STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046021	A. BUILDING: _____ B. WING _____	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON FAMILY CARE HOME	316 EAST RICHARD STREET AHOSKIE, NC 27910

(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
C 000	Initial Comments The Adult Care Licensure Section and the Hertford County Department of Social Services conducted an annual survey on 11/10/15.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that 3 of 3 staff (Staff A, B and C) had been tested for TB (tuberculosis disease) in compliance with the control measures adopted by the Commission for Health Services (2-step Tuberculin Skin Test method). The findings are: 1. Review of Staff A's (Personal Care Assistant) employment record revealed: -Date of hire: 4/16/14.	C 140		

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C 140	Continued From page 1 -Only a one-step TB skin test had been completed on 3/12/14 with a negative reading. -There was no documentation of a second TB skin test. Staff A was unavailable for interview. Refer to interview with Administrator-In-Charge (AIC) on 11/10/15 at 3:15pm. 2. Review of Staff B's (Administrator/Medication Aide) employment record revealed: -Date of hire: 6/1/2009. -Only a one-step TB skin test had been completed on 5/29/09 with a negative reading. -There was no documentation of a second TB skin test. 3. Review of Staff C's (Medication Aide) employment record revealed: -Date of hire: 7/1/14. -Only a one-step TB skin test had been completed on 8/28/14 with a negative reading. -There was no documentation of a second TB skin test. Staff C was unavailable for interview. Refer to interview with Administrator-In-Charge (AIC) on 11/10/15 at 3:15pm. _____ Interview with Administrator in Charge (Staff B) on 11/10/15 at 3:30pm revealed: -She was unaware of the rule requiring a 2nd TB skin test and screening for all applicants for employment in a family care home. -She would immediately make an appointment for a TB skin test and screening for Staff A, B and C. -Staff C worked only as needed once per month. -She hired Staff C a few weeks before Staff C	C 140		

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C 140	Continued From page 2 actually came to work at the facility. -She was aware of the TB testing requirement upon hire.	C 140		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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: Based on observation, interview, and review of records, the facility failed to ensure accurate control logs were available for review for 2 controlled medications (Ativan and Sonata) for 1 of 3 sampled residents (Resident #2) . The findings are: Review of Resident #2 current FL-2 dated 4/19/15 revealed: -Diagnosis of schizophrenia and mild intellectual disability. -Resident had a prn order for Ativan 1mg (a controlled substance used for agitation) and a prn order for Sonata 10mg (a controlled substance used for sleep). Based on observation of medications on 11/10/15 at 2:45pm revealed: -The facility had 17 Ativan tablets and 2 Sonata capsules on hand for Resident #2. -There was a folded pharmacy-issued control log attached by a rubber band to the medication card	C 367		

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C 367	Continued From page 3 for Ativan and Sonata for the facility's tracking of medication administration. Review of the November control log revealed: -There were no written entries for Resident #2's 7 Ativan administrations for the month of November 2015. -There were no written entries for Resident #2's 5 Sonata administrations for the month of November 2015. -The control logs were blank. -The pharmacy's printed label identifying each Ativan and Sonata medication was on the control log sheets. Review of the Resident #2's Medication Administration Record for November 2015 revealed: -7 Ativan tablet administrations had been administered. -5 Sonata capsule administrations had been administered . Review of Resident #2's Medication Administration Record (MAR) for September 2015, October 2015 and November 2015 revealed: -There were administration entries by Staff B and Staff C for both Ativan and Sonata administered to Resident #2. -Administrations of Ativan and Sonata were initialed on Resident #2's MAR by the medication aides for the months of September, October and November 2015. Interview with the Administrator on 11/10/15 at 3:45pm revealed: -Resident #2 arrived with an Ativan supply to the facility on 5/19/2015. -The number of Resident #2's Ativan tablets was	C 367		

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C 367	Continued From page 4	C 367		

not counted upon his entry to the facility.
-She could not verify the number of Ativan tablets that Resident #2 brought to the facility.
-All medication administrations were written on the MAR only.
-The control logs were never used.
-She acknowledged receipt of the control logs with each medication shipment.
-She did not maintain a log book for the controlled medication log sheets from the pharmacy.
-She saw the log sheets attached to the Ativan and Sonata medications as provided by the pharmacy but did not fill them out.
-She did not know it was a requirement that they be filled out.
-She did not know how to fill them out.
-She was unaware of the rule requiring facilities maintain and provide controlled medication log sheets.
-She was going to ensure that all staff fill out the control log for each medication immediately.
-She discarded the previous control log sheets each time when a new shipment of medication arrived.
-She was unaware of the requirement to reconcile the medications when received upon delivery and administration.

Interview with the facility's contract pharmacist on 11/10/15 at 2:45pm revealed:
-The control logs are sent with each control medication dispensed.
-Resident #2 had current orders for Ativan 1mg and Sonata 10mg.
-Resident #2 had been on Ativan 1mg since 2011.
-Resident #2 was dispensed Ativan prior to his admission to the current facility.
-Resident #2 had been issued Ativan while at his previous facility.
-The pharmacist could not verify how many Ativan

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C 367	Continued From page 5 tablets Resident #2 would have had prior to his transfer to this facility. -Resident #2 had been prescribed Sonata 10mg since his admission to the family care home on 5/19/15. -The pharmacy had dispensed 120 Sonata 10mg capsules since 5/19/15. Further review of Resident #2's MARs since Resident #2's admission to the facility on 5/19/15 revealed that 118 Sonata capsules had been administered with 2 capsules remaining which matched the count on hand at the facility. Based on observation and interview, the facility did not document receipt of Ativan brought to the facility upon admission, therefore unable to reconcile of Ativan.	C 367		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	C 934		

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C 934	Continued From page 6 This Rule is not met as evidenced by: Based on personnel record and interview, the facility failed to assure 2 of 3 staff sampled (Staff B, Administrator/Medication Aide; and Staff C, Medication Aide) completed the mandatory annual infection control course. The findings are: 1. Review of Staff B's(Administrator/Medication Aide) employment record revealed: -Date of hire: 6/1/2009. -There was no documentation of completion of the mandatory annual infection control course. Refer to interview with Administrator-In-Charge (AIC) on 11/10/15 at 3:15pm. 2. Review of Staff C's (Medication Aide) employment record revealed: -Date of hire: 7/1/14. -There was no documentation of completion of the mandatory annual infection control course. -Staff C was unavailable for interview. Refer to interview with Administrator-In-Charge (AIC) on 11/10/15 at 3:15pm. Interview with the Administrator in Charge on 11/10/15 at 3:15pm revealed: -She was unaware of the state infection control course completion and course certificate requirement. -She had infection control training provided by the facility's pharmacy in the past. -She did not have the infection control	C 934		

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C 934	Continued From page 7 certifications in her staff charts as taught by the state infection control course. -She would immediately make an appointment with their nurse to to teach and certify her staff in order to complete the mandatory infection control certification requirement.	C 934		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or	C992		

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C992	Continued From page 8 employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed prior to employment for 2 of 3 employees (Staff A and C) hired after 10/1/13. The findings are: 1. Review of Staff A's employment record revealed: -Date of hire: 4/16/14. -Staff A's position title was a Personal Care Aide. -No documentation of completion of controlled substance examination and screening. Refer to interview with Administrator-In-Charge (AIC) on 11/10/15 at 3:15pm. 2. Review of Staff C's employment record revealed: -Date of hire: 7/1/14. -Staff C's position title was Medication Aide. -No documentation of completion of controlled substance examination and screening. Refer to interview with Administrator-In-Charge (AIC) on 11/10/15 at 3:15pm. _____ Interview with the Administrator in Charge on 11/10/15 at 3:15pm revealed: -She was unaware of the rule requiring controlled	C992		

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C992	Continued From page 9 substance exam and screening for all applicants for employment in a family care home hired after 10/1/13. -She would immediately make an appointment for controlled substance screenings for Staff A and C.	C992		

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	FCL011022	A. BUILDING: _____ B. WING _____	10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW FAMILY CARE HOME # 1	256 GRAVELY BRANCH ROAD FLETCHER, NC 28732

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C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a biennial survey on October 15, 16 and 20, 2015.	C 000		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview, observations and record review, the facility failed to assure a clean and orderly environment that was free of all obstructions and hazards as evident of dogs being in the kitchen and animal feces found in the living room and common bathroom. The findings are: Observation when the surveyors entered the facility on 10/15/15 at 8:30 AM revealed: -What appeared to be fresh animal feces on the floor of the living room. -Large wet area in front of couch in living room. -When alerted, the administrator cleaned and mopped the area. Observation during the initial tour of the facility on	C 078		

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C 078	Continued From page 1 10/15/15 from 8:40 AM until 9:30 AM revealed: -What appeared to be fresh animal feces on the floor of the common bathroom on the left-side of the hallway (when alerted, the administrator cleaned and mopped the area). -Two dogs were inside the facility. -Both dogs were observed in the kitchen area. Observations during the survey on 10/15, 16 and 20/15 revealed: -About 3-4 times per day the dogs were removed and kept out of the kitchen and dining area. -Staff used kitchen access to put dogs outside in fenced area. -The facility remained clean and free from any additional animal feces. Review of the Environmental Health Inspection of Residential Care Facility report dated 02/23/15 on 10/15/15 revealed: -Four demerit points indicated for "pets and other animals not allowed where food is prepared or stored, nor in the serving area (.1620)". -Under comments, "pets and other animals are not allowed where food is prepared or stored". Interviews with residents during the survey on 10/15, 16 and 20/15 revealed: -"I go to the bathroom first thing in the morning and I have to step around the mess in the floor to get to the toilet, the mess is from the dogs every day." -"I have to be careful when I go into the bathroom in the morning I don't step in the dog mess." -"I can't be bothered with the dog mess in the bathroom, I have to take care of my business when I'm in there." -"I have to wear my shoes cause I don't want to be stepping in the dog poop in the bathroom." -"It is both wet and poop on the floor in the	C 078		

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C 078	Continued From page 2 bathroom." -"Dogs go to the bathroom in the living room all the time." -"The dogs sneak into the kitchen all the time." -"There is no cleaning schedule." -"Dogs go to the bathroom in the house all the time instead of outside, large piles." Interview with the administrator on 10/15/15 at 9:40 AM revealed: -She had not noticed the feces on the floor in the living room or bathroom until alerted by the surveyors. -The feces had not been present earlier that morning when she had prepared breakfast for two residents who went to a day program and employment during the day. -The dogs are not allowed in the kitchen but will sometimes get in there unnoticed. _____ A Plan of Protection was submitted by the facility on 10/15/15 that included: -The dogs will be kept in the administrator's bedroom. -The kitchen door will remained closed or locked at all times. -Staff will be alerted to immediately clean-up any animal feces if found in the facility. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2015.	C 078		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be	C 185		

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C 185	Continued From page 3 responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the 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 B VIOLATION Based on interview, observations and record review, the facility administrator failed to assure the rules and regulations were met and maintained related to management, housekeeping, therapeutic diets, medications and controlled substances. The findings are: Noncompliance identified during the survey was as follows: 1. Based on interview, observations and record review, the facility failed to assure a clean and orderly environment that was free of all obstructions and hazards as evident of dogs being in the kitchen and animal feces found in the living room and common bathroom. [Refer to Tag 078, 10A NCAC 13G .0315(a)(5)]. 2. Based on interview, observation and record	C 185		

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C 185	Continued From page 4	C 185		

review, the facility failed to assure there was a menu available for staff guidance for a physician-ordered low carbohydrate diet for 1 of 3 sampled residents (Resident #3). [Refer to Tag 270, 10A NCAC 13G .0904(c)(7)].

3. Based on interview, observations and record review, the facility failed to assure verification of a resident's medications within 24 hours of admission to the facility for 1 of 3 sampled residents (Resident #3). [Refer to Tag 315 10A NCAC 13G .1002(a)].

4. Based on interview, observation and record review, the facility failed to assure medications were administered as ordered by a prescribing practitioner to 2 of 3 sampled residents with orders for duloxetine, quetiapine, cyclobenzaprine, Bydureon (Resident #3) and glimepiride 3mg (Resident #2). [Refer to Tag 330 10A NCAC 13G .1004(a)].

5. Based on interview, observation and record review, the facility failed to assure medications prepared in advance for 1 of 3 sampled residents (Resident #3) were identified up to the point of administration and protected from contamination and spillage. [Refer to Tag 335 10A NCAC 13G .1004(f)].

6. Based on interview, observation and record review, the facility failed to assure medication records were accurate and complete for 2 of 3 sampled residents (Residents #2 and #3). [Refer to Tag 342 10A NCAC 13G .1004(j)].

7. Based on interview, observation and record review, the facility failed to assure controlled substances records were accurate and complete for 1 of 3 sampled residents (Resident #3) with

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C 185	Continued From page 5 an order for clonazepam and methadone. [Refer to Tag 367 10A NCAC 13G .1008(a)]. _____ A Plan of Protection was discussed via telephone with the administrator on 11/06/15 at 9:50 AM. A Plan of Protection was faxed to the facility on 11/06/15. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2015.	C 185		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed to assure there was a menu available for staff guidance for a physician-ordered low carbohydrate diet for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 08/18/15 revealed diagnoses included hypertension (high blood pressure), hyper cholesterol (high amounts of cholesterol in the blood) and Type 2 Diabetes Mellitus. Review of Resident #3's record revealed:	C 270		

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C 270	Continued From page 6 -Admission date of 09/30/15. -An order dated 10/09/15 for a low carbohydrate, low-sugar diabetic diet. Observation on 10/15/15 at 12:40 PM revealed: -There was a menu on a kitchen wall signed by a registered dietician. -The menu did not include guidance for making low carbohydrate meals. -The menu did include guidance for making diabetic meals. Observation on 10/15/15 at 11:45 AM of the lunch meal revealed residents were served two sloppy joe sandwiches, on buns, with potato chips and their choice of beverage. Observation on 10/15/15 at 11:55 AM of Resident #3's lunch plate revealed he had eaten all of the sloppy joe meat and one bun. Interview on 10/15/15 at 11:55 AM with Resident #3 revealed: -He had eaten only the sloppy joe meat and one bun due to being on a carbohydrate restricted diet. -He had been living in his own apartment before coming to the facility and was used to eating more fruits, veggies and fish. -"I'm getting allot of carbs here." -"Today we had sloppy joe's and chips for lunch and they didn't offer me anything else." -He stated his blood sugar levels had gotten higher since moving into the facility. -While at home his blood sugar levels were between "80-90" and now they are between "130-200". -He knew what foods he needed to eat and monitors his food intake. -He stated his blood sugar reading taken after	C 270		

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C 270	Continued From page 7 lunch was 262. Review of finger stick blood sugar (FSBS) record for Resident #3 revealed: -He had documented his FSBS readings since admission to the facility. -FSBS ranged from 82 to 264. Interview on 10/15/15 at 12:35 PM with the administrator revealed: -She knew Resident #3 was on a low carbohydrate diet and he was not "to eat breads, he could eat baked potatoes with nothing on it and salads". -They usually had fresh fruit available, apples or bananas. -They were "going to store today". -"We have frozen vegetables, not fresh." -"We don't have a low carbohydrate menu in any house."	C 270		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	C 315		

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C 315	Continued From page 8 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview, observations and record review, the facility failed to assure verification of a resident's medications within 24 hours of admission to the facility for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's record revealed admission date of 09/30/15. Review of Resident #3's current FL2 revealed: -The FL2 was signed by the physician and dated 08/18/15. -Diagnoses included depressive disorder nonspecific, post-traumatic stress disorder, atrial fibrillation, hypertension, hypercholesterol, Type 2 Diabetes Mellitus, chronic pain. Further review of Resident #3's current FL2 dated 08/18/15 revealed medication orders for: -Gabapentin (used to prevent and control seizures) 800mg one tablet three times a day. -Duloxetine (used to treat depression, anxiety disorder, and pain) 60mg one tablet a day. -Clonazepam (used to treat seizures and panic disorder) 1mg every morning and ½ tablet at 2:00 PM. -Methadone HCL (used to treat pain) 10mg, 2 tablets three times a day, as needed. -Metformin (used to treat type 2 diabetes) 1000mg twice a day with meals. -Carvedilol (used to treat high blood pressure and heart failure) 6.25mg 1 tablet twice a day. -Atorvastatin (used to treat high cholesterol) 40mg every day at bedtime.	C 315		

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C 315	Continued From page 9 -Testosterone (used to treat hormonal imbalances) 200mg/1cc, 1cc every ten days. -Vitamin C (used in the maintenance of bones, muscle, and blood vessels) 500mg every morning. -Zestril (used to treat high hypertension) 10mg every day. -Lisinopril (used to treat high hypertension) 20mg every morning. Review of Resident #3's record revealed no evidence the physician was contacted upon admission for verification of medication orders listed on the FL2 dated 08/18/15. Further review of Resident #3's record revealed the next physician's orders was a list of medications signed by the physician and dated 10/09/15. Discrepancies between the FL2 dated 08/18/15 and medication orders dated 10/09/15 included: -Gabapentin 800mg three times a day versus four times a day. -Clonazepam 1mg every morning and ½ tablet at 2:00 PM versus twice a day and ½ tablet at 12:00 PM. -Methadone HCL 10mg, 2 tablets three times a day, as needed versus three times a day. -Testosterone 200mg/1cc, 1cc every ten days versus every two weeks. Further review of Resident #3's record revealed vitamin C 500mg every morning and Zestril 10mg every day were written only on the FL2 dated 08/18/15. Further review of Resident #3's record revealed medications listed only on the orders dated 10/09/15 included: -Bydureon (used to treat type 2 diabetes) inject	C 315		

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2mg subcutaneously (SC) once weekly.
-Fluticasone nasal spray (used to treat nasal congestion), two sprays each nostril, as needed.
-Aspirin (used to prevent a heart attack or a stroke) 81mg every day.
-Quetiapine (used to treat bipolar disorder) 100mg daily.
-Cyclobenzaprine (used as a muscle relaxant) 10mg three times a day, as needed.

Further review of Resident #3's record revealed a piece of paper with a hand-written count of medications. There were no signatures or a date on the piece of paper. The medications listed included:
-Carvedilol, 2 days, 4 tabs.
-Cymbalta, duloxetine HCL 60mg, 18 days (pill).
-Lisinopril 20mg 41 tabs.
-Metformin 18 tabs, 9 days worth.
-Lipitor 61 (61 days).
-Gabapentin 92 tabs, 23 days worth.
-Morphine 53 (6 days).
-Clonazepam 56 (22 days).

Interview on 10/15/15 at 11:05 AM with the administrator revealed:
-Resident #3 was dropped off at facility by his guardian late evening on 09/30/15.
-The guardian brought Resident #3's medications in a seven day pill planner and gave them to Administrator along with 08/18/15 FL2.
-She administered Resident #3's medications from the pill planner until it was empty.
-On 10/05/15 Resident #3's local behavioral health provider representative delivered supply of Resident #3's medications that were held at the local behavioral health provider's office.
-On 10/05/15 local behavioral health provider representative wrote on a piece of paper the medications being delivered to the facility,

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C 315	Continued From page 11 including the number of medications. -Two supervisors in charge from neighboring facilities supervised the medication count with provider representative. No one signed or dated the paper. Observation on 10/15/15 of a seven day pill planner provided by the administrator. The pill planner had no information identifying the planner belonged to Resident #3, had no information identifying medication(s) or doses. The pill planner was empty. Interview on 10/16/15 at 12:10 PM with Resident #3 revealed: -"My (behavioral health) provider filled my pill box when I was at home before I came here." -"I brought the pill box with me when I came here." -"(Administrator's name) had been giving me my pills from my pill box". Telephone interview on 10/16/15 at 10:15 AM with Resident #3's behavioral health provider revealed: -The behavioral health provider's nurse kept his medications in their office while Resident #3 was in private living. -She had brought Resident #3's medications from their office to the facility on 10/05/15. -The medications were in bottles, she counted the medications and wrote the count on a piece paper while at the facility. -Resident #3 already had possession of his controlled medications, "I had nothing to do with controls". -Resident #3 had a lock box with control medications from his house. -The administrator's family member "over-saw my counts".	C 315		

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C 315	Continued From page 12 -"Our nurse watched him set up his medications at home." Telephone interview on 10/16/15 at 11:15 AM with Resident #3's guardian revealed: -She had had brought him to facility "later in the day" on 09/30/15. -She had brought all the medicine from his apartment and refrigerator. -She had brought Resident #3's pill planner and medicine bottles to the facility with Resident #3. -"I don't know about his medicines, I would have to ask our nurse that fills his pill planner." Interview with Supervisor in Charge A from a neighboring facility on 10/16/15 at 11:10AM revealed: -"I oversaw some of the med count with the girl that brought him (Resident #3) here late that night on 09/30/15, some counted with her and some she got ahead of me on." -"The administrator gave Resident #3 the pills from that pill box." -"I told (Administrator's name) that she couldn't do that." -"(Supervisor in Charge B's name) helped count the pills when she brought them." Interview with Supervisor in Charge B from a neighboring facility on 10/16/15 at 1:40 PM revealed she helped oversee counting the medications in October when the (behavioral health representative) brought the rest of Resident #3's medications to the facility. Resident #3 "came here last couple days of September." Further interview on 10/16/15 at 10:45 AM with the administrator revealed: -She had not contacted Resident #3's primary care provider within 24 hours following his	C 315		

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C 315	Continued From page 13 admission to the facility. -"I don't know who his doctor is." -"All I had is what I got before he came." -"Medications came from (behavioral health) provider on 10/05/15." Further interview on 10/20/15 at 9:30 AM with the administrator revealed she was "making a list of questions" for the doctor and will get (a staff member) to take it up to the doctor for clarification. A Plan of Protection was submitted by the facility on 10/16/15 that included: -The administrator will assure all medications are in the facility as ordered by all licensed practitioners. -The administrator will call and obtain clarification if orders are not clear. -The administrator will consult with the pharmacy as needed to clarify orders. -A supervisor in charge from a neighboring facility will review all new orders and make sure new orders have been sent to the pharmacy. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2015.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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	C 330		

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C 330	Continued From page 14 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview, observation and record review, the facility failed to assure medications were administered as ordered by a prescribing practitioner to 2 of 3 sampled residents with orders for duloxetine, quetiapine, cyclobenzaprine, Bydureon (Resident #3) and glimepiride 3mg (Resident #2). The findings are: A. Review of Resident #3's record revealed admission date of 09/30/15. Review of Resident #3's current FL2 dated 08/18/15 revealed: -Diagnoses included depressive disorder nonspecific, post-traumatic stress disorder, atrial fibrillation, hypertension, hyper cholesterol, Type 2 Diabetes Mellitus, chronic pain. -An order for duloxetine (used to treat major depressive disorder) 60mg daily at bedtime. -No orders for quetiapine, cyclobenzaprine or Bydureon. Further review of Resident #3's record revealed a physician signed medication list dated 10/09/15 that included: -Quetiapine (used to treat bipolar disorder) 100mg daily. -Cyclobenzaprine (used as a muscle relaxant) 10mg three times a day, as needed. -Duloxetine 60mg daily at bedtime. -Bydureon (used to treat type 2 diabetes) inject 2mg subcutaneous once weekly.	C 330		

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C 330	Continued From page 15 Review of medications on hand for Resident #3 on 10/15/15 revealed: -One bubble pack of duloxetine 60mg tablet. -One bubble pack of duloxetine 30mg tablet. -No quetiapine, or cyclobenzaprine in the facility. -Bydureon 2mg Pen Inject filled on 10/12/15 by facility pharmacy and ordered to inject 2mg subcutaneously once weekly. Further review of Resident #3's record revealed no physician's order for duloxetine 30mg. Interview on 10/15/15 at 11:45 AM with Resident #3 revealed "I went to the emergency room (ER) in the ambulance on Tuesday (10/12/15) because I was out of my (Bydureon) injection". Further interview on 10/16/15 at 12:10 PM with Resident #3 revealed: -"My (behavioral health) provider filled my pill box when was at home before I came here." -"I brought the pill box with me when I came here." -The administrator "has been giving me my pills from my pill box". -"I had one shot left (Bydureon) and took it on the 4th, should have had another on the 11th, didn't get it until I went to hospital on 10/12/15." Further review of Resident #3's record revealed: -No documentation the physician was contacted to clarify the 10/09/15 orders. -No documentation the pharmacy was contacted to clarify the 10/09/15 orders. Review of October 2015 medication administration record (MAR) revealed: -A hand-written entry for duloxetine 60 mg 1 cap daily at 8:00 AM.	C 330		

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C 330	Continued From page 16 -Duloxetine 60mg was documented as administered at 8:00 AM daily from 10/01/15 - 10/15/15. -No entry or documentation for duloxetine 30mg daily. -No entry or documentation of quetiapine 100mg daily. -No entry or documentation for cyclobenzaprine 10mg three times a day, as needed. Telephone interview on 10/15/15 at 1:25 PM with the facility's pharmacy revealed: -Pharmacy did not have an order for quetiapine 100mg daily. -Pharmacy did not have an order for cyclobenzaprine 10mg three times a day, as needed. -Bydureon 2mg Pen Inject was filled on 10/12/15. Telephone interview on 10/16/15 at 10:15 AM with Resident #3's behavioral health provider revealed: -Resident #3's medications were brought from our office where our nurse kept them while Resident #3 was in private living. -She counted the medications in the bottles and wrote count on piece paper at the facility. -The administrators family member over-saw my counts. -Our nurse watched Resident #3 set up his meds at home. Telephone interview on 10/16/15 at 11:15 AM with Resident #3's guardian revealed: -Guardian brought the resident to the facility on 09/30/15 later in the day. -The medications found in his apartment and in the refrigerator were brought to the facility. -She put all Resident #3's medicine bottles in a bag and brought them to facility with him.	C 330		

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C 330	Continued From page 17 -She brought Resident #3's pill planner with him when she brought him to the facility. -She did not know about Resident #3's medications, she would have to ask the health provider's nurse that filled Resident #3's pill planner. Telephone interview on 10/16/15 at 6:06 PM with Resident #3's primary care physician (PCP) revealed: -If (Resident #3) didn't have the Bydureon, that would a problem. -Lack of medications (quetiapine and cyclobenzaprine) are not related to signs and symptoms of the (10/12/15) emergency room visit. Interview on 10/15/15 and 10/16/15 with the administrator revealed: -Resident #3 self-administers Bydureon pen injection, testosterone injection. -"I will have to get a self-administer order from his doctor." -"I don't know who his doctor is." -"I don't have those (medications) on there." (Referring to order dated 10/09/15, for quetiapine and cyclobenzaprine). -"He got that (Bydureon) when he went to the hospital on 10/12/15." -"I gave him his meds from that pill box." (Administrator showed surveyors the pill box). -"All I had is what I got before he came." -"Meds came from (behavioral health) provider on 10/01/15." Further interview on 10/20/15 at 9:30 AM with the administrator revealed she was "making a list of questions for the doctor and will get (a family member) to take it up to the doctor to ask".	C 330		

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C 330	Continued From page 18 B. Review of Resident #2's current FL2 dated 06/11/15 revealed diagnoses included hypertension, gastroesophageal reflux disease (GERD), peptic ulcer disease (PUD), osteoarthritis (OA), hyperlipidemia and edema. Review of Resident #2's record revealed admission date of 03/16/2000. Further review of Resident #2's record revealed: -A 05/27/15 order for glimepiride (glimepiride is used to treat Type 2 diabetes) 1mg, 1/2 tablet twice a day (BID) before breakfast and supper. -A 07/15/15 order to change glimepiride to 1mg twice a day before breakfast and supper. -A 08/13/15 order to change glimepiride to 2mg at breakfast. -A 09/28/15 order to change glimepiride 2mg to 3mg at breakfast. Review of September 2015 medication administration record (MAR) revealed: -Computer printed entry, dated 08/13/15 for glimepiride 2mg tablet, take one tablet by mouth in, a sticker was placed over the remainder of the entry, directions changed refer to chart. -A hand-written diagonal line was drawn across the 08/13/15 computer printed entry and a line drawn horizontally across the page. -A hand-written entry dated 09/25/15 for glimepiride 3mg, 1 ½ pill, breakfast. -It was documented as administered at 7:00 AM daily from 09/26-30/15. Review of October 2015 medication administration record (MAR) revealed: -Computer printed entry, dated 08/13/15 for glimepiride 2mg tablet, take one tablet by mouth in the morning before breakfast, to be administered at 8:00 AM.	C 330		

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C 330	Continued From page 19 -A hand-written 'X' was drawn across the entry and a line drawn horizontally across the page. -A hand-written entry dated 09/25/15 for glimepiride 2mg, 2 ½ pills, 1mg, ½ pill, breakfast. -It was documented as administered at 7:00 AM daily from 10/01/15 - 10/16/15. Further review of Resident #2's record revealed: -No documentation the physician was contacted to clarify the 09/28/15 glimepiride order. -No documentation the pharmacy was contacted to clarify the 09/28/15 glimepiride order. Review of medications on hand on 10/16/15 revealed: -One bubble pack of glimepiride 2mg to be administered before breakfast. -One bubble pack of glimepiride 1mg ½ tablet (0.5mg) to be administered at supper. Review on 10/16/15 of Resident #2's July 2015 blood sugar monitoring forms revealed: -A range from 95-256 documented at 7:00 AM. -A range from 90-200 documented at 12:00 PM. -A range from 92-260 documented at 4:00 PM. -A range from 91-260 documented at 9:30 PM. Review on 10/16/15 of Resident #2's August 2015 blood sugar monitoring forms revealed: -A range from 80-174 documented at 7:00 AM. -A range from 80-240 documented at 12:00 PM. -A range from 102-167 documented at 5:00 PM. -A range from 93-208 with no time documented on the form. Review on 10/16/15 of Resident #2's September 2015 blood sugar monitoring forms revealed: -Blood sugar levels were documented for 09/25-30/15, all other dates and times were left blank.	C 330		

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C 330	Continued From page 20 -A range from 108-158 documented at 7:00 AM. -A range from 98-158 documented at 12:00 PM. -A range from 114-167 documented at 4:00 PM. -A range from 114-208 documented at 10:00 PM. Interview on 10/20/15 at 3:45 PM with Resident #2 revealed: -He is legally blind. -He was not aware of the 09/28/15 order to increase glimepiride from 2mg to 3mg. -He had no complaints of how staff administered his medication. -He had been "feeling fine, feeling about the same". -Staff were good to get him to the doctor when he didn't feel well. Interview on 10/16/15 at 12:15 PM with the Administrator revealed: -She had been administering Resident #2 one pill from each bubble pack at breakfast. -She was not aware she had been administering Resident #2 glimepiride 2.5mg, not 3mg as ordered on 09/28/15. -When new orders are brought back to the facility staff are to fax the orders to the pharmacy. -She reported the pharmacy did not have the 09/28/15 order. -The 09/28/15 order was immediately faxed to the pharmacy. -The reason the September 2015 blood sugar monitoring form had no documentation from 09/01-24/15 was because Resident #2 was out of the facility in the month of September, yet she could not recall the exact dates. Observation on 10/20/15 at 9:00 AM revealed the facility had glimepiride 3mg on-hand for Resident #2.	C 330		

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C 330	Continued From page 21 Interview with Resident #2's primary care physician was unsuccessful by time of exit. A Plan of Protection was submitted by the facility on 10/27/15 that included: -The administrator will assure all medications are in the facility as ordered by all licensed practitioners. -The administrator will assure all medications are administered as ordered by all licensed practitioners. -The administrator will call and obtain clarification if orders are not clear. -The administrator will consult with the pharmacy as needed to clarify orders. -A supervisor in charge from a neighboring facility will review all new orders and make sure new orders have been sent to the pharmacy. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2015.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed	C 335		

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C 335	Continued From page 22 container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed to assure medications prepared in advance for 1 of 3 sampled residents (Resident #3) were identified up to the point of administration and protected from contamination and spillage. The findings are: Observation on 10/15/15 at 10:00 AM revealed: -Resident #3 came to the kitchen door. -Administrator handed Resident #3 a small paper cup. Interview on 10/15/15 at 10:00 AM with Resident #3 revealed he was a late sleeper and his	C 335		

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C 335	Continued From page 23 morning medications were in the small paper cup. Observation on 10/15/15 at 10:02 AM revealed the small paper cup did not have the resident's name, had no identifying information on it, no name or strength of each medication. Interview on 10/15/15 at 10:30 AM with the administrator revealed: -Resident #3 was a late sleeper and she would put Resident #3's morning medications in a small paper cup during the morning medication pass. -The paper cup with Resident #3's medications were placed a cabinet in the kitchen. Further interview on 10/15/15 at 11:10 AM with Resident #3 revealed: -Since his admission to the facility, his morning medication were given to him in the small paper cup by the administrator. -He knew what his medication were and how many pills he was supposed to have. Observation on 10/15/15 at 11:20 AM of the kitchen cabinet revealed the cabinet used to stage the pre-pour medications had two doors, was used to keep first aid supplies and did not have locks. Review of Resident #3's October 2015 medication administration record (MAR) revealed his morning medications were as follows: -Betapace 120mg. -Aspirin 81mg. -Glipizide 5mg. -Metformin 1000mg. -Cymbalta 60mg. -Lipitor 40mg. -Gabapentin 800mg. -Clonazepam 1mg.	C 335		

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C 335	Continued From page 24 -Lisinopril 20mg. -Coreg 625mg. -Methadone 20mg. Further interview on 10/15/15 at 11:30 AM with the administrator revealed: -She was not aware of the specific rule requirements for pre-pouring medications. -She would no longer pre-pour Resident #3's medications.	C 335		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interview, observation and record	C 342		

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C 342	Continued From page 25 review, the facility failed to assure medication records were accurate and complete for 2 of 3 sampled residents (Residents #2 and #3). The findings are: A. Review of Resident #3's current FL2 dated 08/18/15 revealed: -Diagnoses included depressive disorder nonspecific, post-traumatic stress disorder, atrial fibrillation, hypertension, hyper cholesterol, Type 2 Diabetes Mellitus, chronic pain. -An order for testosterone (used to treat hormonal imbalances) 200/1ml injection 1 ml every two weeks. -An order for duloxetine (used to treat major depressive disorder) 60mg daily at bedtime. Review of Resident #3's record revealed admission date of 09/30/15. Further review of Resident #3's record revealed a physician signed medication list dated 10/09/15 that included: -Quetiapine (used to treat bipolar disorder) 100mg daily. -Cyclobenzaprine (used as a muscle relaxant) 10mg TID PRN. -Testosterone 200/1ml injection 1 ml every two weeks. -Duloxetine 60mg daily at bedtime. -Bydureon (used to treat type 2 diabetes) inject 2mg SC once weekly. -Carvedilol (used to treat hypertension) 6.25mg twice a day. -Metformin (used to treat diabetes) 1000mg twice a day. -Methadone (used as a pain reliever) 10mg 2 tablets three times day. -Atorvastatin (used to treat high cholesterol) 40	C 342		

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C 342	Continued From page 26	C 342		

mg daily.
-Lisinopril (used to treat high blood pressure) 20mg daily.
-Gabapentin (used to treat seizures) 800 mg four times daily.
-Clonazepam (used to treat anxiety) 1mg twice a day and ½ tab at noon.
-Fluticasone (used to treat nasal symptoms) nasal spray 2 sprays each nostril as needed.
-Aspirin (used to treat or prevent heart attacks) 81 mg daily.

Review on 10/15/15 at 10:00 AM of October 2015 medication administration record (MAR) revealed:
-A hand-written entry for duloxetine 60 mg 1 cap daily at 8:00 AM.
-A hand-written entry for Bydureon inject 2mg subcutaneous once weekly.
-A hand-written entry carvedilol 6.25mg twice a day.
-Two hand-written entries for metformin 1000mg twice a day.
-A hand-written entry for methadone 10mg 2 tablets three time's day.
-A hand-written entry for atorvastatin 40 mg daily.
-A hand-written entry for lisinopril 20mg daily.
-A hand-written entry for gabapentin 800 mg 4 times daily.
-A hand-written entry for clonazepam 1mg twice a day and ½ tab at noon.
-No entry for fluticasone nasal spray 2 sprays each nostril as needed.
-No entry for aspirin 81 mg daily.
-No entry for quetiapine 100mg daily.
-No entry for cyclobenzaprine 10mg three times a day, as needed.
-No entry for testosterone 200/1ml injection 1 ml every two weeks.

Further review on 10/15/15 at 10:00 AM of the

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C 342	Continued From page 27 October 2015 MAR revealed all routine medications listed were documented as administered through the night time dosing time of 10/14/15. Refer to interview with the administrator on 10/16/15 at 12:15 PM. B. Review of Resident #2's current FL2 dated 06/11/15 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease (GERD), peptic ulcer disease (PUD), osteoarthritis (OA), hyperlipidemia and edema. -An order for glimepiride 1mg, 1/2 tablet twice a day (glimepiride is used to treat Type 2 diabetes). Review of Resident #2's record revealed admission date of 03/16/2000. Further review of Resident #2's record revealed: -A 07/15/15 order to change glimepiride to 1mg twice a day before breakfast and supper. -A 08/13/15 order to change glimepiride to 2mg at breakfast. -A 09/28/15 order to change glimepiride 2mg to 3mg at breakfast. Review of September 2015 medication administration record (MAR) revealed: -Computer printed entry, dated 08/13/15 for glimepiride 2mg tablet, take one tablet by mouth in, a sticker was placed over the remainder of the entry, directions changed refer to chart. -A hand-written diagonal line was drawn across the entry and a line drawn horizontally across the page. -A hand-written entry dated 09/25/15 for glimepiride 3mg, 1 ½ pill, breakfast. -Glimepiride was documented as administered at	C 342		

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C 342	Continued From page 28 7:00 AM daily from 09/26/15 - 09/30/15. Review of October 2015 medication administration record (MAR) revealed: -Computer printed entry, dated 08/13/15 for glimepiride 2mg tablet, take one tablet by mouth in the morning before breakfast, to be administered at 8:00 AM was crossed-out with a 'X' and a line was drawn horizontally across the page. -A hand-written entry dated 09/25/15 for glimepiride 2mg, 2 ½ pills, 1mg, ½ pill, breakfast. -Glimepiride was documented as administered at 7:00 AM daily from 10/01/15 - 10/16/15. Refer to interview with the administrator on 10/16/15 at 12:15 PM. Interview on 10/16/15 at 12:15 PM with the Administrator revealed: -She had no explanation for the MAR discrepancies and inaccuracies. -"I guess I was just not paying attention."	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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 B VIOLATION Based on interview, observation and record	C 367		

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C 367	Continued From page 29 review, the facility failed to assure controlled substances records were accurate and complete for 1 of 3 sampled residents (Resident #3) with an order for clonazepam and methadone. The findings are: Review of Resident #3's record revealed admission date of 09/30/15. Review of Resident #3's current FL2 dated 08/18/15 revealed diagnoses included depressive disorder nonspecific, post-traumatic stress disorder, atrial fibrillation, hypertension, hyper cholesterol, Type 2 Diabetes Mellitus, chronic pain. A. Review of Resident #3's current FL2 dated 08/18/15 revealed an order for methadone (used as a pain reliever) 10mg 2 tablets twice a day as needed for pain. Review of Resident #3's record revealed: -A physician signed medication list dated 10/09/15 that included methadone 10mg, two tablets three times day. -A hand-written count of medications on solid white piece of paper. No date or signature on hand written piece of paper. Morphine 53 (6 days). No Methadone listed. Further review on 10/15/15 of Resident #3's record revealed: -A control sheet for methadone started with a count of 56 on 10/01/15 continued accurate with alike signature until date 10/13/15 at 27 count. -Control sheet #1 dated 10/13/15 AM started with a count of 26 ½, 1 tablet was documented as administered and 25 was documented as remaining.	C 367		

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C 367	Continued From page 30 -10/13/15 12:00 PM started at 25, ½ tab documented as administered, 26 remained. -10/13/15 4:00 PM started at 26, 1 tablet documented as administered, 24 remained. -10/14/15 8:00 AM started at 25, 1 tablet documented as administered, 23 remained. -10/14/15 12:00 PM started at 24, ½ tablet documented as administered, 22 remained. -10/14/15 4:00 PM started at 23, 1 tablet documented as administered, 21 remained. -10/15/15 8:00 AM started at 22, 1 tablet documented as administered, 20 remained. -Control sheet revealed that the count at 26, 25, 24, 23, 22 are all marked through and in the columns to the left of these marked is written 24, 23, 22, 21, 20. -10/15/15 12:00 PM started at 21, ½ tablet documented as administered, remaining count was left blank. Interview with Administrator on 10/15/15 at 4:40 PM revealed: -Supervisor in Charge B from a neighboring facility "did the control count when the girl (behavioral health representative) brought them and started the control sheet." -"I threw away the first bottle I had of control meds (methadone) because it was empty." -"There is no medicine Morphine, guess it should be methadone that the girl (behavioral health representative) counted." Review on 10/15/15 at 4:40 PM with the administrator of Resident #3's active medications on hand revealed methadone, 180 tablets dispensed on 10/14/15, 174 tablets remained. Review on 10/16/15 at 10:30 AM of methadone control sheet revealed a new control sheet had been generated indicating 170 tablets remained.	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011022	A. BUILDING: _____ B. WING _____	10/20/2015

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C 367	Continued From page 31 Review on 10/16/15 at 10:30 AM with the administrator of Resident #3's methadone tablets revealed 169 tables were on-hand. Review on 10/15/15 of Resident #3's October 2015 medication administration record (MAR) revealed the methadone 10mg, 2 tablets were documented as administered at 4:00 PM on 10/14/15, 8:00 AM and 12:00 PM on 10/15/15. Review on 10/16/15 of Resident #3's October 2015 MAR revealed methadone 10mg, 2 tablets were documented as administered at 4:00 PM on 10/15/15 and 8:00 AM on 10/16/15. Interview with Supervisor in Charge B on 10/16/15 at 1:40 PM revealed: -"I helped oversee counting the meds in October when person (behavioral health representative) brought rest of pills, Resident #3 came here last couple days of September." -"I did control sheet for methadone and redone it to get it right." -"I didn't keep the other control sheets, I ripped them up and threw them away and the trash has already gone." Refer to interview on 10/16/15 at 10:45 AM with the administrator. B. Further review of Resident #3's current FL2 dated 08/18/15 revealed an order for clonazepam (used to treat anxiety) 1mg daily in the morning and ½ tab at 2:00 PM. Further review of Resident #3's record revealed: -A physician signed medication list dated 10/09/15 that included clonazepam 1mg twice a day and ½ tab at noon.	C 367		

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C 367	Continued From page 32 -A hand-written count of medications on solid white piece of paper. No date or signature on hand written piece of paper. Clonazepam 56 (22 days). Review on 10/15/15 at 4:40 PM with the administrator of Resident #3's medications on hand revealed clonazepam, dispensed by pharmacy prior to admission to this facility, the count from bottle was 26, count should be 21 and control sheet showed 20. Review of October 2015 MAR revealed: -A hand-written entry for clonazepam 1 mg, 1 pill two times a day. -Documented as administered at 8:00 AM and 4:00 PM from 10/01-14/15. Interview with Administrator on 10/15/15 at 11:05 AM revealed: -Supervisor in Charge A from a neighboring facility "did the control count when that girl brought them and started the (control) sheet for me." -"I messed that (control sheet) up." -"It was hard for me to follow with the ½ tablet with the whole tablet." Interview with Supervisor in Charge A on 10/16/15 at 1:35PM revealed: -"I did the control sheet for clonazepam." -"We re-did the control sheet over and over to make it right." -"Everybody needs to help (administrator) more." -"I didn't keep the other control sheets, I threw them away." -"It's my fault that that control sheet is off, I wasn't counting giving them by 2, I was just subtracting one each time." -"The Administrator gave the medications to	C 367		

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C 367	Continued From page 33 Resident #3." Interview with Supervisor in Charge B on 10/16/15 at 1:40 PM revealed: -"I helped oversee counting the meds in October when person (behavioral health representative) brought rest of pills, Resident #3 came here last couple days of September." Refer to interview on 10/16/15 at 10:45 AM with the administrator. _____ Interview on 10/16/15 at 10:45 AM with the administrator revealed: -She had no explanation for the clonazepam or methadone count discrepancies. -She had no explanation for the discrepancies on the control sheets. -"I just was not paying close attention and I need to do better." _____ A Plan of Protection was submitted by the facility on 10/16/15 that included: -A new control sheet was made on 10/16/15. -The administrator will pay closer attention to accurately completing the controlled sheets. -Every Friday the administrator will have a supervisor in charge from another facility count the controlled medications and check the records for accuracy. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2015.	C 367		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	C 912		

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C 912	Continued From page 34 2. To receive care and services which are adequate, appropriate, and in compliance with 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 that every resident received care and services which are adequate, appropriate and in compliance with relevant federal and State laws and rules and regulations as related to management, housekeeping, therapeutic diets, medications and controlled substances. The findings are: A. Based on interview, observations and record review, the facility failed to assure a clean and orderly environment that was free of all obstructions and hazards as evident of dogs being in the kitchen and animal feces found in the living room and common bathroom. [Refer to Tag 0078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings (Type B Violation)]. B. Based on interview, observations and record review, the facility administrator failed to assure the rules and regulations were met and maintained related to management, housekeeping, therapeutic diets, medications and controlled substances. [Refer to Tag 0185, 10A NCAC 13G .0601(a) Management and Other Staff (Type B Violation)]. C. Based on interview, observations and record review, the facility failed to assure verification of a resident's medications within 24 hours of admission to the facility for 1 of 3 sampled	C 912		

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C 912	Continued From page 35 residents (Resident #3). [Refer to Tag 0315 10A NCAC 13G .1002(a) Medication Orders (Type B Violation)]. D. Based on interview, observation and record review, the facility failed to assure controlled substances records were accurate and complete for 1 of 3 sampled residents (Resident #3) with an order for clonazepam and methadone. [Refer to Tag 0367 10A NCAC 13G .1008(a) Controlled Substances (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's 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 interview, observation and record review, the facility failed to assure residents were free from neglect related to medication verification. The findings are: Based on interview, observation and record review, the facility failed to assure medications were administered as ordered by a prescribing practitioner to 2 of 3 sampled residents with orders for duloxetine, quetiapine, cyclobenzaprine, Bydureon (Resident #3) and glimepiride 3mg (Resident #2). [Refer to Tag 0330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 914		