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SPRING ARBOR WEST	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

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D 000	Initial Comments The Adult Care Licensure Section conducted an on-site annual and follow-up survey on March 31-April 2, 2015.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure medication was administered in accordance with physician orders for 1 of 6 sampled residents (Resident #6) who had an order for hydrocodone/acetaminophen (Norco). The findings are: Review of Resident #6's FL2 dated 9/17/14 revealed diagnoses which included: -GERD (gastro-esophageal reflux disease) -Depression -Spinal fusion -Venous insufficiency Review of Emergency Room (ER) Patient Visit Information Note for Resident #6 dated 1/17/15 revealed:	D 358		

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- Diagnosis of acute hip pain.
- An order for hydrocodone/acetaminophen (which is generic for Norco) 5/325 mg 1 tablet every 4 to 6 hours as needed for pain, quantity 10 with no refills.

Review of a subsequent physician order from Resident #6's Primary Care Provider (PCP) dated 3/13/15 revealed Norco 5/325 mg 1-2 tablets at bedtime as needed for pain.

Review of Resident #6's e-MAR (electronic Medication Administration Record) from January 2015 revealed:
-A PRN (as needed) medication order for Norco 5/325 mg 1 tablet by mouth every 4-6 hours.
-Documented doses administered on the following:
- -1/19/15 at 7:59pm
- -1/20/15 at 2:17pm and 8:16pm
- -1/21/15 at 6:21am and 11:31pm
- -1/22/15 at 6:11am and 10:33pm
- -1/23/15 at 8:02am and 10:36pm
- -1/24/15 at 6:26am,
- -1/25/15 at 6:08am
- -1/27/15 at 12:11am
- -1/28/15 at 12:04am and 9:19pm
- -1/29/15 at 9:30pm
- -1/30/15 at 10:47pm.

-Thirteen doses documented as administered from 1/21/15 at 6:21am to 1/30/15 at 10:47pm.

Review of Controlled Substance Count Sheet for Norco 5/325 mg, for Resident #7 for January 2015 revealed:
-Staff borrowed 1 tablet for Resident #6 on 1/17/15 at 4:40pm (not on e-MAR).
-Staff borrowed 1 tablet for Resident #6 on 1/18/15 at 12:00am, 6:00am, 4:40pm and 8:40pm (not on e-MAR).

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-Staff borrowed 1 tablet for Resident #6 on 1/19/15 at 6:00am (not on e-MAR).
-Staff borrowed 1 tablet for Resident #6 on 1/20/15 at 6:30am (not on e-MAR).

Review of Resident #6's e-MAR for February 2015 on 4/1/15 revealed:
-A computer generated entry in red that the order for Norco 5/325 mg was discontinued on 2/10/15. (Staff documented nine tablets administered from 2/1/15 to 2/9/15).
-Another computer generated entry for Norco 5/325 mg. (Staff documented twenty tablets administered from 2/10/15 to 2/28/15).

Review of Controlled Substance Count Sheets for Norco 5/325 mg for Residents #8, and #10 revealed a total of nine tablets were borrowed for Resident #6 from 2/1/15 to 2/9/15.

Review of Contolled Substance Count Sheets for Norco 5/325 mg for Residents #8 and #10 revealed a total of nineteen tablets were borrowed for Resident #6 from 2/10/15 to 2/28/15.

Review of eMar for 1 tablet Norco 5/325 mg administered to Resident #6 on 2/16/15 at 10:21pm revealed there was no documentation of where it was obtained.

Review of Controlled Substance Count Sheet for Norco 5/325 mg, for Resident #8 for February 2015 revealed staff borrowed 1 tablet for Resident #6 on 2/14/15 at 10:45pm (not documented on e-MAR).

Review of Resident #6's e-MAR for March 2015 revealed staff documented nine tablets of Norco 5/325 mg were administered from 3/1/15 to

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D 358	Continued From page 3 3/12/15. Review of Contolled Substance Count Sheets for Norco 5/325 mg for Resident #10 revealed a total of nine tablets were borrowed for Resident #6 from 3/1/15 to 3/12/15. Telephone interview with pharmacy staff on 4/1/15 at 2:28pm revealed: -Pharmacy received the order dated 1/17/15 (Saturday) for Norco 5/325 mg 1 every 4-6 hours for pain on 1/19/15 (Monday). - Ten tablets of Norco 5/325 mg were dispensed on 1/20/15 (Tuesday). -When questioned about why the order (Norco 5/325 mg from 1/17/15) was not discontinued after the first 10 tablets were administered the pharmacy staff stated, "I guess I should have canceled it" . -Resident #6 did not have a valid order for Norco after the ten tablets ordered on 1/17/15 were administered. -Resident #6 received the next order for Norco 5/325 mg 1-2 at bedtime as needed for pain on 3/13/15. -The pharmacy dispensed 60 tablets of Norco 5/325 mg on 3/13/15. Review of Resident #6's January, February, and March 2015 e-MARs and review of Controlled Substance Count Sheets for Norco 5/325 mg for Resident #7 and #8 revealed: -The first 10 tablets were administered from 1/17/15 to 1/20/15 at 8:16pm. -After 10 tablets of Norco 5/325 mg were administered per physician orders an additional 52 tablets were administered without a valid order from 1/21/15 to 3/12/15. Interview with Executive Director (ED) and	D 358		

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Resident Care Coordinator (RCC) on 4/1/15 at 4:15pm revealed:
-Resident #6 went to the ER (Emergency Room) for hip pain on 1/17/15 and came back with an order for Norco 5/325 mg 1 every 4-6 hours as needed for pain.
-Staff borrowed Norco from other residents for Resident #6 when she returned to the facility due to prescription not being filled.
-Staff called Resident #6's PCP to get a new order for Norco due to the ER physician only prescribing a quantity of 10 tablets, with no refills.
-The PCP refused to write a new prescription for Norco for Resident #6 until he could see her on 3/13/15.
-Staff continued to borrow Norco from other residents because Resident #6 requested it.
-The e-MAR did not indicate that the 1/17/15 order for Norco was for a quantity of 10 tablets.
-Staff administered medications according to the e-MAR and had no way of knowing that the resident did not have a valid order after the first 10 tablets were given.
-The ED and RCC were unaware that the facility pharmacy does not enter stop dates or quantity limitations on medication orders that have a time or quantity limit.
-The ED stated she would request that the facility pharmacy change the way that time or quantity limited medication orders are entered on the e-MAR.

Interview with Resident #6 was not conducted on 4/2/15 as Resident #6 was out of the facility.

The Plan of Correction provided by the facility revealed:
-Residents in need of medications will have them ordered from the community pharmacy.
-The facility will obtain medications from back up

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D 358	Continued From page 5 pharmacy after normal pharmacy business hours. -Medications will be administered per physicians orders by medication "technicians." -The community will work with pharmacy and electronic Medication Administration Record (eMAR) technician for a plan to improve the way system flags quantity of medications delivered and when orders expire. -The Resident Care Coordinator (RCC) will be in charge of training all medication "technicians" of their notification responsibilities per pharmacy delivery and concerns regarding deliver or physician order concerns or questions. -The RCC will also ensure all physician orders are being followed for medication administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 17, 2015.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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	D 367		

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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 observation, record review and interviews the facility failed to accurately document medication administration of controlled medications (Vicodin, hydrocodone/acetaminophen, and Tramadol) on the Medication Administration Records for 3 of 6 residents. (Residents #1, #2, and #6).

The findings are:

A. Review of Resident #6's FL2 dated 9/17/14 revealed diagnoses which included:
-GERD (gastroesophageal reflux disease)
-Spinal fusion
-Venous insufficiency

Review of Emergency Room (ER) Patient Visit Information Note for Resident #6 dated 1/17/15 revealed:
- Diagnosis of acute hip pain.
- An order for hydrocodone/acetaminophen (generic for Norco) 5/325 mg 1 tablet every 4 to 6 hours as needed for pain, quantity 10 with no refills.

Review of a subsequent order from Resident #6's Primary Care Physician (PCP) dated 3/13/15 revealed Norco 5/325 mg 1-2 tablets at bedtime as needed for pain.

Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #7 for January 2015

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revealed:
-Staff borrowed 1 tablet for Resident #6 on 1/17/15 at 4:40pm.
-Staff borrowed 1 tablet for Resident #6 on 1/18/15 at 12:00am, 6:00am, 4:40pm and 8:40pm.
-Staff borrowed 1 tablet for Resident #6 on 1/19/15 at 6:00am.
-Staff borrowed 1 tablet for Resident #6 on 1/20/15 from at 6:30am.

Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #10 for February 2015 revealed that staff borrowed 1 tablet for Resident #6 on 2/14/15 at 10:45pm.

Review of Resident #6's e-MAR (electronic Medication Administration Record) for January 2015 revealed:
-No documented dose administered on 1/17/15 at 4:40pm.
-No documented dose administered on 1/18/15 at 12:00am, 6:00am, 4:40pm and 8:40pm.
-No documented dose administered on 1/19/15 at 6:00am.
-No documented dose administered on 1/20/15 at 6:30am.
-An entry for Norco 5/325 mg dated 1/20/15 with documented doses on the following:
- -1/19/15 at 7:59pm
- -1/20/15 at 2:17pm and 8:16pm
- -1/21/15 at 6:21am and 11:31pm
- -1/22/15 at 6:11am and 10:33pm
- -1/23/15 at 8:02am and 10:36pm
- -1/24/15 at 6:26am
- -1/25/15 at 6:08am
- -1/27/15 at 12:11am
- -1/28/15 at 12:04am and 9:19pm
- -1/29/15 at 9:30pm
- -1/30/15 at 10:47pm

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D 367	Continued From page 8 Review of Resident #6's e-MAR and Controlled Substance Count Sheet from Resident #7 from January 2015 revealed a total of 10 tablets of Norco 5/325 mg were given from 1/17/15 at 4:40pm to 1/20/15 at 8:16pm. Review of Resident #6's record revealed that the order for Norco 5/325 mg was faxed to the pharmacy on 1/17/15 but was not filled until 1/20/15. Interview with Resident #6 was not conducted on 4/2/15 as Resident #6 was out of the facility. Refer to combined interview with RCC and ED on 4/2/15 at 12:35pm. B. Review of Resident #1's FL2 dated 3/04/15 revealed diagnoses which included: -COPD (chronic obstructive pulmonary disease) -High cholesterol -End stage renal disease -High blood pressure -Diastolic congestive heart failure -Atrial fibrillation -Hypothyroidism -Depression Review of dental notes for Resident #1 dated 3/10/15 revealed: - Diagnosis of left 1st molar extraction with local anesthetic. - A physician order for Vicodin 5/300 mg 1 tablet every four hours as needed for pain. Observation of medication on hand for Resident #1 on 4/1/15 at 11:15am revealed a bottle of Vicodin 5/300 mg, with a fill date of 3/10/15 for quantity 20, with 17 tablets remaining.	D 367		

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D 367	Continued From page 9 Review of the Controlled Substance Count Sheet for Vicodin 5/300 mg for Resident #1 revealed: - Documented administration of one tablet on 3/10/15 at 4:35pm by staff. - Documented administration of one tablet on 3/10/15 at 9:20pm by staff. - Documented administration of one tablet on 3/11/15 at 8:00am by staff. Review of Resident #1's e-MAR for March 2015 revealed: -The number of Vicodin 5/300 mg tablets administered according to the e-Mar was one. -The e-MAR was missing documentation of Vicodin 5/300 mg administered on 3/10/15 at 4:35pm and 9:20pm. Interview with Medication Aide (MA), Staff B on 4/1/15 at 11:15am revealed the missing doses on the e-MAR "could have been borrowed by another resident". A second interview with Staff B on 4/1/15 at 1:44pm revealed: -The Vicodin for Resident #1 was "possibly loaned to Resident #6". - "If the medication was borrowed by another resident the name of that resident would be written on Resident #1's controlled substance count sheet or the Narcotic Borrow Sheets". Review of the facility Narcotic Borrow Sheets on 4/1/15 revealed that Vicodin 5/300 mg was not documented as borrowed from Resident #1 in March 2015. Interview with Resident #1 was not conducted on 4/1/15 as Resident #1 was out of the facility.	D 367		

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Interview with Medication Aide, Staff C, on 4/1/15 at 3:30pm revealed:
-She remembered administering Vicodin 5/300 mg to Resident #1 on 3/10/15 at 4:35pm and on 3/10/15 at 9:20pm.
-She stated she "just forgot to click 'given' on the e-MAR".

Interview with Resident #1 on 4/2/15 at 11:00am revealed that she has never ran out.

C. Review of Resident #2's FL2 dated 9/15/14 revealed an order for tramadol (an opioid and Schedule IV controlled substance medication for moderate pain) 50 milligrams (mg) one tablet three times a day and one tablet every 6 hours PRN (as needed) for pain.

Review of neurology notes for Resident #2 dated 11/4/14 revealed:
- Diagnoses of right shoulder pain and neck pain.
- Review of her medication for these problems included tramadol 50 mg one three times a day.

Review of physician order for Resident #2 dated 11/25/14 documented to continue current medications.

Review of the controlled substance count sheets (count sheets) for Resident #2's tramadol compared against the hardcopy of the resident's electronic medication administration records (e-MAR) revealed:
- The count sheet documented removal of one tablet on 2/1/15 at "12N" but the e-MAR block for this date and time documented a missed dose (defined in the e-MAR key and designated by a backslash symbol (/)).
- The count sheet documented an entry dated 2/2/15 at "12N" by staff with the time and staff

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signature crossed out. Adjacent to the crossed out entry was documented the time "5:30 P" and another signature for staff. The e-MAR block for 2/2/15 at 12:00 PM documented a missed dose and the e-MAR block for 2/2/15 at 5:30 PM contained staff initials.
- The count sheet documented removal of one tablet on 2/11/15 at "12N" but the e-MAR block for this date and time documented a missed dose.
- The count sheet documented removal of one tablet on 2/16/15 at "12N" but the e-MAR block for this date and time documented a missed dose.
- The count sheet documented removal of one tablet on 2/28/15 at "12N" but the e-MAR block for this date and time documented a missed dose.
- The count sheet documented removal of one tablet on 3/1/15 at "12N" but the e-MAR block for this date and time documented a missed dose.
- The count sheet documented no removal of tramadol on 3/2/15 at 12:00 PM and the e-MAR block for this date and time documented a missed dose.
- The count sheet documented no removal of tramadol on 3/27/15 at 12:00 PM and the e-MAR block for this date and time documented a missed dose.

Based on diagnosis and observation of Resident #2 she was not interviewable.

Interview with Medication Aide (MA), Staff B on 4/2/15 at 9:50 AM revealed:
- Sometimes when a medication was administered "off time" the e-MAR recorded it as missed by the staff.
- She was familiar with Resident #2 and stated the resident sometimes slept until after 1 PM and that was the reason why the tramadol was

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D 367	Continued From page 12 sometimes given late. - The e-MAR would permit staff to enter that a medication was given late, but staff had to do this by physically hitting a key to permit documentation of the late time, and only then would the e-MAR record the medication as given. Interview with Staff B on 4/2/15 at 11:45 AM revealed: - If staff signed out a medication on the count sheet and the medication was given they were expected to document on the e-MAR that it was given, even if given late. - If a medication was given late the MA would have to go into the e-MAR manually to document this but she was not sure what this would look like to the reader if the e-MAR was printed. Combined interview with the Resident Care Coordinator (RCC) and Executive Director on 4/2/15 at 12:35 PM revealed: - If a medication was given late there was to be a documented reason. - The e-MAR did not prompt MAs for additional documentation if a medication was administered beyond the one hour window after the time it was due. Refer to combined interview with RCC and ED on 4/2/15 at 12:35pm. --- Combined interview with the Resident Care Coordinator (RCC) and Executive Director (ED) on 4/2/15 at 12:35 PM revealed if a medication was signed out on the Controlled Substance count sheet, they expected the medication was to be documented on the e-MAR and "everything should match."	D 367		

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D 372	Continued From page 13	D 372		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on interview, observation, and record review, the facility failed to assure 6 of 10 sampled residents' (#2, #5, #7, #8, #9, and #10) medications, hydrocodone/acetaminophen and Tramadol, were not borrowed for 2 of 6 residents (#2, #6). The findings are: A. Review of Resident #6's FL2 dated 9/17/14 revealed diagnoses which included: -GERD (gastroesophageal reflux disease) -Depression -Spinal fusion -Venous insufficiency Review of Emergency Room (ER) Patient Visit Information Note for Resident #6 dated 1/17/15 revealed: - Diagnosis of acute hip pain. - An order for hydrocodone/acetaminophen (which is generic for Norco) 5/325 mg 1 tablet every 4 to 6 hours as needed for pain, quantity 10 with no refills.	D 372		

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D 372	Continued From page 14 Review of a subsequent physician order dated 3/13/15 for Resident #6 revealed Norco 5/325 mg 1-2 tablets at bedtime as needed for pain. Review of a facility document titled "Narcotic Borrow Sheet" revealed that staff had borrowed Norco 5/325 mg, twenty-three times, for Resident #6, from residents #2, #7, #8, #9, and #10, from the period of 1/17/15 to 3/13/15. Telephone Interview with pharmacy staff on 4/1/15 at 2:28 pm revealed: -Pharmacy received the order dated 1/17/15 (Saturday) for Norco 5/325 mg 1 every 4-6 hours for pain on 1/19/15 (Monday). - Ten tablets of Norco 5/325 mg were dispensed on 1/20/15 (Tuesday). -When questioned about why the order (Norco from 1/17/15) was not discontinued after the 10 tablets were administered the pharmacy staff stated, "I guess I should have canceled it". -The pharmacy received the next order for Norco 5/325 mg 1-2 at bedtime as needed for pain and dispensed sixty tablets on 3/13/15. Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #10 for February and March 2015 revealed staff borrowed Norco for Resident #6 from Resident #10 thirty-five times on the following dates and times: -2/4/15 at 7:15pm -2/5/15 at 11:15pm -2/6/15 at 10:50pm -2/7/15 at 10:50pm -2/8/15 at 10:45pm -2/9/15 at 10:30pm -2/10/15 at 10:44pm -2/11/15 at 6:30am and 10:35pm -2/12/15 at 10:30pm	D 372		

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D 372	Continued From page 15 -2/13/15 at 10:45pm -2/14/15 at 10:45pm -2/15/15 at 10:00pm -2/17/15 at 10:35pm -2/18/15 at 10:15pm -2/19/15 at 10:45pm -2/20/15 at 10:40pm -2/21/15 at 11:30pm -2/22/15 at 10:30pm -2/23/15 at 10:05pm -2/24/15 at 10:25pm -2/25/15 at 10:20pm -2/26/15 at 10:25pm -2/27/15 at 10:30pm -2/28/15 at 10:30pm -3/1/15 at 10:30pm -3/2/15 at 10:10pm -3/3/15 at 9:50pm -3/4/15 at 10:30pm -3/5/15 at 10:30pm -3/6/15 at 10:00pm -3/7/15 at 9:45pm -3/8/15 at 10:30pm -3/12/15 at 10:35pm -3/13/15 at 10:00pm Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #10 for February and March 2015 revealed Resident #10 always had a supply of Norco available for use. Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #7 for January 2015 revealed staff borrowed Norco for Resident #6 from Resident #7 seven times on the following dates and times: -1/17/15 at 4:40pm. -1/18/15 at 12:00am, 6:00am, 4:40pm and 8:40pm. -1/19/15 at 6:00am.	D 372		

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D 372	Continued From page 16 -1/20/15 at 6:30am. Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #7 for January 2015 revealed Resident #7 always had a supply of Norco available for use. Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #9 for January 2015 revealed staff borrowed Norco for Resident #6 from Resident #9 four times on the following dates and times: -1/27/15 at 12:00am -1/28/15 at 12:00am -1/29/15 at 9:30pm -1/30/15 at 10:45pm Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #9 for January 2015 revealed Resident #9 always had a supply of Norco available for use. Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #8 for February 2015 revealed staff borrowed Norco for Resident #6 from Resident #8 four times on the following dates and times: -2/1/15 at 8:00pm -2/2/15 at 10:25pm -2/3/15 at 11:00pm -2/13/15 at 2:30am Review of Controlled Substance Count Sheet for Norco 5/325 mg for Resident #8 for February 2015 revealed Resident #8 always had a supply of Norco available for use. Telephone interview with pharmacy staff on 4/2/15 at 12:20pm revealed: -"We never know when they (facility staff) borrow	D 372		

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medications from other residents".
-That the facility pharmacy does not get copies of the Narcotic Borrowing Sheets or Controlled substance Count Sheets.
-The order for Norco 5/325 mg that was written on 1/17/15, remained on the e-MAR for the month of February 2015 due to not receiving a discontinue order from the facility or the primary care physician (PCP).

Interview with the Resident Care Coordinator (RCC) on 4/1/15 at 2:00 PM revealed:
-The facility did not have a written policy on borrowing medications.
-If a resident was out of a medication, the staff could borrow from a resident who had the same medication.
-The borrowing of "narcotic" medication was documented by staff on a "narcotic shift" note.
-If the borrowed medication was not a narcotic, the facility notified the pharmacy for the pharmacy to credit the resident from whom it was borrowed.

Interview with Executive Director and RCC on 4/1/15 at 4:15pm revealed:
-Resident #6 went to the ER for hip pain on 1/17/15 and came back with an order for Norco 5/325 mg 1 every 4-6 hours as needed for pain.
-Staff borrowed Norco for Resident #6 when she returned to the facility due to prescription not being filled.
-Staff called PCP to get a new order for Norco due to the ER physician only prescribing a quantity of 10 tablets, with no refills.
-The PCP refused to write a new prescription for Norco for Resident #6 until he could see her on 3/13/15.
-Staff continued to borrow Norco from other residents because Resident #6 requested it.
-The e-MAR did not indicate that the order for

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Norco was for a quantity of 10 tablets.
-Staff administered medications according to the e-MAR and had no way of knowing that the resident did not have a valid order after the first 10 tablets were given.
-The ED and RCC were unaware that the pharmacy does not enter stop dates or quantity limitations on medication orders that have a time or quantity limit.
-The ED stated she would request that the facility pharmacy change the way that time or quantity limited medication orders are entered on the e-MAR.

Interview with Resident #6 was not conducted on 4/2/15 as Resident #6 was out of the facility.

Refer to interview with ED on 4/2/15 at 12:35pm.

B. Review of current FL2 for Resident #2 dated 9/15/14 revealed an order for tramadol 50 mg 1 tablet three times a day and another order for 1 tablet every 6 hours PRN for pain.

Review of neurology notes for Resident #2 dated 11/4/14 revealed:
- Diagnoses of right shoulder pain and neck pain.
- A review of her medication list for these diagnoses included tramadol 50 mg 1 tablet three times a day.

Review of orders for Resident #2 dated 11/25/14 revealed documentation to continue current medications.

Review of the controlled substance count sheet (count sheet) for Resident #2's tramadol revealed 3 tablets in the "quantity left" column on 3/20/15 (Friday) after the 9:00 PM dose was documented as given.

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D 372	Continued From page 19 Review of a fax transmittal verification report dated 3/20/15 (Friday) at 9:24 PM revealed a request to Resident #2's physician for refill orders for various medications, including tramadol 50 mg. Further review of the count sheet for Resident #2's tramadol revealed: - Single tablets documented as given on 3/21/15 (Saturday) at 12:00 PM, 5:30 PM and 9:00 PM - Zero tablets in the "quantity left" column after the last tablet was given on 3/21/15 (Saturday) at 9:00 PM. Review of the count sheets for Resident #2's tramadol compared against the hardcopy of the resident's electronic medication administration records (e-MAR) revealed: - Documentation on the e-MAR that the medication was given on 3/22/15 (Sunday) at 12:00 PM, 3/22/15 (Sunday) at 5:30PM, 3/22/15 (Sunday) at 9:00 PM and 3/23/15 (Monday) at 12:00 PM. - No corresponding documentation for these dates and times were noted on Resident #2's count sheets. Review of a facility document titled "Narcotic Borrow Sheet" (which included the time period of March 2015) and other facility residents' count sheets revealed the source of the single tablet of tramadol documented as given to Resident #2 on 3/23/15 (Monday) at 12:00 PM. Review of a pharmacy delivery sheet for Resident #2 dated 3/23/15 (Monday), provided by the facility, revealed various medications for Resident #2 including tramadol 50mg, quantity 90 tablets, listed with the "received by" and "time received"	D 372		

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D 372	Continued From page 20 lines of the sheet blank. Review of the count sheet for tramadol 50 mg for Resident #5 revealed: - The comment "borrowed for [Resident #2's name]" documented each time for single tablets given on 3/22/15 (Sunday) at 12:00 PM, 3/22/15 (Sunday) at 5:30PM and 3/22/15 (Sunday) at 9:00 PM. - 24 tablets in the "quantity left" column on 3/31/15 after the 5:25 PM dose was given. - No further documentation that the tablets borrowed for Resident #2 were credited back to Resident #5. Based on diagnosis and observation of Resident #2, the resident was not interviewable. Interview with the Resident Care Coordinator (RCC) on 4/1/15 at 2:00 PM revealed: -The facility did not have a written policy on borrowing medications. -If a resident was out of a medication, the MAs (medication aides) could borrow from a resident who had the same medication. -The borrowing of "narcotic" medication was documented by the MAs on a "narcotic shift" note. -If the borrowed medication was not a narcotic, the facility notified the pharmacy for the pharmacy to credit the resident from whom it was borrowed. Interview with Medication Aide, Staff B, on 4/2/15 at 9:50 AM revealed: - MAs did borrow medications and when the medication arrived from the pharmacy, the quantity of medication borrowed was returned. - If Resident #2 was out of her tramadol, MAs would borrow from another resident. - When medications hit a blue line on the card of	D 372		

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medications, MAs were responsible for reordering.
- With most residents, the MAs reordered medications by hitting a button on the e-MAR, but as Resident #2 used a different pharmacy, refill requests could not be done that way.
- For Resident #2, if the medication required a new prescription her pharmacy had to call the doctor for the prescription.
- The pharmacy labels on the cards of medications noted the number of refills left which MAs could make note of, but the pharmacy could also note it and get a prescription from the doctor which the pharmacy had done most recently.
- Staff recently making an attempt to contact the physician for a "hard script."
- Staff were not always documenting when contact was made with a doctor for a prescription.

Phone Interview with the Pharmacy Manager for Resident #2's pharmacy on 4/2/15 at 10:20 AM revealed:
- If the facility delivered to the Pharmacy medication requests by 2:00 PM on Monday through Friday, the medications were delivered the same day.
- He took call in the pharmacy on weekends but there were no routine medication deliveries on Saturdays and Sundays, requiring the facility to use their back-up pharmacy on weekends.
- Staff would know on Thursday or Friday if a medication would run out on Saturday and they could call in a request early to prevent running out.
- His pharmacy discouraged borrowing medications from other residents.
- He usually had no problems getting prescriptions from Resident #2's physician, usually in one day.
- The tramadol prescription that was filled and

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D 372	Continued From page 22 delivered on 3/23/15 required a new physician's prescription that was faxed to his pharmacy on 3/23/15. - His pharmacy's delivery records showed no record of when the tramadol request was received by his pharmacy, as the request was usually sent via fax by the facility, but his records did show the facility received this medication from the pharmacy for Resident #2 on 3/23/15 at 3:00 PM by MA A. Combined interview with the RCC and Executive Director on 4/2/15 at 12:35 PM revealed: - Resident #2's medications should have been re-ordered on Thursday, 3/19/15. - Staff should check first for any overstock of medications that might be missing from the medication carts. - The facility's ability to re-order medications was also contingent upon Medicare rules that limited residents to no more than a three day supply before a refill could be obtained. Refer to interview with ED on 4/2/15 at 12:35pm. _____ Interview with ED on 4/2/15 at 12:35pm revealed she credited the residents' pharmacy accounts for medications which had been borrowed.	D 372		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 23 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facilty failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observation, interview, and record review, the facility failed to assure medication was administered in accordance with physician orders for 1 of 6 sampled residents (Resident #6) who had an order for hydrocodone/acetaminophen (Norco). Refer to Tag 358 10A NCAC 13F .1004 (a) Medication Administration (Type B Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including	D932		

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D932	Continued From page 24 cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection control consistent with the Centers for Disease Control and Prevention guidelines on infection control procedures and facility policy with assisted glucose monitoring related to storage of resident glucometers for 3 of 5 residents (Resident #2, #11, and #12) in the facility with orders for fingerstick blood sugar (FSBS) testing. The findings are:	D932		

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D932	Continued From page 25 Observations of Staff A, Medication Aide, during the noon medication pass on 3/31/15 at 11:27am revealed: -Staff A performed hand hygiene and applied gloves. -Staff A opened the top drawer of the medication cart A and two glucometers were visible stored each in a separate plastic tray. -Staff A removed a glucometer from the top drawer of medication cart A. -The glucometer was labeled in pen with the resident's name. -The glucometer was not enclosed in a case or bag to prevent cross contamination. -The glucometer was stored in a plastic tray labeled with the resident's last name that matched the handwritten label on the glucometer. -Staff A did not disinfect the glucometer before use. -Staff A then correctly performed FSBS testing on Resident #13. Observation of glucometer storage on medication cart B on 3/31/15 at 12:25pm revealed: -Staff B, Medication Aide, opened the top drawer of the medication cart B. -There was one plastic tray in the drawer that held three glucometers stacked in contact with one another. -The glucometers were not encased or bagged to prevent cross contamination. -The glucometers were labeled in ink with Resident #2, #11, and #12's names. -Staff B was not observed to perform any FSBS testing at this time. Observation of Staff C, Medication Aide (MA), during an afternoon medication pass on 3/31/15 at 4:35pm revealed: -Staff C performed hand hygiene and pushed	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045092	A. BUILDING: _____ B. WING _____	R 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D932	Continued From page 26	D932		

medication cart B to the entrance of Resident #11's room.
-Staff C applied gloves.
-Staff C prepared an oral medication in applesauce for Resident #11.
-Staff C then opened the top drawer of the medication cart B and withdrew a glucometer labeled in ink with Resident #11's name from a plastic tray which held two additional glucometers stacked in contact with one another.
-None of the glucometers stored in the plastic tray were encased or bagged to prevent cross contamination.
-Staff C then proceeded to gather a cotton ball, single use lancet, and reagent strip to perform FSBS testing for Resident #11.

Interview with Staff C on 3/31/15 at 4:44pm revealed when asked when Resident #11's glucometer had last been cleaned or disinfected she stated "To be honest, I don't know."

Observation of Staff C on 3/31/15 at 4:45pm revealed:
-Staff C then proceeded to clean the outside of Resident #11's glucometer with an 70% alcohol swab.
-At this point, a surveyor intervened and asked Staff C to properly disinfect the glucometer before performing a FSBS test on Resident #11.

Interview with Staff C on 3/31/15 at 4:46pm revealed:
-Staff C stated disinfecting wipes were not currently available on the medication cart.
-She stated she thought there might be some disinfecting wipes available at the front desk.

Interview with the Resident Care Coordinator on 3/31/15 at 4:48pm revealed:

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D932	Continued From page 27 -"We have alcohol wipes on the cart to clean the glucometers." -She stated they also had disinfecting wipes at the front desk and available for medication aides use. -Facility policy was for each resident's glucometer to be stored in their individual separate trays labeled with their names. -She was unsure why the glucometers on medication cart B were stored in a single plastic bin all together instead of in each resident's labeled tray. -Third shift staff were disinfecting all the glucometers with the disinfecting wipes every night whether the glucometers were used or not. Interview with the Executive Director on 3/31/15 at 5:00pm revealed: -It was the facility's policy to store the glucometers on the medication carts in their respective resident specific plastic trays. -She was unsure why staff would have stored the glucometers all together in one tray on medication cart B. -"All of the glucometers are supposed to be cleaned on third shift [daily] using the disinfecting wipes." -"We all just had blood borne pathogen training last week." Confidential interview with a third shift MA revealed: -The medication aides on third shift were responsible for completing various cleaning tasks on their shift including cleaning and straightening the medication carts. -She stated they would wipe inside the medication cart drawers and " fill up needles and diabetic supplies" as part of their cleaning ritual. -"We make sure everything is situated for the	D932		

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D932	Continued From page 28 medication aides for the next day." -"We wipe [the glucometers] down with alcohol swabs and make sure to keep them in their own separate bins." Interview with Staff B, MA, on 4/1/15 at 11:30am revealed: -She had performed FSBS testing using glucometers stored on medication cart B on th 7am to 3pm shift on 3/31/15. -"The girl two nights ago had cleaned out the [medication] cart and replaced the glucometers that way." -Resident #2 received FSBS tests two times a day at lunch and dinner. -Resident #11 received FSBS tests two times a day at lunch and dinner. -Resident #12 received a FSBS test once per month. -"I didn't clean them before checking their blood sugars." -She was aware alcohol was not adequate for disinfection of equipment. -Disinfecting wipes were not stored on the medication carts, however they were available in the medication room. -"Third shift is supposed to clean the [glucometers] each night, but I don't know if they do cause I don't work that shift."	D932		