STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldsboro Rehabilitation and Healthcare Center	1700 Wayne Memorial Drive Goldsboro, NC 27534

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50404 Based on observation, record review, resident, facility staff, pharmacist, and Nurse Practitioner (NP) interviews the facility failed to obtain a narcotic refill prescription to provide pain medication for 1 of 3 residents reviewed for pain management (Resident #57). The findings included: Resident #57 was admitted to the facility on [DATE] with diagnosis that included osteoarthritis of the right knee, and spinal stenosis. Record review of the Physician order dated 3/5/24, oxycodone-acetaminophen oral tablet 5-325 milligram (mg). Give 1 tablet by mouth every 8 hours as needed for pain (PRN). Review of the controlled drug record sheet for Resident #57 which was received on 7/19/24 revealed the last dose of medication in the card was administered on 8/30/24. Review of the Medication Administration Record (MAR) for Resident #57 dated August 2024 revealed she last received an as needed dose of pain medication on 8/30/24 (Friday) at 9:17 PM. There were no doses recorded as being administered on 8/31/24 (Saturday). Review of an electronic dispensing system report revealed there were no doses of oxycodone-acetaminophen 5-325mg dispensed for Resident #57 from 8/30/24 through 9/5/24. Review of Physician order provided by the pharmacy disclosed a prescription renewal order for Resident #57's oxycodone-acetaminophen 5-325mg was reordered on 9/2/24 at 11:09 AM. The renewal order was required for each time the controlled medication ran out or was close to running out. Review of the controlled drug record of oxycodone-acetaminophen 5-325mg revealed Resident #57's medication card was received on 9/3/24 and the first dose from the new card was administered on 9/3/24. Review of the MAR for Resident #57 dated for the month of September 2024 revealed administration of oxycodone-acetaminophen 5-325mg was administered on 9/3/24. There were no doses recorded as being administered on 9/1/24 (Sunday) or 9/2/24 (Labor Day). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 5:08 PM, an interview was conducted with Resident #57, she stated she requested oxycodone-acetaminophen 5-325mg on Saturday (8/31/24), Sunday (9/1/24) and Monday (9/2/24). Nurse #1 told her it was not available. An observation was conducted in conjunction with an interview with Nurse #1 on 9/5/24 at 11:28 AM. During the interview she stated she had provided the last dose from the card to Resident #57 on 8/30/24 and she was unable to obtain the prescription requested from the NP or the on-call service for the narcotic. An observation of Nurse #1 was conducted as she used the medication dispensing system. During the observation the nurse was unable to demonstrate how to obtain narcotics from the electronic medication dispensing system. She scrolled through Resident #57 list and stated there were no narcotics available. She stated she did call the physician several times to follow up on the order on the day of the request. She did not recall if she texted or called the Physician and could not provide evidence that she had made the request for the prescription. When the Nurse Practitioner (NP) was in the facility she gave the request directly to the NP. An interview with Nurse #2 on 9/5/24 at 1:31 PM, revealed to obtain a new narcotic hard script on the weekend or holiday she called the NP, the NP then sent the prescription electronically to the pharmacy. The procedure was to reorder medication when there were 8 pills remaining in the card. An interview with NP on 9/5/24 at 1:46 PM, revealed there was an on-call service for holidays, nights, and weekends. She expected the facility to notify her or the on-call service when the medication count gets low to prevent a delay of obtaining the medications. She explained there was also an electronic medication dispensing system and that was the first back up if a resident was out of medication. When she received a request from the facility for a prescription it was electronically sent to the pharmacy. An interview with the Pharmacist on 9/5/24 at 10:29 AM, via telephone revealed the order for Resident #57's oxycodone-acetaminophen was ordered by the facility on 9/2/24 and delivered to the facility on [DATE]. The Pharmacist reviewed the transactions on the electronic medication dispensing system and indicated it showed nothing was dispensed for Resident #57 from 8/31/24 through 9/2/24. The Pharmacist stated the facility was to order medications when there were 5 doses remaining for the resident. They had not received a request for Resident #57 for oxycodone- acetaminophen until 9/2/24. The Director of Nursing (DON) was interviewed on 9/6/24 at 2:11 pm. She stated the nurses assigned to the medication carts were responsible for ordering medications. The nurse notified the provider for a new narcotic prescription electronically. On the weekends or holidays the nurse called the Provider and had them fax the prescription or send it directly to the pharmacy. The DON stated residents should not go without medications at any time including narcotic medication and all nurses knew how to access the backup medication dispensing machine. When a resident complained of pain, the nurse should check in the electronic backup system first then follow the re-ordering procedure. She also stated there was a recent pharmacy change and it was possible Nurse #1 missed the training of how to obtain narcotics from the medication dispensing system.