STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011133	A. BUILDING: _____ B. WING _____	R-C 12/16/2015

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 the Buncombe County Department of Social Services conducted a follow-up survey and complaint investigation on December 4, 7 - 8, 10 - 11 and 16, 2015.	{D 000}		
D 176	10A NCAC 13F .0601 (a) 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 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 related to resident rights (exploitation and privacy), medication aide training, medication administration, controlled substances, pharmaceutical care, transferring medications to another container and controlled substance medication storage. The findings are:	D 176		

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D 176	Continued From page 1 Interview with the Owner/Administrator on 12/11/15 at 4:30pm revealed: -The Director and Resident Care Coordinator were responsible for medications. -The Personnel Manager was responsible for all personnel records. -He came to the facility 2 days a week, whichever 2 days he thought were needed to work on new tactics, meetings and repairs. -He was ultimately responsible for the overall operation of the facility. Based on observation, interviews and record reviews, non-compliance was identified in the following areas: A. Based on 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 1 of 5 sampled residents (Resident #4) with orders for controlled substances which included Oxycodone, resulting in 1,203 tablets of the controlled substance being unaccounted for [Refer to Tag 914, G.S. 131D-21(4), Resident Rights (Type A2 Violation)]. B. Based on observation, interview, and record review, the facility failed to assure privacy was maintained in the female common bathroom during showers [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights]. C. Based on record review and interviews the facility failed to assure 1 of 1 re-hired staff (Staff C) completed the required training before being allowed to work as a Medication Aide (MA) [Refer to Tag 935, G.S. 131D-4.5B(b) Medication Aides; Training and Competency].	D 176		

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D 176	Continued From page 2 D. Based on observation, interviews and record reviews, the facility failed to assure prescribed medications (Oxycodone, Fentanyl patch and Metformin) were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (#4 and #5). [Refer to Tag 358, 10A NCAC 13F .1004(a), Medication Administration (Type A2 Violation)]. E. Based on 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 1 of 5 sampled residents (Resident #4) with orders for controlled substances which included Oxycodone, resulting in 1,203 tablets of the controlled substance being unaccounted for. [Refer to Tag 392, 10A NCAC 13F .1008(a), Controlled Substances (Type A2 Violation)]. F. Based on observation, 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, accountability of controlled substances including disposition, receipt and administration of controlled substances, transferring medications to another container and medication storage for 1 of 5 sampled residents (Resident #4). [Refer to Tag 401, 10A NCAC .1009(a)(2-6), Pharmaceutical Care]. G. Based on observation, interview and record review, the facility failed to assure two controlled substance medications (Oxycodone and Fentanyl patches) were not transferred from one container to another for 1 of 1 residents (Resident #4) [Refer to Tag 356, 10A NCAC 13F .1003(e),	D 176		

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D 176	Continued From page 3 Medication Labels (Type B Violation)]. H. Based on observation, interview, and record review, the facility failed to assure a controlled substance medication was maintained in a safe manner, under locked security. [Refer to Tag 393, 10A NCAC 13F .1008(b) Controlled Substance (Type B Violation)]. A Plan of Protection provided by the facility included: -Management will increase training of all staff members through in services and staff trainings. -Management to develop quality assurance program to include other staff members to find and correct any issues dealing with medications. -In-services to be completed by 12/29/15. -Staff meeting to be held 12/16/15. CORRECTION DATE FOR THE TYPE A2 VIOLATIONS SHALL NOT EXCEED JANUARY 15, 2016. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 30, 2016.	D 176		
{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 and interview, the facility failed to assure privacy was maintained in the female common bathroom during showers.	{D 338}		

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{D 338}	Continued From page 4 The findings are: Confidential interviews with 3 female residents during the survey revealed: -There was no shower curtain in the common shower room at the shower. -The common shower room door would not lock. -They often use the men's common shower room because the men's shower room could be locked. Observation of the common female shower room on 12/4/15 at 10:00am revealed: -A shower with no shower curtain. -A tub with a shower curtain folded over the shower curtain rod. -A door handle with no lock. -A toilet to the left of the door with no privacy curtain. -No designations in use that showers were occupied/not occupied. Random observation of the female shower room door during the survey dates revealed the shower door was always closed and there were no signs indicating if it was occupied or not occupied. Interview with the Director and the Personnel Manager on 12/4/15 at 4:15pm revealed: -The local fire marshal would not allow a lock on the common shower room door. -There was a shower curtain in the bathroom, near the tub. Interview with the local fire marshal on 12/11/15 at 3:10pm revealed: -A lock was allowed on the shower room door as long as it was a single action release lever-type door handle. -Staff must have a way to unlock from the door	{D 338}		

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{D 338}	Continued From page 5 from the outside. Follow on observation of the common female shower room on 12/11/15 at 4pm revealed: -No shower curtain at the shower in the common female shower room. -No privacy curtain at the toilet. -A door handle with no lock.	{D 338}		
D 356	10A NCAC 13F .1003 (e) Medication Labels 10A NCAC 13F .1003 Medication Labels (e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for administration to a resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure two controlled substance medications (Oxycodone and Fentanyl patches) were not transferred from one container to another for 1 of 1 residents (Resident #4). The findings are: A. Review of current FL2, dated 9/22/15, for Resident #4 revealed: -A history of lung and rectal cancer. -A medication order for Oxycodone 15mg, 2 tablets every four hours as needed for pain. Observation of Resident #4's bottle of Oxycodone	D 356		

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D 356	Continued From page 6 on 12/8/15 at 4pm revealed: -A computer-generated pharmacy label with 336 tablets dispensed on 11/27/15. -There were 52 tablets in the bottle. Review of handwritten controlled substance sheet for December 2015 revealed: -A handwritten entry for Oxycodone 15mg; 2 tablets every 4 hours as needed for pain. -Quantity dispensed was documented as 10. Interview with the Director on 12/8/15 at 4:35pm revealed: -There was a discrepancy between the bottle and the control sheet because the Director, Resident Care Supervisor and an assistance put "varying amounts" of Oxycodone in a separate bottle and kept the majority of the tablets locked in the medication room. -She stated she knew she was not supposed to transfer the medication into a different bottle. -This was done to try to prevent theft of the tablets. Observation of a second bottle of Oxycodone for Resident #4 on 12/8/15 at 4:40pm revealed: -A computer-generated pharmacy label with 336 tablets dispensed on 10/25/15. -There were 10 tablets in the bottle. B. Review of current FL-2, dated 9/22/15, for Resident #4 revealed: -A history of lung and rectal cancer. -A medication order for Fentanyl 100mcg every 3 days to be used with 50mcg patch. (Fentanyl is used to manage moderate to severe pain, usually in people who have chronic pain, breakthrough pain and in cancer pain.) -A medication order for Fentanyl 50mcg every 3 days to be used with 100mcg patch.	D 356		

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D 356	Continued From page 7 An interview with Resident #4 on 12/8/15 at 4pm revealed: -His Fentanyl pain patch had not been changed in "5 or 6 days." -When asked, he was unsure if this had happened before. Observation of Resident #4's Fentanyl pain patch on 12/8/15 at 4pm revealed: -One pain patch was located on his upper back near his right shoulder. -No other pain patches were observed on the resident. -A handwritten date on the one patch of 12/3/15. Observation of Resident #4's box of Fentanyl patches on 12/8/15 at 4:30pm revealed: -A computer printed label from the resident's pharmacy containing the resident's name, prescription number, number of patches dispensed (5), Fentanyl 50mcg per patch, and an order to apply with 100mcg patch every 3 days. -The prescription label was affixed to the box of Fentanyl patches as packaged by the manufacturer. -A computer printed label from the resident's pharmacy containing the resident's name, prescription number, number of patches dispensed (5), Fentanyl 100mcg per patch, and an order to apply with 50mcg patch every 3 days. -The prescription label was affixed to the box of Fentanyl patches as packaged by the manufacturer. Review of the December 2015 hand written Medication Administration Record (MAR) revealed: -An entry for Fentanyl patch 100mcg apply every 3 days with 50mcg.	D 356		

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D 356	Continued From page 8 -An entry for Fentanyl 50mcg apply every 72 hours with 100mcg patch. -Both were documented as being applied on 12/3/15, 12/6/15 and 12/9/15, as ordered. Review of the December 2015 controlled substance sheet revealed both Fentanyl patches were documented as being applied on 12/3/15, 12/6/15 and 12/9/15. Interview with the Director on 12/8/15 at 4:45pm revealed she did not know why the Fentanyl patches had not been administered as ordered. Interview with the Director on 12/10/15 at 10:35am revealed: -An envelope was just found today in the Personnel Manager's mailbox. -The envelope contained the Fentanyl patches (1 each of 50mcg and 100mcg doses) that was supposed to be administered on 12/6/15. -The envelope was put into an employee mailbox for the weekend staff by the administrative staff. -Staff always placed the patches in an envelope so the full supply was not accessible to the staff. Observation of the envelope on 12/10/15 at 10:40am revealed: -A sealed envelope with hand written documentation as resident's name, patch, date (12/6/15) and time (11am) for administration. -Upon opening the envelope, the contents revealed (1 each- 50mcg and 100mcg) Fentanyl patches that were supposed to be administered on 12/6/15. Review of the policy and procedures revealed facility staff would not label, relabel or transfer medication from one container to another except when preparing for administration or to give to the	D 356		

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D 356	Continued From page 9 resident for administration. _____ A Plan of Protection provided by the facility included: -The facility would immediately stop removing medications from the original packaging. -This would be addressed with staff at a meeting on 12/16/15. DATE OF CORRECTION SHALL NOT EXCEED JANUARY 30, 2016.	D 356		
{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: FOLLOW UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure prescribed medications (Oxycodone, Fentanyl patch and Metformin) were administered as ordered by a licensed prescribing practitioner for 2 of 5	{D 358}		

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{D 358}	Continued From page 10 sampled residents (#4 and #5). The findings are: A. Interview with Resident #4 on 12/4/15 at 9:45am revealed: -He had been admitted to the facility in August 2015 but was unsure of the exact date. -He often ran out of Oxycodone "towards the end of every month." -When he asked staff they could not tell him why this happened. -He wanted to know why this happened so often. -He stated he asked for Oxycodone every 4 hours and sometimes it was not available. -When he asked staff they said he was out of the medication. -On a scale of 1-10 with Oxycodone his pain level was a 2 and without Oxycodone his pain level was a 6 . -He stated he had lost sleep at times because of his pain. 1. Review of current FL2, dated 9/22/15, for Resident #4 revealed: -A history of lung and rectal cancer. -A medication order for Oxycodone 15mg, 2 tablets every four hours as needed for pain. Review of Resident #4's record revealed no subsequent orders for the Oxycodone. Interview with a pharmacy representative on 12/11/15 at 9:30am revealed on September 30, 2015, 336 Oxycodone tablets were dispensed. Interview with the back-up pharmacy representative on 12/11/15 at 10:15am revealed on October 16, 2015, 60 Oxycodone tablets were dispensed.	{D 358}		

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{D 358}	Continued From page 11 Review of October 2015 computer-generated Medication Administration Record (MAR) revealed: -An entry for Oxycodone 15mg, take 2 tablets every 4 hours as needed for pain. -Oxycodone was documented as being administered beginning 10/6/15 through 10/31/15 for a total of 41 doses which equaled 82 Oxycodone tablets. (If administered as Resident #4 stated he requested the medication (6 times daily), there should have been 156 doses which equaled 312 Oxycodone tablets.) -There was no documentation of Oxycodone being administered on 10/13/15, 10/14/15, 10/25/15 and 10/26/15. -There were no dates documented when the resident received 6 doses daily. Review of controlled substance sheets for Oxycodone from 10/6/15-10/31/15 revealed: -From 10/6/15 to 10/17/15, 56 doses were documented as being administered which equaled 112 tablets. -From 10/18/15, 12am dose to 10/24/15, 10am dose, only one tablet was documented as administered at each scheduled dose for a total of 30 tablets (if given as ordered, it would have required 60 tablets). -No documentation of administration after 10/12/15, 5am dose until the 10/13/15, 8pm dose. -No documentation of administration after 10/24/15, 10am dose until the 10/26/15, 11am dose. -From 10/26/15 to 10/31/15, 36 doses were documented as being administered which equaled 72 tablets. -214 tablets were documented as being administered in October 2015 (if administered as Resident #4 stated he requested the medication	{D 358}		

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{D 358}	Continued From page 12 (6 times daily), 312 tablets should have been administered). Interview with a pharmacy representative on 12/11/15 at 9:30am revealed on October 27, 2015, 336 Oxycodone tablets were dispensed. Review of November 2015 computer-generated MAR revealed: -An entry for Oxycodone 15mg, take 2 tablets every 4 hours as needed for pain. -Oxycodone was documented as administered beginning 11/1/15 through 11/30/15 for a total of 55 doses which equaled 110 Oxycodone tablets (if administered as Resident #4 stated he requested the medication (6 times daily), there should have been 156 doses which equaled 312 Oxycodone tablets). -No documentation of administration of Oxycodone being administered on 11/18/15 and 11/30/15. -There were 11 dates when only one dose of Oxycodone was documented as being administered. -No documentation of dates of administration where the resident received 6 doses daily. Review of the controlled substance sheets for Oxycodone from 11/1/15-11/30/15 revealed: -From 11/1/15 to 11/30/15, 77 doses were documented as being administered which equaled 154 tablets. -There were no Oxycodone tablets documented as being administered on 11/25/15 and 11/26/15. -154 tablets were documented as administered (if administered as Resident #4 stated he requested the medication (6 times daily), 360 tablets should have been administered). Interview with a pharmacy representative on	{D 358}		

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{D 358}	Continued From page 13 12/11/15 at 9:30am revealed on November 25, 2015, 336 Oxycodone tablets were dispensed. Review of December 2015 handwritten MAR revealed: -A hand written entry for Oxycodone 15mg, take 2 tablets every 4 hours as needed for pain. -Oxycodone was documented as administered beginning 12/1/15 through 12/10/15 for a total of 18 doses which equaled 36 Oxycodone tablets (if administered as Resident #4 stated he requested the medication, there should have been 60 doses which equaled 120 Oxycodone tablets). -There were 6 dates when only one dose was documented as being administered. -There were no dates documented where the resident received 6 doses daily. Review of controlled substance sheets for Oxycodone from 12/1/15 to 12/10/15 revealed: -From 12/1/15 to 12/10/15, 25 doses were documented as being administered which equaled 50 tablets. -There were no Oxycodone tablets documented as being administered on 12/2/15. -50 tablets were documented as administered (if administered as Resident #4 stated he requested the medication (6 times daily), 120 tablets should have been administered). Review of Oxycodone on hand for Resident #4 on 12/4/15 at 3pm revealed 34 tablets of Oxycodone were available for administration. Interviews with 3 medication aides on 12/8/15 revealed 3 of 3 could not confirm Resident #4 was out of Oxycodone when they administered medications. Interview with the Director on 12/8/15 at 4:30pm	{D 358}		

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{D 358}	Continued From page 14 revealed: -Resident #4 had been taking the Oxycodone routinely based on her review of controlled substance sheets. -She needed to get the order changed to routine. Interview with the Director on 12/11/15 at 8:45am revealed she did not know that there were so many discrepancies with the Oxycodone Interview with staff at the primary physician's office on 12/16/15 at 9:30am revealed: -They had been contacted by the Director of the facility on 12/15/15 to report missing Oxycodone. -Based on this information, the physician refused to refill any more Oxycodone prescriptions in December 2015. -Resident #4 could have withdrawal from not receiving Oxycodone. -He had not been hospitalized since admission to the current facility on 8/5/15. -He had primary care visits on 9/3/15 and 9/8/15. -"Missing Oxycodone seems to be an ongoing issue." B. Review of the current FL-2 dated 9/22/15 for Resident #4 revealed: -A history of lung and rectal cancer. -A medication order for Fentanyl 100mcg every 3 days to be used with 50mcg patch (Fentanyl is used to manage moderate to severe pain, usually in people who have chronic pain, breakthrough pain and for pain associated with cancer). -A medication order for Fentanyl 50mcg every 3 days to be used with 100mcg patch. Interview with Resident #4 on 12/8/15 at 4pm revealed: -His Fentanyl pain patch had not been changed in "5 or 6 days."	{D 358}		

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{D 358}	Continued From page 15 -He was unsure if this had happened before. Observation of Resident #4's Fentanyl pain patch on 12/8/15 at 4pm revealed: -One pain patch was located on his upper back near his right shoulder. -No other pain patches were observed on the resident. -A handwritten date on the patch of 12/3/15. Review of Resident #4's December 2015 handwritten Medication Administration Record (MAR) revealed: -An entry for Fentanyl patch 100mcg apply every 3 days with 50mcg. -An entry for Fentanyl 50mcg apply every 72 hours with 100mcg patch. -Both were documented as being applied on 12/3/15, 12/6/15 and 12/9/15, as ordered. Review of the December 2015 controlled substance sheets revealed both Fentanyl patches were documented as being applied on 12/3/15, 12/6/15 and 12/9/15. Interview with the Director on 12/8/15 at 4:45pm revealed she did not know why the Fentanyl patches had not been administered as ordered. Review of the December 2015 MAR on 12/10/15 revealed the Fentanyl patch was applied on 12/9/15. Review of the October and November 2015 MARs revealed both the 100mcg and 50mcg patches were documented as being applied as ordered, for a total of 21 of each strength of patch being documented as administered. Interview with the pharmacy on 12/11/15 at	{D 358}		

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{D 358}	Continued From page 16 9:30am revealed: -A total of 40 100mcg patches had been delivered since the resident had been at the facility (10 patches on 8/5/15, 10 patches on 9/2/15, 10 patches on 9/30/15 and 10 patches on 11/12/15). -A total of 20 50mcg patches had been delivered since the resident had been at the facility (10 patches on 8/5/15 and 10 patches on 9/2/15). Interview with the back-up pharmacy on 12/11/15 at 10am revealed: -A total of 10 100mcg patches had been delivered since the resident had been at the facility on 8/5/15. -A total of 10 50mcg patches had been delivered since the resident had been at the facility on 8/5/15. Review of controlled substance sheets revealed the Fentanyl patch was documented as administered as ordered for a total of 32 doses each of the 50mcg and 100mcg patches. Observation of the Fentanyl patches on hand for Resident #4 on 12/8/15 revealed there were 23 100mcg patches remaining and no 50mcg patches remaining. C. Review of the Resident #5's record revealed he was admitted to the facility on 9/2/15. Review of the FL-2 dated 8/18/15 revealed: -Diagnoses included diabetes. -Medication orders for Glimepiride 2mg daily and Metformin HCL ER, 500mg take two tablets twice daily. (Both medications are used to treat diabetes.) Review of the current FL-2 for Resident #5 dated 11/9/15 revealed:	{D 358}		

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{D 358}	Continued From page 17 -Diagnoses included diabetes. -No diabetic medication orders. -No order to check finger stick blood sugars. Review of the resident record revealed no discontinue order or clarification for Metformin or Glimepiride. Review of Resident #5's handwritten September 2015 Medication Administration Record (MAR) revealed: -An entry for Glimepiride 2mg daily. -An entry for Metformin HCL 500mg twice daily. -Glimepiride was documented as administered 9/3/15 through 9/30/15. -Metformin was documented as administered 9/2/15 (pm dose) through 9/30/15 (pm dose). Review of the computer-generated October and November 2015 MARs revealed: -No entry for Metformin. -No entry for Glimepiride. -No diabetic medication orders. Review of the computer-generated December 2015 MAR revealed: -An entry for Glimepiride 2mg daily. -An entry for Metformin HCL 500mg twice daily. -Both medications were documented as administered 12/1/15 through 12/4/15 (am dose). -The computer generated date of order for both medications was 9/1/15. Review of the medications on hand for Resident #5 on 12/4/15 at 2:30pm revealed Metformin and Glimepiride were not available for administration. Review of the Onsite Medication Review for Resident #5 dated 10/29/15 revealed: -Handwritten documentation of medications	{D 358}		

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{D 358}	Continued From page 18 Glucophage (Metformin) 500mg twice daily and Glimepiride 2mg one daily. -Documentation under Recommendations as "suggest...HgA1C q [every] 6-12 months while patient on above medications." Interview with the Resident Care Supervisor (RCS) on 12/4/15 at 3:15pm revealed: -She "sometimes" would clarify orders if there were differences between an older FL-2 and a new FL-2. -She gave no explanation regarding the changes in orders for the Metformin and the Glimepriride. Interview with Resident #5 on 12/4/15 at 3:30pm revealed: -He was unsure of all the medications he was prescribed. -He was a diabetic and thought he was on diabetic medication at one time. -Recently had had no complications related to his diabetes. -Had seen the facility physician "a few times" since being admitted to the facility a few months prior. Interview with the Director on 12/7/15 at 2:10pm revealed: -"Technically we do not have an order for Metformin or [brand name for Glimepiride] since the 11/9/15 FL-2. " -There was no discontinue order for Metformin and Glimepiride after the 9/2/15 physician order sheet. Telephone interview with the dispensing pharmacy on 12/7/15 at 2:00pm revealed: -A 30-day supply of Metformin and Glimepiride were dispensed to the facility on 9/2/15. -Metformin and Glimepiride had not been	{D 358}		

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{D 358}	Continued From page 19 dispensed again until 12/4/15, after the facility contacted them to fill both Metformin and Glimepiride on 12/4/15. -Prior to 12/4/15 the facility had made no contact with the pharmacy concerning either medication. -There was no discontinue order on file. -"Sometimes we fail to enter the medication codes for automatic refills and we rely on the facility to contact us if a medication was not delivered in the medication tote" was given as a possible reason why medications were not sent after 9/2/15. Telephone interview with the physician for Resident #5 on 12/7/15 at 2:30pm revealed: -He did not have the resident record in front of him, but if there was no discontinue order on file and the pharmacy did not have a discontinue order, then the medication "more than likely" had not been discontinued. -He "thought" the resident refused fingerstick blood sugar checks when he was first admitted to the facility so he ordered an A1C lab test be drawn. -He had no concerns regarding this resident. -He would be at the facility in a few days and would evaluate Resident #5 at that time. Review of a physician note dated 12/9/15 on 12/11/15 revealed a discontinue order for Metformin, until an A1C lab was drawn and results were reviewed. Review of the A1C results dated 12/10/15 on 12/11/15 revealed the A1C was 6.2. (The Reference Range on the A1C were [4.5-6.2]). Plan of Protection provided by the facility included: -The Director will do a sampling of MARs,	{D 358}		

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{D 358}	Continued From page 20 declining inventory sheets, medications and narcotic sheets to be monitored weekly. -Facility will contact physician for residents who take as-needed medications on a routine basis to explore changing the order to routine. -The director will monitor any residents on pain medications for any breakthrough pain issues. -Facility to address pain patch use and placement procedures on the MAR and monitored daily by Director or Resident Care Supervisor (RCS). -The Director will schedule an in-service on medication to include narcotics, control sheets, proper storage of medications and documentation. -Any staff not adhering to these guidelines will be removed from administering medications and/or further action if deemed necessary by the management. -A staff meeting will be held on 12/16/15 and the in-service will be completed by 12/29/15. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 15, 2015.	{D 358}		
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 interviews and record reviews, the	D 392		

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D 392	Continued From page 21 facility failed to assure accurate reconciliation and readily retrievable records for the receipt, administration and disposition of controlled substances for 1 of 5 sampled residents (Resident #4) with orders for controlled substances which included Oxycodone, resulting in 1,203 tablets of the controlled substance being unaccounted for. The findings are: Review of Resident #4's Resident Register revealed he was admitted to the facility on 9/10/15 (Telephone interview with staff at the local veteran's hospital revealed Resident #4 was discharged from hospice to the current facility on 8/5/15). During tour of the facility, interview with Resident #4 on 12/4/15 at 9:45am revealed: -He had been admitted to the facility in August but was unsure of the exact date. -He often ran out of Oxycodone (an opiod narcotic analgesic for pain) "towards the end of every month." -When he asked staff they could not tell him why this happened. -He wanted to know why this happened so often. -He asked for Oxycodone every 4 hours and sometimes it was not available. -When he asked staff they said he was out of the medication. -On a scale of 1-10 with Oxycodone his pain level was a 2; without Oxycodone his pain level was a 6. -He stated he had lost sleep at times because of his pain.	D 392		

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D 392	Continued From page 22 Review of controlled substance sheets on 12/4/15 revealed: -A sheet dated 8/11/15 and 8/12/15 with documented administration of Oxycodone. -A sheet dated 9/3/15 through 9/5/15 with documented administration of Oxycodone. -A sheet dated 9/8/15 through 9/9/15 with documented administration of Oxycodone. Interview with the Director and Personnel Manager on 12/10/15 at 9:30am revealed: -They were unsure of the exact admission date for Resident #4. -They stated the medication aide must have meant to document September 11 and 12, 2015 for the August dates as a reason for controlled substance sheets dated prior to the admission date documented on the resident register. -They were unable to explain the dates on the September sheets prior to admission, 9/10/15. Review of the current FL-2, dated 9/22/15, for Resident #4 revealed: -A history of lung and rectal cancer. -A medication order for Oxycodone 15mg, 2 tablets every four hours as needed for pain. Review of handwritten controlled substance sheets dated August 11 through August 12, 2015 revealed: -No medication label or prescription number on the control sheet. -A hand written entry for "Oxycodone 15mg take 2 tablets every 4 hours for breakthrough pain." -Quantity dispensed was handwritten as 8. -There was no dispense date documented on the control sheet. -Handwritten administration entries were as follows: 8/11/15 1pm; 2 tablets	D 392		

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D 392	Continued From page 23 8/11/15 5pm; 2 tablets 8/11/15 10pm; 2 tablets 8/12/15 3am; 2 tablets -Control count as of 8/12/15 at the 3am dose were documented as being zero. There were no Medication Administration Records (MAR) on file for August 2015. Interview with the Director on 12/7/15 at 4:15pm revealed: -There were no other August 2015 controlled substance sheets or MARs at the facility. -She was unsure why there was a discrepancy. Interview with the pharmacy on 12/11/15 at 9:30am revealed 336 Oxycodone tablets were dispensed on 8/5/15. Based on the pharmacy interview, a total of 336 Oxycodone tablets were dispensed for the month of August 2015. Review of the controlled substance sheet for August 2015 revealed 8 Oxycodone tablets were documented as being administered. There were a total of 328 Oxycodone tablets that were not accounted for through documentation for August 2015. Review of handwritten controlled substance sheets for September 2015 through 9/23/15, 4pm dose revealed: -No medication label or prescription number on the control sheet. -A handwritten entry for "Oxycodone 15mg take 2 tablets every 4 hours." -No documented entries for administration on 9/1/15 or 9/2/15.	D 392		

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D 392	Continued From page 24 -Hand written administration entries as follows: From 9/3/15 through 9/5/15, 8 doses (16 tablets) were documented as administered From 9/6/15 through 9/7/15, none were documented as administered. From 9/8/15 through 9/10/15, 10 doses (20 pills) were documented as administered. From 9/10/15 6pm dose through 9/13/15 3am dose, 20 doses (40 pills) were documented as administered. After the 9/13/15 3am dose, there were none documented as administered until 9/22/15, 10am dose. From 9/22/15 through 9/24/15 5am dose, 10 doses (20 pills) were documented as administered. -Beginning 9/24/15, 11am dose through 9/26/15, 3pm dose, a new controlled substance sheet was started from the back-up pharmacy. A review of a computer-generated medication label on a controlled substance sheet provided by the back-up pharmacy revealed: -Oxycodone 2 tablets every four hours as needed for pain. -Dispensed 9/22/15, 24 tablets. -Handwritten entries were as follows: 9/24/15 through 9/26/15, 11 doses (22 tablets) were documented as administered. -Review of another computer-generated medication label on a controlled substance sheet provided by the back-up pharmacy revealed: -60 tablets dispensed on 9/25/15 for Oxycodone 15mg 2 tablets every 4 hours as needed (prn) for pain. -Handwritten entries as follows; 9/26/15-10/2/15, 29 doses (58 tablets) were documented as administered. Interview with the Director on 12/7/15 at 4:15pm	D 392		

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D 392	Continued From page 25 revealed: -There were no other September 2015 control sheets or MARs at the facility. -She was unsure why there was a discrepancy. Interview with the pharmacy on 12/11/15 at 9:30am revealed: -16 Oxycodone tablets were dispensed for Resident #4 on 8/29/15. -336 Oxycodone tablets were dispensed for Resident #4 on 8/31/15. Interview with back-up pharmacy on 12/11/15 at 10:15am revealed: -24 Oxycodone tablets were dispensed on 9/22/15. -60 Oxycodone tablets were dispensed on 9/25/15. Interview with the Director on 12/11/15 at 11:10am revealed: -There were 2 controlled substance sheets from another pharmacy that was the back-up pharmacy (one for 9/22/15 and the other for 10/16/15), used when a resident was out of a medication. -She was unaware if any medication aide had told her Resident #4 had run out of medication. -Medication Aides were expected to verify the counts on the controlled substance sheets at change of shift but they were not expected to document this. -The Director and the Resident Care Supervisor were expected to check controlled substance sheets behind the Medication Aides. Based on interviews with both pharmacies, a total of 436 Oxycodone were dispensed for the month of September 2015.	D 392		

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D 392	Continued From page 26 Based on review of controlled substance sheets for September 2015, 267 tablets were documented as administered. Review of the handwritten September 2015 MAR revealed 86 tablets were documented as administered. There were a total of 169 Oxycodone tablets that were not accounted for through documentation. Review of handwritten controlled substance sheets for 10/2/2015, no time documented, through 10/31/15 revealed: -No medication label or prescription number on any of the control sheets. -A handwritten entry for "Oxycodone 15mg take 2 tablets every 4 hours as needed for pain." -Handwritten administration entries as follows: -No documentation of administration on 10/1/15. 10/2/15 through 10/17/15, 8pm dose, 72 doses (144 tablets) were documented as administered. 10/17/15, 12am, through 10/24/15, 10am dose, 30 different time entries where only one tablet was documented as administered for a total of 30 tablets. -After the 10/24/15, 10am dose, there was no documentation until 10/26/15, 11am dose. 10/26/15, 11am dose, through 10/31/15, 10:30pm dose, 36 doses (72 tablets) were documented as administered. -A separate handwritten controlled substance sheet with duplicate documented dates 10/28/15, 8pm through 10/29/15, 2pm, which were duplicate dates from the other control sheet, all with different administration times than the other documented administration dates for a total of 5 doses (10 tablets). -On 10/30/15, 8am dose, documentation revealed 282 tablets remaining; and the next dose, on	D 392		

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D 392	Continued From page 27 10/30/15, 200 tablets remaining. Interview with the Director on 12/7/15 at 4:15pm revealed: -There were no other October 2015 controlled substance sheets or MARs at the facility. -She was unsure why there was a discrepancy. Interview with the pharmacy on 12/11/15 at 9:30am revealed: -336 Oxycodone tablets were dispensed on 9/30/15. -336 Oxycodone tablets were dispensed on 10/27/15. Interview with back-up pharmacy on 12/11/15 at 10:15am revealed: -60 Oxycodone tablets were dispensed on 10/16/15. Based on pharmacy interviews, a total of 832 Oxycodone tablets were dispensed for the month of October 2015. Based on review of controlled substance sheets, 256 Oxycodone tablets were documented as administered. Review of the handwritten October 2015 MAR revealed 100 Oxycodone tablets were documented as administered. There were a total of 576 Oxycodone tablets that were not accounted for through documentation. Review of handwritten controlled substance sheets for 11/1/15 through 12/10/15 revealed: -No medication label or prescription number on the controlled substance sheets. -A handwritten entry for "Oxycodone 15mg every	D 392		

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D 392	Continued From page 28 4 hours as needed for pain." -Handwritten administration entries as follows: 11/1/15, 2:30pm dose through 11/8/15, 4:30pm dose 45 doses (90 tablets) were documented as administered. No documentation from 11/8/15, 4:30pm dose until 11/18/15, 9pm dose. From 11/18/15, 9pm dose, through 11/30/15 12pm dose, 33 doses (66 tablets) were documented as administered. An entry on 11/8/15, 4:30pm dose; and the next entry as 11/18/15, 9pm dose. There were no documented entries between the 11/8/15 through 11/18/15. The 12/1/15 dose at 8am (2 tablets) was documented as administered. No documentation for 12/2/15. 48 tablets (24 doses) were documented as administered from the 12/3/15 dose at 8am through the 12/10/15 dose at 12pm. Interview with the Director on 12/7/15 at 4:15pm revealed there were no other November or December 2015 controlled substance sheets or MARs at the facility. Interview with the pharmacy on 12/11/15 at 9:30am revealed 336 Oxycodone tablets were dispensed on 11/25/15. Based on pharmacy interviews, a total of 336 Oxycodone tablets were dispensed for the months of November and December 2015. Based on review of controlled substance sheets, 206 Oxycodone tablets were documented as administered. Review of the handwritten November and December 2015 MARs revealed 146 Oxycodone	D 392		

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D 392	Continued From page 29 tablets were documented as administered. There were a total of 130 Oxycodone tablets that were not accounted for through documentation. Interview with Resident #4 on 12/11/15 at 2:30pm, related to discrepancies in his Oxycodone, revealed: -He recalled he ran out of medication in September 2015. -When he went to his doctor's office in September 2015 to get a refill for the missing medication, the doctor gave him a hard time about his medications being missing. Interview with staff at the primary physician's office on 12/16/15 at 9:30am revealed: -They had been contacted by the Director of the facility on 12/15/15 to report missing Oxycodone. -Based on this information, the physician refused to refill any more Oxycodone prescriptions in December 2015. -Resident #4 could have withdrawal from not receiving Oxycodone. -He had not been hospitalized since admission to the current facility on 8/5/15. -He had primary care visits on 9/3/15 and 9/8/15. -"Missing Oxycodone seems to be an ongoing issue" for this resident. There was a total of 1,203 Oxycodone unaccounted for. A Plan of Protection provided by the facility included: -On 12/7/15 the Director notified local law enforcement and the pharmacy of the drug discrepancy. -A lock was purchased and placed on the back-up medication cabinet on 12/11/15.	D 392		

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D 392	Continued From page 30 -All back-up medications would be placed under a double lock system in the medication room. -Medications were to be counted two times per week by the Director and a staff member. -Only 2 members of management would have keys to the double lock cabinet. THE DATE OF CORRECTION SHALL NOT EXCEED JANUARY 15, 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 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: TYPE B VIOLATION This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a controlled substance medication was maintained in a safe manner, under locked security. The findings are: Observations on 12/8/15 at 4:30pm of the Resident Care Supervisor's (RCS's) office where the controlled medications were stored revealed: -The RCS's office was located off the medication room which was located off the main hallway. -Back-up controlled medications were in an unlocked cabinet	D 393		

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D 393	Continued From page 31 -The unlocked cabinet on the wall contained bubble-packed, plastic medication bottles and plastic zipper-type locked bags of controlled medications. -The Director and the RCS were in the RCS office at the time of the observation. Random observations during the survey (12/4/15 through 12/16/15) of the RCS's office revealed: -The medication room and the RCS's office were unlocked and unsupervised on multiple occasions. -The cabinet which housed the controlled medications was observed to be unlocked on at least 2 occasions when there was no staff in the office. Interview with the Director on 12/8/15 at 4:30pm revealed all back-up controlled medications were stored in a cabinet in the Resident Care Supervisor's (RCS) office. Interview with the Director on 12/10/15 at 1:35pm revealed: -The key had broken off in the lock to the medication room. -The Director, RCS and Medication Aides were supposed to always be supervising the medication room. -Sometimes the administrative staff forgot to lock the padlock on the backup control medication cabinet. -She had recently purchased a new padlock on either 12/9/15 or 12/10/15. -The new padlock was put in place on 12/10/15. Review of facility policy revealed "all medication, prescription and non-prescription administered by facility staff will be kept locked except when staff available for medication administration are in	D 393		

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D 393	Continued From page 32 close proximity." A Plan of Protection provided by the facility included: -The facility had purchased a new lock for the back-up cabinet. -All medications would be placed under a double lock system in the medication room. THE DATE OF CORRECTION DATE SHALL NOT EXCEED JANUARY 30, 2015.	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	D 401		

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D 401	Continued From page 33 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; (C) side effects and medication interactions; and (D) policies and procedures. This Rule is not met as evidenced by: Based on 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, accountability of controlled substances including disposition, receipt and administration of controlled substances, transferring medications to another container and medication storage for 1 of 5 sampled residents (Resident #4). The findings are: Review of Resident #4's record on 12/4/15 revealed: -A quarterly medication review completed by the pharmacy dated 10/29/15. -The review revealed no recommendations by the pharmacist. Interview with the Director on 12/11/15 at 2:45pm	D 401		

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D 401	Continued From page 34 revealed: -The pharmacy representative looked at a sample of control medications but not all resident's control medications. -The pharmacy had not mentioned any problem related to control medication for any residents.	D 401		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record review, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rule and regulations related to management of facilities, transferring medications from one container to another, administering prescribed medications and maintaining controlled substance medication in a safe manner under locked security. The findings are: Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility related to resident rights (exploitation and privacy), medication aide training, medication administration, controlled substances, pharmaceutical care, transferring medications to another container and controlled	{D912}		

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{D912}	Continued From page 35 substance medication storage [Refer to Tag 176, 10A NCAC 13F .0601(a), Management of Facilities (Type A2 Violation)]. Based on observation, interview and record review, the facility failed to assure two controlled substance medications (Oxycodone and Fentanyl patches) were not transferred from one container to another for 1 of 1 residents (Resident #4) [Refer to Tag 356, 10A NCAC 13F .1003(e), Medication Labels (Type B Violation)]. Based on observations, interviews and record reviews, the facility failed to assure prescribed medications (Oxycodone, Fentanyl patch and Metformin) were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (#4 and #5) [Refer to Tag 358, 10A NCAC 13F .1004(a), Medication Administration (Type B Violation)]. Based on observation, interview, and record review, the facility failed to assure a controlled substance medication was maintained in a safe manner, under locked security [Refer to Tag 393, 10A NCAC 13F .1008(b), Controlled Substance (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, interview and record review, the facility failed to assure residents were free of mental and physical abuse, neglect and	D914		

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D914	Continued From page 36 exploitation related to missing controlled substance medication ordered for Resident #4, resulting in Resident #4 experiencing pain. The findings are: Based on 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 1 of 5 sampled residents (Resident #4) with orders for controlled substances which included Oxycodone, resulting in 1,203 tablets of the controlled substance being unaccounted for [Refer to Tag 392, 10A NCAC .1008(a), Controlled Substance (Type A2 Violation].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 37 applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 1 re-hired staff (Staff C) completed the required training before being allowed to work as a Medication Aide (MA). The findings are: Review of Staff C's personnel file revealed: -A hire date of 09/03/15 as an MA. -Validated as competent to pass medication on 09/07/15. -Verification that she had passed the North Carolina Division of Health Service	D935		

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D935	Continued From page 38 Regulation/Adult Care Licensure Section Medication Aide Test on 11/23/2004. Interview with Staff C on 12/11/15 at 9:00am revealed: -She was a CNA (Certified Nursing Aide). -She had worked at the facility "about 3 years ago" (unsure of exact dates) as an MA. -She had completed MA training in the past, had not worked as an MA since she left the facility and had come back to work at the facility "about 3 months ago" as an MA on third shift. -She only passed 2 routine medications on third shift plus an occasional PRN (as needed) medication for sleep, anxiety or pain. Interview with the facility's Personnel Manager on 12/11/15 at 10:10am revealed: -Staff C had previously worked at the facility as an MA (unsure of exact dates) and had returned to be employed as an MA on 09/03/15. -She had not verified Staff C for any past 24 month employment as an MA. -Staff C had been competency validated 09/07/15 but had not taken any more training. -Since Staff C had the MA training in the past and had passed the state test, the Personnel Manager was confused whether Staff C needed the 5 and/or 10 hour training or if she just needed to be competency validated.	D935		