410		