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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE SAMARITAN ASSISTED LIVING	30 DALEA DRIVE ASHEVILLE, NC 28805

(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
D 000	Initial Comments The Adult Care Licensure Section and Buncombe County DSS conducted an annual survey, a follow-up survey, and a complaint investigation from June 24-26, 2015 and June 29-July 1, 2015.	D 000		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 7 of 7 sampled staff (C, E, H, I, K, L, and M) received and successfully completed an 80 hour personal care training program including competency evaluation.	D 150		

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D 150	Continued From page 1 The findings are: 1. Review of the employee record for Staff H revealed: -Staff H was hired on 6/20/13. -Staff H was currently working as a medication aide. -There was no documentation of completion of a 80 hour personal care training program. -Licensed Health Professional Support validation was completed on 6/17/13. Refer to confidential interviews with two staff. Refer to interview with staff G on 6/26/15 at 1:55pm. Refer to interview with facility Director 6/26/15 at 11:40am. Refer to interview with facility Director on 7/1/15 at 4:35pm. 2. Review of the employee record for Staff I revealed: - Staff I was hired on 3/20/14. - Staff I was currently working as a personal care aide - There was no documentation of completion of a 80 hour personal care training program. -Licensed Health Professional Support validation was completed on 3/25/14. Refer to confidential interviews with two staff. Refer to interview with staff G on 6/26/15 at 1:55pm. Refer to interview with facility Director 6/26/15 at	D 150		

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D 150	Continued From page 2 11:40am. Refer to interview with facility Director on 7/1/15 at 4:35pm. 3. Review of the employee record for Staff L revealed: -Staff L was hired on 10/8/14. -Staff L was currently working as a personal care aide. -There was no documentation of completion of a 80 hour personal care training program. -Licensed Health Professional Support validation was completed on 10/12/14. Refer to confidential interviews with two staff. Refer to interview with Staff G on 6/26/15 at 1:55pm. Refer to interview with facility Director 6/26/15 at 11:40am. Refer to interview with facility director on 7/1/15 at 4:35pm. 4. Review of the employee record for Staff C revealed: -Staff C was hired on 10/8/14. -Staff C was currently working as a personal care aide -There was no documentation of completion of a 80 hour personal care training program. -Licensed Health Professional Support validation was completed on 10/12/14. Refer to confidential interviews with two staff. Refer to interview with staff G on 6/26/15 at 1:55pm.	D 150		

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D 150	Continued From page 3 Refer to interview with facility Director 6/26/15 at 11:40am. Refer to interview with facility director on 7/1/15 at 4:35pm. 5. Review of the employee record for Staff M revealed: -Staff M was hired on 7/2/14. -Staff B was currently working as a personal care aide -There was no documentation of completion of a 80 hour personal care training program. -Licensed Health Professional Support validation was completed on 3/25/14. Refer to confidential interviews with two staff. Refer to interview with staff G on 6/26/15 at 1:55pm. Refer to interview with facility Director 6/26/15 at 11:40am. Refer to interview with facility Director on 7/1/15 at 4:35pm. 6. Review of the employee record for Staff K revealed: -Staff B was hired on 3/1/14 . -Staff B was working as personal care aide, but left employment sometime in June 2015. -Licensed Health Professional Support validation was completed on 8/27/14. Refer to confidential interviews with two staff. Refer to interview with staff G on 6/26/15 at 1:55pm.	D 150		

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D 150	Continued From page 4 Refer to interview with facility Director 6/26/15 at 11:40am. Refer to interview with facility director on 7/1/15 at 4:35pm. 7. Review of the employees record for Staff E revealed: -Staff E was hired on 7/12/14. -Staff E was currently working as a personal care aide. -There was no documentation of completion of a 80 hour personal care training program. -Licensed Health Professional Support validation was completed on 8/25/14. Observation on 7/1/15 at 4:05pm revealed Staff E provided incontinence care for Resident #13 using appropriate infection control practices. Refer to confidential interviews with two staff. Refer to interview with staff G on 6/26/15 at 1:55pm. Refer to interview with facility Director 6/26/15 at 11:40am. Refer to interview with facility Director on 7/1/15 at 4:35pm. --- Confidential interviews with two staff during the survey revealed: -Three residents required total assistance with transfers, were non-ambulatory and in geri-chairs. -Nine residents required help with transfers, were non-ambulatory and in wheelchairs. -Two residents required help with transfers and	D 150		

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D 150	Continued From page 5 walked pushing their wheelchair for stability. -Three residents required help with transfers, were able to walk short distances but preferred to use wheelchairs. Interview with Staff G, a nursing assistant, on 6/26/15 at 1:55pm revealed: -She trains new staff about resident care which includes showers, transfers, and the residents routines. -She trains new staff on 1st shift. Interview with the facility Director on 6/26/15 at 11:40am revealed: -She had "no excuse," the personal care training had not been completed. -All the staff are first hired as a housekeeper until they can be trained by the Medication Aide who is a nursing assistant -All personal care aides and medication aides have received Licensed Health Professional Support training by the Registered Nurse. -All staff spend no less than three days with a nursing assistant staff before working as a personal care aide. Interview on 7/1/15 at 4:35pm with the facility Director revealed the personal care aides assist residents with showers and routinely provide nail care.	D 150		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the	D 176		

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county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to resident rights, personal care training program, staffing, health care, medication administration, controlled substances, pharmaceutical care, and declaration of resident rights.

The findings are:

Interview with the Executive Director and Administrator on 6/26/15 at 2:45pm revealed:
-The Resident Care Coordinator, the Director, and the Executive Director were responsible for medications.
-The facility apparently had poor documentation, poor filing, and things not "put in place."

Based on observation, interviews and record reviews, the following non-compliance was identified for the facility:

A. Based on observation, interview, and record

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D 176	Continued From page 7 review, the facility failed to assure 7 of 7 sampled staff (C, E, H, I, K, L, and M) received and successfully completed an 80 hour personal care training program including competency evaluation. [Refer to Tag 153 10A NCAC 13F .0501(a) Personal Care Training And Competency] B. Based on interviews, observation, and record review, the facility failed to assure third shift was staffed with 16 hours of personal care aide in addition to a supervisor on duty for a census of 48 residents in an unsprinklered facility. [Refer to Tag 214 10A NCAC 13F .0605(c) Staffing Of Personal Care Aide Supervisors (Type B Violation).] C. Based on observation, interviews, and record review, the facility failed to assure written orders for Coumadin from the physician were documented in the residents record for 1 of 6 residents (#1). [Refer to Tag 276 10A NCAC 13F .0902(c) Health Care (Type B Violation).] D. Based on observation, interview, and record review, the facility failed to assure all residents' rights were maintained related to the facility providing timely transportation and related to privacy during showers. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights.] E. Based on observations, interviews and record reviews, the facility failed to assure prescribed medications (Xanax, Valium, MS Contin, and Lorazepam,) were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#3, #5, #6). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D 176		

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D 176	Continued From page 8 F. Based on interview and record review, the facility failed to assure 2 of 2 sampled residents' (#3 and #7) medications (Coumadin and Ativan), were not borrowed for other residents (#1 and #11) and failed to assure the borrowing and replacement of the medication was documented. [Refer to Tag 372 10A NCAC 13F .1004(o) Medication Administration.] G. Based on observations, interviews and record reviews, the facility failed to assure accurate reconciliation and readily retrievable records for the receipt, administration and disposition of controlled substances for 4 of 5 sampled residents (Resident #5, #6, #7, and #8) with orders for controlled substances which included Valium, MS Contin, Oxycodone, Oxycodone-acetaminophen, Xanax, Tramadol, and Morphine Sulfate resulting in amounts which ranged from 41 tablets of MS Contin 15 mg to 221 tablets Oxycodone 20 mg of the controlled substances being unaccounted for. [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation).] H. Based on observation, interview, and record review, the facility failed to assure that all Scheduled II medications were always maintained under double lock. [Refer to Tag 393 10A NCAC 13F .1008(b) Controlled Substance.] I. Based on observations, interview and record review, the facility failed to assure the quarterly on-site medication review included a review of all aspects of the facility's systems for medication administration, including accountability of controlled substances including disposition, receipt and administration of controlled substances and medication storage. [Refer to Tag 401, 10A NCAC 13F .1009(a)(2-6)	D 176		

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D 176	Continued From page 9 Pharmaceutical Care.] Plan of Protection submitted by the facility included: -All items cited during the survey will be addressed immediately by management and administrator. -Policies and procedures will be followed. -Management will assure these violations do not reoccur by reviewing policies and procedures with daily staff meetings and inservices. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 31, 2015.	D 176		
D 214	10A NCAC 13F .0605 (c) Staffing Of Personal Care Aide Supervisor 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (c) On third shift in facilities with a capacity or census of 31 to 60 residents, the supervisor shall be in the facility or within 500 feet and immediately available, as defined in Rule .0601 of this Subchapter. In facilities sprinklered for fire suppression with a capacity or census of 31 to 60 residents, the supervisor's time on duty in the facility on third shift may be counted as required aide duty. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, observation, and record review, the facility failed to assure third shift was staffed with 16 hours of personal care aide in	D 214		

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D 214	Continued From page 10	D 214		

addition to a supervisor on duty for a census of 48 residents in an unsprinklered facility.

The findings are:

Interview with the Executive Director on 6/26/15 at 4:30pm revealed the current facility census was 48 and the facility was not sprinklered.

Confidential interviews with five staff during the survey revealed there were routinely only two staff, (1 personal care aide and 1 supervisor) on site third shift from 11:00pm to 7:00am.

Interview with the facility director on 6/25/15 at 5:15pm revealed they only had two staff, one personal care aide and one supervisor on duty during third shift.

Interview with the facility director on 7/1/15 at 4:00pm revealed:
-They conducted fire drills monthly.
-Third shift fire drills were conducted at least once per quarter.
-Sometimes they had three staff available to conduct fire drills on third shift and sometimes they had four staff.

Review of documentation of facility fire drills conducted the past 11 months revealed:
-The last documented third shift fire drill was completed on 9/07/14 at 11:06pm with time to evacuate as 5 minutes and 14 seconds.
-The four staff documented to be present during the drill were Staff H, a medication aide, and Staff I, C, and Staff O (all personal care aides).

Confidential interviews with two staff during the survey revealed at least 17 residents would require some form of assistance during a fire drill

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D 214	Continued From page 11 as follows: -Three residents required total assistance with transfers, were non-ambulatory and in geri-chairs. -Nine residents, one of whom was totally blind, required help with transfers, were non-ambulatory and in wheelchairs. -Two residents required help with transfers and walked pushing their wheelchairs in front of them for stability. -Three residents required help with transfers, were able to walk short distances but preferred to use their wheelchairs. -Residents #12, #13, #15 required a two person assist for transferring. _____ The Plan of Protection provided by the facility revealed a third shift staff, a personal care aide, would begin work in the facility on 7/3/15. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2015.	D 214		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276		

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D 276	Continued From page 12 TYPE B VIOLATION Based on observation, interviews, and record review, the facility failed to assure written orders for Coumadin from the physician were documented in the resident's record for 1 of 6 residents (#1). The findings are: A review of the current FL2, dated 4/9/15, for Resident #1 revealed diagnoses which included: -Atrial Fibrillation (A-Fib) -Cardio-Vascular Accident (CVA) -Prostate Cancer Review of Resident Register revealed Resident #1 was admitted to the facility on 2/6/12. On 6/24/15 at 9:20 AM during an initial interview with Resident #1 revealed: -He was taking Coumadin each day. (Coumadin is an anticoagulant (blood thinner) that reduces the formation of blood clots). -When asked if he ever missed his Coumadin, he stated, "Sometimes they tell me there is no Coumadin." -He said he tells staff he takes Coumadin every day and tells staff to go "find it." Review of Resident #1's Resident Record revealed the INR Labs results completed at the physician's office on 5/14/15 were 2.2. (INR is international normalized ratio- lab work to measure the effectiveness of the Coumadin results.) Review of Resident #1's record revealed no documentation of Coumadin orders dated 5/14/15 when the INR was completed.	D 276		

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D 276	Continued From page 13 Review of Medication Administration Record (MAR) from May 1 through June 24 2015 revealed: -Transcription for Coumadin 1.25 mg on Sunday and Friday and 2 mg on Monday Tuesday, Wednesday, Thursday and Saturday. -Daily documentation that Coumadin was administered except on 6/17/15, with no documentation on that day. -There were no other transcriptions on the May and June 2015 MARs for Coumadin.. Review of the medications on hand for Resident #1 on 6/24/15 at 2:15pm with Staff A, Medication Aide, revealed no Coumadin available for Resident #1. Telephone interview on 6/30/15 at 9:30 am with staff at the Primary Care Physicians office revealed the current Coumadin orders, dated 5/12/15, for Resident #1. The order was Coumadin 2.5 mg ½ tab by mouth every Monday, Wednesday and Friday and Coumadin 3 mg take ½ tablet by mouth every Tuesday, Thursday, Saturday and Sunday and they would fax orders and the current INRs. Review of Resident #1's records faxed to the office by the physician's office on 7/1/15 revealed: -INR of 2.2. on on 5/12/15. -Orders, dated 5/12/15, for Coumadin 2.5 mg ½ tab (1.25) by mouth every Monday, Wednesday and Friday and Coumadin 3 mg take ½ tablet (1.5 mg) by mouth every Tuesday, Thursday, Saturday and Sunday. -INR of 2.2 on 6/11/15 with no change in Coumadin orders.	D 276		

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D 276	Continued From page 14 Review of Coumadin documented as administered per the MARs from May 12 through June 23 2015 compared to the physician orders revealed Resident #1 was administered a total of 12.5 mg of Coumadin each week (with the exception of 6/17/15 with none documented and no explanation) but Resident #1's Physician had ordered a total of 9.75 mg of Coumadin for the week. Interview with the Director on 7/1/15 at 3:45pm revealed: -A physician's order sheet and a copy of the current MAR are sent with the Resident #1 to the physican office each visit. -If the physician orders any medication changes or labs, the information is written on the physician order sheet and returned to the facility with the resident. -She was not aware the Coumadin order had changed on the 5/12/15 office visit. -Facility staff notify the pharmacy of any Coumadin order changes. Review of Resident #1's record revealed no physician order sheets with Coumadin orders and INR for the office visit on 5/12/15. Interview with the pharmacy on 6/24/15 at 12:08 pm revealed -The facility's request for Resident #1's Coumadin 1.25 mg, 1 tablet by mouth daily on Sunday and Friday and Coumadin 2 mg, 1 tablet by mouth daily on Monday, Tuesday, Wednesday, Thursday and Saturday was last received by the pharmacy on 6/4/15 at 5:46 PM with no subsequent orders or requests. - The pharmacy dispensed 10 Coumadin 2 mg tablets and 2 Coumadin 2.5 mg tablets on 6/4/15.	D 276		

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D 276	Continued From page 15 - The Pharmacy was again notified on 6/24/15 requesting refills for the Coumadin 1.25 mg, 1 tablet by mouth daily on Sunday and Friday and Coumadin 2 mg, 1 tablet by mouth daily on Monday, Tuesday, Wednesday, Thursday and Saturday. - On 6/24/15 the facility asked for and received 10 Coumadin 2 mg tablets and 4 Coumadin 2.5mg tablets. Interview with the facility Director on 7/1/15 at 3:45pm revealed: -The facility Director was unaware that Resident #1's had been receiving the wrong dose Coumadin. -She was responsible for monitoring the medications and order changes for residents who took Coumadin. -She had not contacted the physician after Resident #1's appointment on 5/12/15 to determine if the Coumadin order had changed. -The facility Director stated " I am responsible for the Coumadin. I messed up." -The facility Director said she notified Resident #1's physician to let him know Resident #1 had been receiving the wrong dose Coumadin, but the physician did not order another INR until 7/6/15 as already scheduled. _____ The Plan of Protection provided by the facility revealed The RCC will be responsible for making sure all medications are ordered from the pharmacy and available for administration to residents. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2015	D 276		

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents' rights were maintained related to the facility providing timely transportation and related to privacy during showers. The findings are: A. Telephone interview with the receptionist at the local Veteran's (VA) hospital on 6/26/15 at 1:15pm revealed: -Hospital staff called the facility at 1:20am on 6/26/15 and requested they pick up Resident #10 at the emergency room (ER) because he was ready to leave. -Hospital staff also called "a couple hours" later (after 1:20am) and facility staff told them the Resident would be picked up at 8:00am. -Hospital staff called at 9:00am and at 10:20am and requested Resident #10 be picked up. -Facility staff arrived at the VA ER at 10:25am to transfer Resident #10. Review of Resident #10's ER discharge report revealed he arrived at the ER at 12:25am, was treated and discharged at 1:20am. Telephone interview with Staff I, a personal care aide for 3rd shift, on 7/1/15 at 10:05am revealed: -She was working 3rd shift on the night of 6/25/15	D 338		

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when Resident #10 was sent to the ER at the local VA hospital in an ambulance.
-There were only 2 staff on duty during 3rd shift and they could not leave the facility to transport Resident #10 home from the ER.
-Most of the residents were not treated at the VA hospital ER and the other hospitals always brought residents home in an ambulance if they were transported to the hospital in an ambulance.
-Staff I said she told the hospital staff Resident #10 would have to wait until 1st shift until more staff were on duty.
-She did not know if she was supposed to call her supervisor who lived near by when a resident needed transportation during 3rd shift.

Interview with the facility Director on 6/26/15 at 1:45 pm revealed:
-No one called her the night of 6/25/15 to let her know a resident needed transportation home from the VA ER.
-She was not aware Resident #10 needed transportation until 9:00am on 6/26/15.
-The Activity Director first went to the VA hospital (about 9:40am) front entrance to pick up Resident #10 but could not find Resident #10 so the Activity Director came back to the facility without him.
-The Activity Director returned again to the VA hospital and picked up Resident #10 at the ER entrance at 10:25am.
-The facility Director said "staff know they are to call" her.

Interview with Resident #10 on 6/26/15 at 2:05pm revealed he waited for transportation sitting in a chair at the ER, did not receive any medications nor any meals during the wait.

B. Confidential interview with 3 female residents during the survey revealed:

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D 338	Continued From page 18 -"People" have walked in while they are getting a shower in the common shower room. -The common shower room will not lock. -Although they have a shower curtain, they would like more privacy while showering. Observation of the common female shower room on 6/24/15 on 10:00am revealed: -Two showers with shower curtains folder over the shower curtain rod. -A door handle which could not be locked. -No designations in use that showers were occupied/not occupied. Random observation of the female shower room door during the survey revealed the shower door was always closed and there were no signs indicating if it was occupied or not occupied. Interview with the Executive Director on 7/1/15 at 4:15pm revealed the State Construction Section would not allow a lock on the common shower room door.	D 338		
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	D 358		

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D 358	Continued From page 19 Based on observations, interviews and record reviews, the facility failed to assure prescribed medications (Xanax, Valium, MS Contin, Lorazepam,) were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#3, #5, #6). The findings are: A. Review of current FL2, dated 3/11/15, for Resident #5 revealed diagnoses which included: -Schizophrenia -Borderline psychotic disorder -Addison's disease -Hepatitis C -Heart disease -Hypertension Review of Resident Register revealed Resident #5 was admitted to the facility on 12/17/15. Review of Resident discharge documentation revealed Resident #5 was discharged from the facility on 4/23/14. On 6/26/15 at 10:45am, telephone interview with Resident #5's guardian (guardian at the time Resident #5 resided in this facility) revealed Resident #5 "always" said she was not getting her medications as ordered. 1. Review of records revealed physician orders included Valium 5 mg, twice daily, dated originally on 12/31/14 (Valium is a medication used for the management of anxiety disorder and symptoms associated with alcohol withdrawal, muscle spasms, and seizures. According to MedlinePlus, when Valium is stopped suddenly, there can be withdrawal symptoms such as restlessness,	D 358		

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D 358	Continued From page 20 confusion, irritability and extreme anxiety. In extreme situations withdrawal symptoms may include sensitivity to sound, sensitivity to light, sensitivity to personal contact and hallucinations. Symptoms tend to be more severe and pronounced in those that were given Diazepam for long periods of time or those who were given very high doses of the medication.) The only records provided by the pharmacy for Valium 5 mg revealed: -One delivery sheet for 60 tablets Valium 5 mg on 12/31/14. -Dispensing records which listed 60 tablets Valium 5mg dispensed on 3/20/15 and 60 tablets on 4/24/15. Review of a Control Drug Sheet for Resident #5's Valium 5 mg revealed 60 tablets were dispensed on 3/1/15. Telephone interview with staff at the pharmacy on 6/25/15 at 11:40am revealed they could not provide any further documentation Valium 5 mg tablets that was delivered to the facility for Resident #5. Review of Resident #5's Control Drug Sheets for Valium 5 mg twice daily revealed there was no documentation regarding the administration of Valium 11 times from 2/4/15 through 4/3/15 at the following times: -2/4/15 8am -2/13/15 8am -3/3/15 8pm -3/4/15 8am -3/14/15 8am -3/16/15 8am -3/28/15 8am -3/31/15 8am	D 358		

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D 358	Continued From page 21 -4/2/15 8am -4/3/15 8am Review of the Medication Administration Records (MARs), dated 2/4/15 through 4/3/15, revealed staff documented administration of Valium 5 mg twice daily at 8:00am and 8:00pm. Interview with the Executive Director on 6/26/15 at 11:55am revealed Resident #5 sometimes slept late and may have missed her Valium, but staff should have documented the medication was not given on the MAR. Review of Resident #5's records revealed: -Control Drug Count Sheet revealing the 60 tablets Valium 5 mg which were delivered to the facility on 3/1/15 were all administered by 4/6/15 at 8:00am. -No Control Drug Sheet for Valium 5 mg twice daily for Resident #5 from 4/7/15 through 4/23/15 (date of discharge from facility). -The 60 tablets delivered to the facility on 3/20/15 should have been documented on a Control Drug Sheet beginning 4/6/15 at 8:00pm. Review of April 2015 Medication Administration Record revealed Valium 5mg was documented twice daily from 4/7/15 through 8:00am on 4/23/15 with the exceptions of 8am on 4/22/15 (no initials and no explanation) and 8am on 4/1/15 and 4/12/15 with noted explanation of "unable to wake Resident." Review of Resident #5's record revealed no documentation she had refused her Valium. Review of a "Prescription returned to the pharmacy" form, dated 4/28/15, signed by the facility Director, and noted medications "to be	D 358		

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picked up by family," for Resident #5 revealed:
-39 tablets Valium were to be returned.
-There were no Control Drug Count Sheets or identifying information with the form to track when the Valium was dispensed.
-The form had not been signed by any of Resident #5's family nor the guardian as receiving the medication.

Based on the dispensing information for 03/04/15 through 04/23/15 provided by the facility and pharmacy, 60 tablets of Valium 5 mg. were dispensed on 03/20/15.

Based on the physician order, dated 12/31/14, Valium 5 mg. twice daily and review of the control substance record for 8:00am on 3/01/15 through 8:00am on 4/06/15, Resident # 5 should have been administered 35 tablets (of the 60 dispensed which would leave a count of 25 tablets) from 8:00pm on 04/06/15 until discharge on 04/23/15.

Based on the dispensing records, review of control substance records for 03/01/15 through 04/06/15 and the quantity of Valium 5mg. (39 tablets) documented on the facility release form and interviews with facility staff, only 11 tablets were available for administration (from 4/6/15 through 4/23/15); therefore, Resident #5 was not administered Valium 5 mg. as ordered between 04/06/15 through 04/23/15.

Interview with the facility Director on 6/25/15 at 10:15am revealed:
-Resident #5 was discharged from the facility by the facility because she was a threat to the safety of other residents.

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-She attacked another resident on 4/19/15 and was admitted to a psychiatric unit on 4/23/15.
-The 39 Valium 5 mg tablets listed on the "Prescription returned to the pharmacy" form have not been located nor was there any record that Resident #5's family member/guardian had received the medication.

Confidential interview with three personal care aides and one medication aide revealed Resident #5's behavior was different the last month she lived in the facility and described her behavior as follows:
-"She really changed the last 2 weeks she was here...more aggressive."
-"She seemed to have more problems the last couple of weeks...wanted more attention."
-"The last few weeks she was more agitated and confrontational..she would lash out at [staff name]."
-"She was more anxious" the last two weeks.
-Resident #5's usual behavior was that she was verbally aggressive to staff and residents but that she was not known to be physical or touch staff or other residents.

2. Review of Resident #5's record revealed physician orders, dated 2/25/15, for MS Contin 15mg twice daily for chronic pain. (MS Contin is narcotic pain reliever used to treat moderate to severe pain. According to MedlinePlus, there can be symptoms of withdrawal whenever any chronic use of morphine is discontinued or reduced. Withdrawal symptoms may include agitation, anxiety, sweating and insomnia.)

Review of Resident #5's Control drug sheet for MS Contin 15 mg twice daily revealed
-Sixty tablets were received on 2/25/15.
-The first tablet was documented as administered

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D 358	Continued From page 24 on 2/25/15 and the last one at 8:00pm on 3/29/15. Review of the pharmacy delivery sheet, dated 3/25/15, revealed 60 tablets MS Contin were received by the facility on 3/25/15. Review of record revealed no Control Drug Sheet for MS Contin 15 mg for Resident #5 for the 60 tablets received on 3/25/15. If MS Contin 15 mg was administered twice per day from 3/30/15 (date previous 60 tablets count was documented as 0) through date of discharge, 4/23/15, a total of 48 tablets would have been administered and 12 tablets of the 60 tablets delivered on 3/25/15 should have remained. Review of a "Prescription returned to the pharmacy" form, dated 4/28/15, signed by the facility Director, and noted medications "to be picked up by family," included the following controlled medications for Resident #5: -MS Contin: 41 tablets -There was no signature by anyone as receiving Resident #5's medications. Review of the March and and April 2015 MAR, the MS Contin 15 mg, 1 tablet every twelve hours was routinely documented as administered twice daily, 8:00am and 8:00pm through April 23, 2015 (date Resident #5 was discharged). Interview with the facility Director on 6/25/15 at 10:15am revealed: -Resident #5 was discharged from the facility by the facility because she was a threat to the safety of other residents. -She attacked another resident on 4/19/15 and was admitted to a psychiatric unit on 4/23/15.	D 358		

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D 358	Continued From page 25 -The 41 tablets MS Contin 15 mg tablets listed on the "Prescription returned to the pharmacy" form have not been located nor was there any record that Resident #5's family member/guardian had received the medication. Confidential interview with three personal care aides and one medication aide revealed Resident #5's behavior was different the last month she lived in the facility and described her behavior as follows: -"She really changed the last 2 weeks she was here...more aggressive." -"She seemed to have more problems the last couple of weeks...wanted more attention." -"The last few weeks she was more agitated and confrontational and she would lash out at [staff name]." -"She was more anxious" the last two weeks. -Resident #5's usual behavior was that she was verbally aggressive to staff and residents but that she was not known to be physical or touch staff or other residents. B. Review of Resident #3's current FL2 dated 3/4/15 revealed: -Diagnoses included adjustment disorder, mild mental retardation, depression and congenital blindness. -Medication orders included Lorazepam 1mg, one tablet by mouth, four times a day (Lorazepam is used to treat anxiety). Review of the Control Substance Count Sheets dated 3/1/15 through 6/30/15 for Resident #3's Lorazepam 1mg, four times daily for anxiety, revealed the following 27 doses had not been administered: -Eight doses at 8am (3/24, 3/25, 4/2, 4/15, 4/23, 5/5, 5/7, and 6/28).	D 358		

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D 358	Continued From page 26 -Ten doses at 12pm (3/25,4/15, 4/16, 5/6, 5/12, 5/20, 6/5, 6/9, 6/24 and 6/25). -Five doses at 4pm (4/12, 5/24, 6/18, 6/24 and 6/25). -Four doses at 8pm (5/26, 6/3, 6/17 and 6/18). Review of all the hand written Control Drug Count Sheets for Lorazepam 1mg revealed no prescription number, no dispensing information, and no tracking information. Review of the March 2015 through June 2015 Medication Administration Records (MARs) revealed staff documented Lorazepam 1mg as administered four times each day with the following exceptions: -No documentation of administration on 4/10 at 4pm) -5/24 at 4pm (initialed, circled with no reason given) -Two doses on 5/29/15 (4pm-8pm), Medication Aides (MAs) initials circled. Note on the MAR indicated the resident was in the hospital. Observations of medications on hand for Resident #3 on 6/25/15 at 7:45am revealed 23 tablets of Lorazepam 1 mg which matched the number of Lorazepam 1 mg on the Controlled Substance Count Sheet. Interview on 6/25/15 at 2:15pm with the facility Director revealed: -If medication was not administered, the reason should have been documented on the MAR. -She could not explain why Resident #3's Lorazepam 1mg had been signed on the MAR as administered when review of the Control Substance Count Sheet revealed the staff had not documented the declining count.	D 358		

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D 358	Continued From page 27 Per observation and review of Resident #3" diagnoses, Resident #3 was not interviewable. C. Review of Resident #6's FL2 dated 12/17/14 revealed: -Diagnoses included dementia and chronic obstructive pulmonary disease. -Medications included Xanax 0.25mg, one tablet, twice a day as needed for anxiety. -Admission date of 12/17/14. Interview on 6/25/15 at 3:30pm with Resident #6's family member revealed: -The resident went to the hospital with a hip fracture on 3/30/15. -From 4/7/15 through 6/12/15, he had been at a local nursing home for therapy. -He returned to this facility on 6/12/15. -On 6/19/15 Resident #6 was sent back to the hospital with swallowing difficulties. -Currently, he remained in the hospital undergoing tests. Review of the current FL2 for Resident #6, dated 6/12/15, revealed no order for Xanax. Review of the December 2014 through March 30, 2015 (date Resident #6 was admitted to the hospital) Medication Administration Record (MAR) for Resident #7 revealed: -Hand written transcriptions for Xanax 0.25mg, one tablet, twice a day as needed for anxiety. -No documentation Xanax had been administered to the resident. Interview on 6/25/15 at 11:05am with the facility Director and the Resident Care Coordinator (RCC) revealed: -They were not aware Resident #6 ever had an order for Xanax 0.25 mg.	D 358		

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D 358	Continued From page 28 -They both stated they had not seen Xanax in the medication carts or in the locked cupboard in the RCC's office. -They both gave medications on a routine basis. -The RCC stated if any [Xanax] had come from the pharmacy she didn't know where it might be. -They would look for a pharmacy delivery sheet to see if any had been sent from the pharmacy. Interview on 6/25/15 at 11:35am with a pharmacy representative revealed: -On 12/17/14, 60 tablets of Xanax 0.25mg were delivered to the facility for Resident #6. -The delivery sheet had been signed by Staff K, medication aide. -There was no record of the Xanax having been returned to the pharmacy. -A copy of the delivery sheet would be faxed to the facility. Interview on 6/25/15 at 2:15pm with the facility Director revealed the 60 Xanax 0.25mg tablets were not located in the facility. Interview on 6/25/15 at 3:30pm with Resident #6's family member revealed: -The resident and his spouse had been living in a facility in another state before admission to this facility in December, 2014. -Before admission to this facility, Resident #6 had become pushy with his spouse, had started yelling, had been belligerent with staff and had increasing anxiety. -Resident # 6's physician ordered a medication based on the behavior of the resident. -The family member was not certain of the name of the medication but stated there was a "very good chance it was Xanax". -The Resident and his spouse had moved to this facility in December 2014.	D 358		

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D 358	Continued From page 29 -Since admission to the facility in December, family member had witnessed Resident #6 yelling at the staff, demonstrating belligerent behaviors, being "pushy" with his spouse and blocking the doorway in his room preventing staff from entering and/or wheeling his spouse out into the hallway. -She had made the facility Director aware of Resdient #6's behaviors. Interviews on 6/26/15 from 1:55pm to 5:01pm with five personal care aides and 1 medication aide revealed: -Resident #6 had been very protective of his spouse. -He did not want the staff to get her up in a wheelchair. -He did not want the staff to take her out of their room. -He could be very belligerent and rude to the staff. -He liked to be in control and boss the staff around. -He could get pretty upset, impatient and yell at the staff, but he never tried to hurt anyone. --- The Plan of Protection Provided by the facility revealed: -All medications will be evaluated and accounted for daily by the Resident Care Coordinator (RCC). -The facility will schedule an inservice the second week in July, 2015 for the medication aides. -The Rcc will be responsible for making sure all medications are ordered from the pharmacy and available for administration tot residents. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2015.	D 358		

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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 and record review, the facility failed to assure 2 of 2 sampled residents' (#3 and #7) medications (Coumadin and Ativan), were not borrowed for other residents (#1 and #11) and failed to assure the borrowing and replacement of the medication was documented. The findings are: A. A review of the current FL2, dated 4/9/15, for Resident #1 revealed diagnoses which included: -Atrial Fibrillation (A-Fib) -Cardio-Vascular Accident (CVA) -Prostate Cancer Review of Resident #1's Resident Register revealed he was admitted to the facility on 2/6/12. On 6/24/15 at 9:20 AM during an initial interview with Resident #1 revealed: -He was taking Coumadin each day. (Coumadin is an anticoagulant (blood thinner) that reduces the formation of blood clots). -When asked if he ever missed his Coumadin, he stated, "Sometimes they tell me there is no	D 372		

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Coumadin."
-He said he tells staff he takes Coumadin every day and tells staff to go "find it."
-He had run out of his Coumadin and the facility staff were borrowing Coumadin from Resident #7.

Review of Resident #1's May 1 through June 24 2015 Medication Administration Record (MAR) revealed:
-The transcription for Coumadin 1.25 mg on Sunday and Friday and 2 mg on Monday Tuesday, Wednesday, Thursday and Saturday.
-Daily documentation as administered except for 6/17/15, with no documentation.
-There was no documentation any Coumadin had been borrowed from another resident.

During an interview on 6/24/15 at 2:15pm Staff A, Medication Aide revealed:
- "I did not have the Coumadin on the cart to give Resident #1 today."
- "I had to to borrow Coumadin" from Resident #7' to give to Resident #1.
- Staff are to write a note on the back of the MAR to document borrowing.

Review of the medications on hand for Resident #1 on 6/24/15 at 2:15pm with Staff A, Medication Aide, revealed no Coumadin available for Resident #1.

Telephone interview on 6/24/15 at 12:08 with staff at the dispensing pharmacy revealed:
-The facility last requested Coumadin on 6/4/15.
-On 6/4/15, the pharmacy dispensed 2 tablets 2.5 mg Coumadin (four doses) and 10 tablets 2 mg Coumadin (10 doses)
-The Coumadin dispensed on 6/4/15 would have been a supply covering 14 days.
-The pharmacy had not received any requests for

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D 372	Continued From page 32 Coumadin since 6/4/15 and had not received any new orders for Coumadin. If the facility first administered the Coumadin (which was dispensed on 6/4/15) on 6/5/15 and continued for 14 days, Resident #1's would not had any Coumadin for administration from 6/19 through 6/24/15 (day of survey). Interview with the Director on 6/24/15 at 2:25pm revealed: - She was responsible for monitoring the medications and ordering medication for residents who took Coumadin. -The Director stated she had called the backup Pharmacy for Resident #1's Coumadin for his daily dose on 6/24/15. -The Director further stated she was not sure when Resident #1 had ran out of his Coumadin but she knew that Resident #1 had the Coumadin because she borrowed it from Resident #7. - "I know he has not missed any. The Coumadin is my responsibility. I messed up." On 6/24/15 at 2:45pm the Director provided a prescription bottle from the back up Pharmacy for Resident #1 labeled Coumadin 2mg with one pill. Interview with the Director on 6/24/15 at 2:45pm revealed she had called the Pharmacy and the rest of Resident #1's Coumadin would come tonight. On 6/25/15 at 11:17am during an observation of Resident #1's medications on hand with the Director revealed 8 pills of Coumadin 1.25mg and 10 pills of Coumadin 2 mg tablets received from Pharmacy. Review of record revealed Resident #7 had	D 372		

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D 372	Continued From page 33 orders, dated 5/13/15, and 5/25/15, for Coumadin 1.5 mg Monday, Wednesday, and Friday and 1 mg Tuesday, Thursday, Saturday, and Sunday. Review of medications on hand for Resident #7 on 6/24/15 at 2:15pm revealed no Coumadin 1.5 mg tablets and 4 tablets for Coumadin 1 mg. On 6/24/15 at 3:00pm, review of 5/15/15 through 6/24/15 Medication Administration Records (MAR)revealed: -No documentation of any dose Coumadin administered on 6/11/15. -No documentation of any dose Coumadin administered on 6/22/15. -No documentation of any dose Coumadin administered on 6/23/15. -No documentation of any dose Coumadin administered on 6/24/15. -No documentation any Coumadin had been borrowed from Resident #1 or borrowed for Resident 7. During an interview on 6/24/15 at 2:15pm, Staff A revealed: -"I borrowed Coumadin from #7 to administer to Resident #1 "today." -Resident #7 currently only had four Coumadin tablets 1 mg on hand, with no Coumadin 1.5 mg available. -She did not administer any Coumadin to Resident #7 "today" because there was no 1.5 mg Coumadin available. Interview with the Director on 6/26/15 at 10:30am revealed the residents always received their Coumadin regardless if it had not been documented.	D 372		

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D 372	Continued From page 34 Interview with the home health nurse on 6/25/15 at 11:55am revealed: -Resident #7's INR was 4.3 "today" and the physician ordered the facility to hold the Coumadin "today and tomorrow" and start 1 mg daily on 6/27/15. Refer to interview with Staff A on 6/26/15 at 8:30am. Refer to interview with the facility Executive Director and Director on 6/26/15 at 10:38am. Refer to interview with Administrator on 6/26/15 at 2:35pm. B . Review of Resident #3's current FL2 dated 3/4/15 revealed: -Diagnoses including adjustment disorder, mild mental retardation, depression and congenital blindness. -Medications including Ativan 1mg, one tablet by mouth four times a day. (Ativan is used to treat anxiety.) Review of the Controlled Substance Count Sheet, hand written and dated 1/11/15 through 1/26/15 for Lorazepam 1mg tablets dispensed for Resident #3 revealed: -Documentation on 1/17/15 at 8:00am, one 1mg tablet was borrowed for Resident #11. -No indication the medication had been borrowed due to an emergency. -No documentation the borrowed medication had been replaced. Refer to interview with Staff A on 6/26/15 at 8:30am. Refer to interview with the facility Executive	D 372		

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D 372	Continued From page 35 Director and Director on 6/26/15 at 10:38am. Refer to interview with Administrator on 6/26/15 at 2:35pm. --- Interview on 6/26/15 at 8:30am with Staff A, Medication Aide (MA), revealed: -"We are supposed to call the Resident Care Coordinator or the facility Director and ask if we can borrow medication". -When borrowing, a note is to be written on the back of the Medication Administration Record (MAR). -She had never borrowed a controlled medication. -If she were to borrow a controlled medication, she would document on the back of the MAR from whom she borrowed it. Interview on 6/26/15 at 10:38am with the facility Director and the Executive Director revealed: -The facility did not have a written policy about borrowing medications. -There would be a policy put in place. -They had always been told they could borrow medication in a life threatening emergency. -They were not knowledgeable of the rules regarding borrowing medications. Interview on 6/26/15 at 2:35pm with the Administrator revealed: -There should be no borrowing of medications. -The residents should always have plenty of their own medications in the building. -Controlled and non-controlled medications have been borrowed on occasion but only if it's an emergency. -He was not familiar with the process of replacement and documentation required by rule regarding the borrowing of medications.	D 372		

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D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure accurate reconciliation and readily retrievable records for the receipt, administration and disposition of controlled substances for 4 of 5 sampled residents (Resident #5, #6, #7, and #8) with orders for controlled substances which included Valium, MS Contin, Oxycodone, Oxycodone-acetaminophen, Xanax, Ultram, and Morphine Sulfate resulting in amounts which ranged from 41 tablets of MS Contin 15 mg to 221 tablets Oxycodone 20 mg of the controlled substances being unaccounted for. The findings are: A. Review of the current FL2, dated 3/11/15, for Resident #5 revealed diagnoses which included: -Schizophrenia -Borderline psychotic disorder -Addison's disease -Hepatitis C -Heart disease -Hypertension Review of Resident #5's Resident Register	D 392		

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revealed she was admitted to the facility on 12/17/14.

Review of Resident #5's discharge record revealed Resident #5 was discharged from the facility on 4/23/15.

1. Review of physician orders for Resident # 5 revealed:
-3/11/15 - Order for Valium 5 mg twice daily. (Diazepam is generic for Valium. It is used for the management of anxiety disorder and symptoms associated with alcohol withdrawal, muscle spasms, and seizures), .
-12/31/14 and 2/25/15 - Orders for MS Contin 15 mg twice daily. (MS Contin is a narcotic pain reliever used to treat moderate to severe pain.).
-3/11/15 - Order for Oxycodone 20 mg 1 tablet every 4 hours for severe pain. (Oxycodone is a narcotic pain reliever used to treat moderate to severe pain),
-3/11/15 - Order for Oxycodone 20 mg, 1/2 tablet every 4 hours for mild pain.

Interview with the facility Director on 6/25/15 at 4:00pm revealed:
-Medications on hand when Resident #5 was discharged were given to Resident #5's family member, date unknown and staff person who handed the medications to family member unknown.
-The facility director said she was not in the facility when the family member picked up the medications.
-The facility director said she did not have the family member's telephone number.

Review of a "Prescription returned to the pharmacy" form, dated 4/28/15, signed by the facility Director, and noted medications "to be

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picked up by family," included the following controlled medications for Resident #5:
-Valium: 39 tablets
-MS Contin: 41 tablets
-Oxycodone 20 mg, 1 tablet: 25 tablets.
-Oxycodone 20 mg, 1/2 tablet: 37 tablets
-There was no signature by anyone as receiving Resident #5's medication.

Telephone interview with Resident #5's family member on 6/25/15 at 9:10am revealed:
-He picked up two bags of Resident #5's clothes.
-He was not offered, nor given, any medications and he did not sign for any medications.
-He did not know the date nor who was on duty when he picked up the clothes.
-He was the only family member who lived in the State and he knew of no family member who had been to the facility to get Resident #5's belongings.

Telephone interview with a personal care aide, Staff I, on 6/30/15 at 8:30am revealed:
-She gave Resident #5's family member clothes and books.
-She did not give Resident #5's family member any medications.
-She did not see any staff give Resident #5 any of Resident #5's medications.
-She could not remember what date the family member came to the facility and could not remember who the Supervisor was on the day the family member came.

On 6/26/15 at 10:45am, a telephone interview with Resident #5's guardian (guardian at the time Resident #5 resided at this facility) revealed:
-She had not received Resident #5's medications.
-She did not know of any family members who had received Resident #5's medications.

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D 392	Continued From page 39 -She had not requested any of Resident #5's family member pick up the medications. Interview with the Executive Director on 6/25/15 at 11:00am revealed: -She had no idea what happened to the medications which remained in the facility when Resident #5 was discharged. -She did not have a telephone number for Resident #5's family member and had never met any of Resident #5's family. Interview with the Administrator on 7/1/15 at 4:30pm revealed: -Staff were supposed to have family members sign for resident medications released to them. -He did not know what happened to Resident #5's medications. -In the future, staff would release medications only to family members (having proper identification) listed on record as having access to the Resident's medications and staff would obtain a signature. -Medications should be returned to the pharmacy or given to resident's family member/guardian within 3 days of the resident leaving the facility. Confidential interview with eight facility staff revealed none of the staff had provided Resident #5's discharge medications to family or anyone. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with the facility Director on 6/25/15 at 10:12am. Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am.	D 392		

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D 392	Continued From page 40 2. Review of Resident #5's record revealed physician orders, dated originally on 12/31/14 and subsequently on 3/11/15, for diazepam 5mg, 1 tablet twice daily (a medication used for the management of anxiety disorder). Review of pharmacy delivery sheet for diazepam 5 mg twice daily for Resident #5 revealed 60 tablets were delivered on 12/31/14. Review of Resident #5's record revealed no Control Drug Count Sheet for diazepam 5 mg twice daily in December 2014 nor January 2015. Review of January 2015 Medication Administration Records (MARs) revealed diazepam 5 mg twice daily was documented as administered twice daily (60 doses). The only other records provided by the pharmacy for Valium 5 mg revealed: -Dispensing records which listed 60 tablets Valium 5mg dispensed on 3/20/15. -Dispensing records which listed 60 tablets Valium 5mg dispensed on 4/24/15. Review of Control Drug Sheets for Resident #5's Valium 5 mg revealed: -Sixty tablets were dispensed on 2/1/15. -Sixty tablets were dispensed on 3/1/15. The first Control Drug Count Sheet (for tablets dispensed on 2/1/15) available for Resident #5's diazepam 5 mg revealed the first administration of diazepam was documented on 1/31/15 and the last one on 3/3/15. Review of another Control Drug Count Sheet (for tablets dispensed on 3/1/15) for Resident #5's	D 392		

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D 392	Continued From page 41 diazepam 5 mg revealed the first administration was documented on 3/4/15 and the last one at 8:00am on 4/6/15. Review of Resident #5's records revealed: -Control Drug Count Sheet revealing the 60 tablets Valium 5 mg which were delivered to the facility on 3/1/15 were all administered by 4/6/15 at 8:00am. -No Control Drug Sheet for Valium 5 mg twice daily for Resident #5 from 4/7/15 through 4/23/15 (date of discharge from facility). -The 60 tablets delivered to the facility on 3/20/15 should have been documented on a Control Drug Sheet beginning 4/6/15 at 8:00pm. Review of April 2015 MAR revealed 31 tablets diazepam 5mg were documented as administered from 8:00pm on 4/6/15 through 4/23/15. Review of a "Prescription returned to the pharmacy" form, dated 4/28/15, signed by the facility Director, and noted medications "to be picked up by family," included the following controlled medications for Resident #5: -Valium (diazepam): 39 tablets -There was no signature by anyone as receiving Resident #5's discharge medications. Telephone interview with staff at the dispensing pharmacy on 6/25/15 at 11:40am revealed: -They did have in their records 60 tablets of Diazepam 5 mg were delivered to the facility on 4/27/15 and were never returned to the pharmacy. (Resident #5 was discharged on 4/23/15.) -They could not provide further documentation of diazepam 5 mg delivered to the facility.	D 392		

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D 392	Continued From page 42 Review of pharmacy dispensing records revealed 60 tablets diazepam 5mg were dispensed on 4/24/15 after Resident #5 had been discharged from the facility. (These 60 tablets were the same ones the pharmacy said they delivered on 4/27/15.) Interview with the facility director on 6/24/15 at 4:00pm revealed: -She did not know where the 60 tablets of diazepam were that were dispensed on 4/24/15 and had no record when they came into the facility nor any record when they were sent back to the pharmacy. -She did not know where the 39 tablets were which were listed on the "Prescription returned to the pharmacy" form. -The facility did not have a system where staff routinely counted controlled drugs and reconciled the count with the Control Drug Sheets. On 6/25/15 at 4:10pm, interview with a medication aide from a sister facility (who had come in to assist staff at this facility) revealed: -Today (6/25/15) she found a bubble pack of 60 tablets diazepam 5 mg, twice daily, in an unlocked tote box under the desk in the Medication Aide's office. -She did not know why the diazepam was stored in the tote box. Observation of the label of the bubble pack of 60 tablets Diazepam, 5 mg, revealed it was for Resident #5 and dispensing date of 5/1/15. Interview with the facility director on 6/25/15 at 4:30pm revealed she did not know why the diazepam 5 mg was in the tote box nor why it had not been sent back to the pharmacy.	D 392		

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D 392	Continued From page 43 Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with the facility Director on 6/25/15 at 10:12am. Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. 3. Review of Resident #5's record revealed orders, dated originally on 1/7/15 with subsequent orders on 3/11/15 as follows: -Oxycodone 20 mg, 1 tablet every 4 hours as needed for moderate to severe pain, order, (a medication used to treat moderate to severe pain). -Oxycodone 20 mg, 1/2 tablet every 4 hours as needed for mild pain. Review of the pharmacy medication delivery sheets for Resident #5 revealed a total of 480 tablets Oxycodone 20 mg were received by the facility: -1/7/15- 120 tablets -1/20/15-60 tablets -1/28/15-60 tablets -3/6/15-120 tablets -4/1/15-120 tablets Telephone interview with staff at the dispensing pharmacist on 6/25/15 at 11:40am revealed they dispensed an additional 120 tablets Oxycodone 20 mg, on 4/22/15 and these were never returned to the pharmacy. A total of 600 tablets Oxycodone 20 mg were dispensed to the facility from 1/7/15 through 4/24/15 per the delivery sheets and interview with the pharmacy staff.	D 392		

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D 392	Continued From page 44 Review of Resident #5's record revealed no Control Drug Sheet for Oxycodone 20 mg, 1 tablet every 4 hours for moderate to severe pain for the following dates: -1/20/15 after 6:00 am through 6:00pm on 2/1/15 -3/26/15 after 12:00 pm through 10:00pm on 4/1/15 -4/19/15 after 2:00pm through 4/23/15 (date of Resident #5's discharge) Review of Control Drug Sheets for Oxycodone 20 mg, 1/2 tablet every 4 hours for mild pain revealed 39 tablets Oxycodone 20 mg, 1/2 tablets were documented to have been administered from 1/28/15 to 2/12 and from 2/25 through 3/26/15. Review of record revealed Oxycodone 20 mg, 1 tablet every 4 hours for moderate to severe pain from 1/7/15 (date of order) through 4/23/15 (date Resident #5 was discharged) revealed 340 tablets out of 600 tablets were accounted for as administered on the Control Drug Sheets as follows: -1/7/15 through 1/20/15- 60 tablets with 0 remaining -2/1/15 through 2/12/15- 55 tablets with 0 remaining -2/12/15 through 2/25- 60 tablets with 0 remaining -2/27/15 through 3/10/15- 45 tablets with 0 remaining -3/7/15 through 3/26/15- 60 tablets with 0 remaining -4/1/15-through 4/19/15- 57 tablets with 3 remaining Review of the facility form, dated 4/28/15, "Prescriptions returned to the pharmacy" revealed:	D 392		

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D 392	Continued From page 45 -Twenty-eight Oxycodone 20mg tablets to be released to Resident #5's family. - No signature of receipt of the Oxycodone by family or any other individual as receiving the medication. Interview with facility staff, including management, and Resident # 5's family member and guardian during the survey revealed the Oxycodone were not provided to the family and could not be accounted for. A total of 221 tablets of Resident # 5's Oxycodone 20 mg were unaccounted for based on the control drug sheets and interviews. Review of January through April 2015 Medication Administration Records (MARs) revealed: -January 2015 - Staff documented the administration of 59 tablets Oxycodone 20 mg, 1 tablet every 4 hours as needed for severe pain and 18 tablets Oxycodone 10 mg from 1/8/15 to 1/31/15. -February 2015 MAR - Staff documented the administration of 79 tablets Oxycodone 20 mg, 1 tablet every 4 hours as needed for moderate to severe pain and 2 tablets for Oxycodone 10 mg every 4 hours as needed for mild pain. -March 2015 MAR - Staff documented the administration of 59 tablets Oxycodone 20 mg, 1 tablet every 4 hours as needed for moderate to severe pain. - April 2015 MAR - Staff documented the administration of 46 tablets Oxycodone 20 mg, 1 as needed for moderate to sever pain and 3 tablets Oxycodone 10 mg, 1 as needed for mild pain documented as administered from 4/01/15 through 4/23/15. Interview with the facility director on 6/24/15 at	D 392		

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D 392	Continued From page 46 4:00pm revealed: -She did not know where the missing Control Drug Sheets were for the Oxycodone. -She was sure that Resident #5 always received all her Oxycodone as ordered and as requested for pain. -The facility did not have a system where staff routinely counted controlled drugs and reconciled the count with the Control Drug Sheets. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with the facility Director on 6/25/15 at 10:12am. Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. 4. Review of Resident #5's admission FL2, dated 12/31/14 revealed an order for Oxycodone-acetaminophen 10-325 mg, 1 tablet every 6 hours as needed for pain. Review of record revealed the Oxycodone-acetaminophen 10-325 mg, 1 tablet every 6 hours was discontinued on 1/7/15. Review of pharmacy delivery sheet, dated 12/31/14, revealed 120 tablets Oxycodone-acetaminophen 10/325 for Resident #5 were signed as received by the facility on 12/31/14. Review of record revealed no control drug sheets for Oxycodone-acetaminophen 10/325 for December 2014 or January 2015. Review of the January 2005 Medication	D 392		

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D 392	Continued From page 47 Administration Record revealed staff documented the administration of 12 tablets of Oxycodone-acetaminophen 10/325. Review of record revealed no documentation the remaining 108 tablets were returned to the pharmacy or the disposition of the discontinued Oxycodone-acetaminophen. Interview with the Resident Care Coordinator on 7/1/15 at 3:35pm revealed they would fax to the surveyor any Control Drug Count Sheets for Resident #5 if they located them, but no documentation was provided. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with the facility Director on 6/25/15 at 10:12am. Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. 5. Review of Resident record revealed physician orders, dated 2/25/15, for MS Contin 15mg twice daily for chronic pain. (MS Contin is a narcotic pain reliever used to treat moderate to severe pain.) Review of Resident #5's Control drug sheet for MS Contin 15 mg twice daily revealed -Sixty tablets were received on 2/25/15. -The first tablet was documented as administered on 2/25/15 and the last one at 8:00pm on 3/29/15. Review of the pharmacy delivery sheet, dated 3/25/15, revealed 60 tablets MS Contin were	D 392		

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D 392	Continued From page 48 received by the facility on 3/25/15. Review of record revealed no Control Drug Sheet for MS Contin 15 mg received by the facility on 3/5/15 for Resident #5. Review of the March and and April 2015 Medication Administration Records (MARs), the MS Contin 15 mg, 1 tablet was routinely documented as administered twice daily, 8:00am and 8:00pm through April 23, 2015 (date Resident #5 was discharged). If MS Contin 15 mg was administered twice per day from 3/30/15 through date of discharge, 4/2315, a total of 48 tablets would have been administered and 12 tablets of the 60 tablets delivered on 3/25/15 should have remained. Review of a "Prescription returned to the pharmacy" form, dated 4/28/15, signed by the facility Director, and noted medications "to be picked up by family," included the following controlled medications for Resident #5: -MS Contin: 41 tablets -There was no signature by anyone as receiving Resident #5's medications. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. B. Review of Resident #6's FL2 dated 12/17/14 revealed: -Diagnoses included dementia and chronic obstructive pulmonary disease. -Medications included Xanax 0.25mg, one tablet,	D 392		

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D 392	Continued From page 49 twice a day as needed for anxiety. -Resident #6 was admitted to the facility on 12/17/14. Interview on 6/25/15 at 3:30pm with Resident #6's family member revealed: -The resident went to the hospital with a hip fracture on 3/30/15. -From 4/7/15 through 6/12/15, he had been at a local nursing home for therapy. -He returned to this facility on 6/12/15. -On 6/19/15 Resident #6 was sent back to the hospital with swallowing difficulties. -Currently, he remained in the hospital undergoing tests. Review of the current FL2 for Resident #6, dated 6/12/15, revealed no order for Xanax. Review of medications on hand in the medication cart on 6/25/15 at 7:45am revealed no Xanax 0.25 available. Review of the December 2014 through March 30, 2015 (date Resident #6 was admitted to the hospital) Medication Administration Record (MAR) for Resident #6 revealed: -Hand written transcriptions for Xanax 0.25mg, one tablet, twice a day as needed for anxiety. -No documentation Xanax had been administered to the resident. Interview on 6/25/15 at 11:05am with the facility Director and the RCC revealed: -They both gave medications on a routine basis. -They both stated they didn't think Resident #6 had an order for Xanax. -They both stated they had not seen Xanax in the medication carts or in the locked cupboard in the RCC's office.	D 392		

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D 392	Continued From page 50 -The RCC stated if any [Xanax] had come from the pharmacy she didn't know where it might be. -They would look for a pharmacy delivery sheet to see if any had been sent from the pharmacy. Interview on 6/25/15 at 11:35am with a pharmacy representative revealed: -On 12/17/14, sixty tablets of Xanax 0.25mg were delivered to the facility. -The delivery sheet had been signed by Staff K. -There was no record of the Xanax having been returned to the pharmacy. -A copy of the delivery sheet would be faxed to the facility. Review of Resident #6's record revealed no Controlled Drug Count Sheet for the 60 tablets Xanax 0.25 mg delivered to the facility on 12/17/14. Interview on 6/25/15 at 2:15pm with the facility Director revealed sixty Xanax 0.25mg tablets were not located in the facility. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. C. Review of Resident #7's current FL2 dated 9/17/14 revealed diagnoses which included cardiovascular accident (CVA) with right hemiplegia (a stroke with right sided paralysis), coronary artery disease, and renal insufficiency. Review on 6/25/15 at 2:30pm of Resident #7's record revealed: -A physician's order, dated 6/15/15, for Morphine	D 392		

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D 392	Continued From page 51 Sulfate, 100mg/5ml, take 5mg (0.25ml) by mouth every six hours as needed for pain. -A physician's order dated 6/17/15 for Roxanol (morphine sulfate) 20mg/ml solution, 5mg by mouth every hour as needed for pain/dyspnea (difficulty breathing). Continued review of Resident #7's record revealed: -The resident expired on 6/18/15. -A Hospice death summary note which stated, "Medication disposal by facility staff per facility protocol." Observation on 6/25/15 at 2:45pm of prefilled syringes of morphine sulfate (Roxanol) labeled by the pharmacy for Resident #7"s stored in a locked wall cabinet in the RCC's office revealed: -Sixty-one individually labeled syringes (one dose per syringe) in a large zip-lock plastic bag labeled by the pharmacy and dispensed on 6/15/15. -Forty individually labeled syringes, rubber banded together into 4 groups of ten in a large zip-lock plastic bag labeled for Resident #7 and dispensed on 6/15/15. -Nine individually labeled syringes rubber banded together in a smaller plastic zip locked bag with Resident #7's name, morphine sulfate .25ml by mouth every 6 hours as needed for pain hand written on the bag in black marker. -The total doses observed to be on hand totaled 110. Interview on 6/25/15 at 4:10pm with a pharmacy representative revealed: -On 6/15/15, Morphine sulfate (15mls) had been sent to the facility for Resident #7 (60 syringes). -On 6/16/15, an additional 15mls (60 syringes) of Morphine sulfate had been sent to the facility. -The pharmacy had no record of the facility	D 392		

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D 392	Continued From page 52 having returned any Roxanol syringes. Review on 6/25/15 of the Controlled Substance Count Sheet for Resident #7's morphine sulfate (Roxanol) revealed: -The medication name and directions were hand written. -It indicated that 5mg was 0.25ml or 1 syringe. -Ten had been hand written as the number dispensed (in the bag). -One syringe had been documented as administered on 6/16/15 at 11am by Staff K, Medication Aide (MA), but not documented as administered on the June 2015 MAR. -There was no documentation additional doses had been administered and the number of syringes documented as remaining was 9. Review on 6/25/15 of Resident #7's Medication Administration Record (MAR) for June 2015 revealed: -A hand written entry for morphine sulfate (Roxanol), 100mg/5ml, take (0.25ml) by mouth every 6 hours as needed for pain. -Medication Aide (MA) initials were noted on 6/15-Staff H, 6/16-Staff J and 6/17-Staff H. -Documentation on the back of the MAR noted 6 doses morphine sulfate were administered on 6/15, 6/16, and 6/17. -The order had been lined through with the notation, "Orders changed 6/17/15". Continued review on 6/25/15 at 3:00pm of Resident #7's MAR for June 2015 revealed: -A second hand written entry by the Resident Care Coordinator (RCC) for Roxanol (Morphine sulfate) 20mg/ml, take 5mg by mouth every 1 hour as needed for pain/dyspnea. -There were no MA initials indicating the medication had been administered.	D 392		

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D 392	Continued From page 53 -There was no documentation on the back of the MAR that the medication had been administered. Review of Resident #7's June 2015 MAR and review of the Controlled Drug Count Sheet for Roxanol revealed a total of 7 doses (of the 120 doses delivered) were documented as administered but only 110 doses on hand, leaving 3 doses unaccounted for. Interview on 6/25/15 at 4:20pm with the Director revealed: -Resident #7 had received more than one dose of morphine sulfate. -She did not know why the documentation on the June MAR and the Controlled Substance Count Sheet were incorrect. -The facility did not have a system where staff routinely counted controlled drugs and reconciled the count with the Control Drug Sheets. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with the facility Director on 6/25/15 at 10:12am. Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. D. Review of current FL2, dated 1/1/15, for Resident #8 revealed diagnoses which included: -Congestive Heart Failure -Hypertension -Chronic bronchitis -Coumadin Therapy -Left hip fracture -10/29/14 Review of Resident Register revealed Resident	D 392		

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D 392	Continued From page 54 #8 was admitted to the facility on 7/22/13. Interview with the Director on 6/25/14 at 10:12am revealed Resident #8 was sent to the hospital from the facility on 6/15/15 and had not returned to the facility. Review of Resident #8's records revealed the current physician orders which included Tramadol 50 mg, twice daily, order dated originally on 8/12/14 (a medication used for the management of moderate to severe pain). Review of the 4/1/15 through 5/25/15 Medication Administration Records (MARs) revealed staff documented Tramadol 50 mg administered twice per day at 8:00am and 8:00pm. Review of the pharmacy dispensing records revealed Tramadol 50 mg was dispensed for Resident #8 as follows: -60 tablets on 4/24/15 -60 tablets on 5/23/15 There were no Controlled Substance Count Sheet for Tramadol 50 mg twice daily for Resident #8 from 5/2/15 through 5/27/15. Review of the 5/2/15 through 5/27/15 Medication Administration Records (MARs) revealed staff documented Tramadol 50 mg administered twice per day. A review was made on 6/25/15 at 11:10 am Resident #8's medications on hand. The Tramadol 50 mg by mouth twice a day revealed 23 pills left in accordance with the Controlled Substance Count Sheet. Interview with the pharmacy on 6/26/15 at	D 392		

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D 392	Continued From page 55 10:05am revealed: -Resident #8's Tramadol 50 mg twice a day is dispensed on a regular basis each month. -The Pharmacy stated that no medication had been returned to the pharmacy for Resident #8. Interview with Executive Director on 6/26/15 at 11:40 am revealed: -She stated she was not aware of Resident #8 not receiving medications as ordered. -She further stated the Resident Care Coordinator was responsible for checking the medications then the Director and then herself. Refer to interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED). Refer to interview with the facility Director on 6/25/15 at 10:12am. Refer to interview with staff at the dispensing pharmacy owner on 6/25/15 at 9:40am. _____ Interview on 6/25/15 at 4:20pm with the facility Director, Resident Care Coordinator (RCC) and the Executive Director (ED) revealed paperwork had not been filed for "quite a while" and they were having difficulty finding narcotic delivery sheets and Controlled Substance Count Sheets for the sampled residents. Interview with the Director on 6/25/15 at 10:12am revealed the facility did not have a system where staff routinely counted controlled drugs and reconciled the count with the Control Drug Sheets. Telephone interview with staff at the dispensing	D 392		

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D 392	Continued From page 56 pharmacy owner on 6/25/15 at 9:40am revealed: -The pharmacy does not get a "lot of returns" (medications) from this facility. -The facility had returned no medications to the pharmacy since March, 2015. -They encourage the facility to track and document. --- The Plan of Protection provided by the facility revealed: -All Control substance sheets will be placed in a binder and in alphabetical order by the Resident Care Coordinator (RCC). -The RCC will be the only staff with access to the control drug records after they are placed in the binder. -The Director or the RCC will review shift change reports and narcotic counts daily and document inventory sheet. -Medcations on hand when residents are discharged will be signed by the person receiving the medications. and witnessed by 2 staff. -Medications on hand when residents are discharged which are returned to pharmacy will be returned within 48 hours of resident discharge and a copy of the documentaion will be put in a notebook. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 31, 2015	D 392		
D 393	10A NCAC 13F .1008 (b) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (b) Controlled substances may be stored together in a common location or container. If	D 393		

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D 393	Continued From page 57 Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that all Scheduled II medications were always maintained under double lock. The findings are: Observations on 6/25/15 at 7:35am of the Resident Care Coordinator's (RCCs) office revealed: -It was located off of the Director's office which is entered through a doorway off of the main hallway. -There was a common doorway between the Director's office and the RCCs office. -It contained a table with piles of papers stacked across the surface, shelving containing resident records, and a locked cabinet on the wall and an unlocked file cabinet on the floor. -The locked cabinet contained bubble packed and plastic zip locked bags of controlled medication. -The unlocked file cabinet contained extra bubble packs of resident medication (non-controls). -Doors to the Director's office and the RCC's office were open and staff were walking in and out of both offices. -There were no Medication Aide (MA) or administrative personnel in the offices. Observations on 6/25/15 at 11:20am of the Director and RCC offices revealed: -Both offices were unlocked.	D 393		

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D 393	Continued From page 58 -No facility staff were present. -A staff person from an outside agency had entered both offices and looked at resident records. Confidential interview with two MAs during the survey revealed: -The pharmacy delivered medications in the afternoon/evenings in a tote box. -Delivery time varied from 4:00pm to 11:00pm -The MA on duty opens the tote box (there is a plastic tag lock on the tote which is removed) and reconciles the medications delivered with the delivery sheet. -The MA leaves the tote box (with no lock on it) on top of the cabinet or in the metal file cabinet (with no lock) in the facility Director's office. -The MAs do not have a key for the adjoining RCC's office which has a lockable door and a locked wall cabinet for medications. -If the RCC or the facility Director do not come back to the facility in the afternoon/evenings, the tote box remains in the Director's office in front of a security camera, until the next morning when the RCC or facility Director come into work. During the survey, medications which were not accounted for by reconciliation of medications delivered, returned and administered included Oxycodone, Oxycodone with acetaminophen, Morphine Sulfate (Roxanol) and MS Contin. Interview with the Executive Director on 6/26/15 at 11:40am revealed: -The previous pharmacy delivered medications by 4:00pm each day so the RCC or the facility director could lock up medications. -This pharmacy supposed to deliver medications before 4:00pm, but do not. -The facility has no written contract with the	D 393		

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D 393	Continued From page 59 pharmacy.	D 393		
D 401	10A NCAC 13F .1009(a)(2-6) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas; (3) review of the medication system utilized by the facility, including packaging, labeling and availability of medications (4) review the facility's procedures and records for the disposition of medications and provide assistance, if necessary; (5) provision of a written report of findings and any recommendations for change for Subparagraphs (a)(1) through (4) of this Rule to the facility and the physician or appropriate health professional, when necessary; (6) conducting in-service programs as needed for facility staff on medication usage that includes the following: (A) potential or current medication related problems identified; (B) new medications;	D 401		

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D 401	Continued From page 60 (C) side effects and medication interactions; and (D) policies and procedures. This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure the quarterly on-site medication review included a review of all aspects of the facility's systems for medication administration, including accountability of controlled substances including disposition, receipt and administration of controlled substances and medication storage. The findings are: Review of 5 sampled resident's (Resident #1, #2, #3, #4, and #5), quarterly medication reviews and interview with the facility Director, the last quarterly onsite reviews by the pharmacy were completed on 04/17/15. Telephone interview on 6/26/15 at 9:15am with the owner of the dispensing pharmacy revealed: -His expectations of the consulting pharmacist doing a quarterly review included record reviews, review of medication storage (on the medication carts and in the medication room) and observing for expired medications. -A report related to medication storage and expired medications would be issued only if discrepancies were identified. -The consulting pharmacist was out of the office and would be available for interview on Wednesday (7/1/15).	D 401		

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D 401	Continued From page 61 -If the pharmacist had made any recommendation for medication storage and narcotic procedures, he would have left the facility a report. Interview on 6/26/15 at 10:05am with the Resident Care Coordinator revealed: -The consulting pharmacist who completed the resident medication reviews did not inspect the medication carts or any medication storage areas. -The consulting pharmacist did not look for expired drugs. -If the consulting pharmacist had asked to see the facility's procedures and records for the disposition of medications he would have been told the facility had no written policy. -The consulting pharmacist only did on site review of the resident records. -The consulting pharmacist would have been able to provide assistance in organizing their records. -The consulting pharmacist had never left any documentation related to the facility medication storage areas or procedures related to disposition of medications. Interview with the facility Director on 6/26/15 at 11:40am revealed: -She did not know a pharmacist by the name of [consulting pharmacist name] and had never met him. -She knew the owner of the pharmacy and he came out to do pharmacy reviews. -She was not aware of the consulting pharmacy leaving any documents related to medication storage. Interview with the Administrator on 7/1//15 at 4:10pm revealed: -The facility had no written contract with the	D 401		

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D 401	Continued From page 62	D 401		

pharmacy.
-The consulting pharmacist was hired by the pharmacy which provided medications to the residents.
-He was not aware the consulting pharmacy was supposed to inspect medication storage areas.

Interview with the Executive Director on 7/1/15 at 4:00pm revealed they had no written policies on the following:
-What the expectation were for the consulting pharmacist during his quarterly visits and medication reviews.
-How staff were to routinely reconcile controlled medications with control drug count sheets.
-How and when medications were to be returned to the family/pharmacy after a resident was discharged.

Telephone interview with staff at the dispensing pharmacy on 7/1/15 at 11:15am revealed:
-The consulting pharmacist was not available for surveyors to talk with him.
-The pharmacy contracted with the consulting pharmacist for services.
-She would ask the consulting pharmacist to contact the surveyor.
-She had talked to the consulting pharmacist and he reported that he did inspect the facility's medication storage area but had left no report because he had not found any problems.
-They had no signed contract agreement with the facility related to what services the consulting pharmacist would provide.

Attempted telephone interview with the consulting pharmacist before date of exit on 7/1/15 was not successful.

Non-compliance was identified with accountability

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D 401	Continued From page 63 of controlled substances and maintaining records of receipt, administration and disposition of controlled substances. Refer to Tag 392 10A NCAC 13F .1008 (a) Controlled Substances and Tag 393 10A NCAC 13F .1008 Controlled Substance.	D 401		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents were treated with respect, consideration, dignity, and full recognition of their right to privacy related to facility providing timely transportation and related to privacy during showers. The findings are: Based on observation, interview, and record review, the facility failed to assure all residents' rights were maintained related to the facility providing timely transportation and related to privacy during showers. [Refer to Tag 338 10A NCAC 13F .0909 (Resident Rights).]	D911		
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	D912		

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D912	Continued From page 64 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility 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 management of facilities, health care, medication administration, staffing, and resident rights. The findings are: A. Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to resident rights, personal care training program, staffing, health care, medication administration, controlled substances, pharmaceutical care, and declaration of resident rights. [Refer to Tag 176 10A NCAC 13F .0601(a) Management of Facilities (Type A2 Violation).] B. Based on interviews, observation, and record review, the facility failed to assure third shift was staffed with 16 hours of personal care aide in addition to a supervisor on duty for a census of 48 residents in an unsprinklered facility. [Refer to Tag 214 10A NCAC 13F .0605(c) Staffing Of Personal Care Aide Supervisors (Type B Violation).] C. Based on observation, interviews, and record review, the facility failed to assure written orders for Coumadin from the physician were documented in the residents record for 1 of 6 residents (#1). [Refer to Tag 276 10A NCAC 13F	D912		

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D912	Continued From page 65 .0902(c) Health Care (Type B Violation).] D. Based on observations, interviews and record reviews, the facility failed to assure prescribed medications (Xanax, Valium, MS Contin, and Lorazepam,) were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#3, #5, #6). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure residents were free of exploitation as evidenced by the lack of accountability of the residents' controlled substances resulting in no accountability of 41 tablets to 221 tablets of various controlled substances. The findings are: Based on observations, interviews and record reviews, the facility failed to assure accurate reconciliation and readily retrievable records for the receipt, administration and disposition of controlled substances for 4 of 5 sampled residents (Resident #5, #6, #7, and #8) with orders for controlled substances which included Valium, MS Contin, Oxycodone, Oxycodone-acetaminophen, Xanax, Tramadol, and Morphine Sulfate resulting in amounts which	D914		

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D914	Continued From page 66 ranged from 41 tablets of MS Contin 15 mg to 221 tablets Oxycodone 20 mg of the controlled substances being unaccounted for. [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation).]	D914		