PRINTED: 05/17/2017 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
					R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
	conducted an annual and a complaint investigation 13, 2017 with a teleph.  The complaint investigation in the complaint in the complaint investigation in t	sure Section and the partment of Social Services survey, a follow-up survey stigation on April 11, 12, and none exit on April 25, 2017.  gation was initiated by the ht of Social Services on April			
D 079	Furnishings  10A NCAC 13F .0306 Furnishings (a) Adult care homes	shall an uncluttered, clean and of all obstructions and	D 079		
	failed to maintain the free from hazards rela butts, cigarette ashes up and left in a corner an ashtray/trash rece	as evidenced by: as and interviews, the facility home in a clean manner ated to a pile of cigarette , dirt and paper trash swept r of the smoking porch and ptacle on the screened in flammable trash and			
		acility's screened porch at g on 4/11/17, 4/12/17 and			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

DIVISION	of Health Service Regu	lation	_		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_
			D. MING		R
		hal002004	B. WING		04/25/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZIR CODE	
NAME OF T	TOVIDER OR SOLT LIER				
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S		
		TAYLORS	VILLE, NC 286	81	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE DAIE
				52.18.2.16.17	
D 079	Continued From page	e 1	D 079		
	-The floor was concre	ete.			
	-The porch contained	several chairs and multiple			
	round tables, one with	n an ashtray containing old			
	cigarette butts and on	ne with a small tin can			
	containing cigarette b				
		rash approximately 2 and			
		d approximately 4 inches			
		wept into the corner by a			
	•	can on the right side of the			
		same location for three			
	•	same location for three			
	days.	sisted of singualty cabos			
		sisted of cigarette ashes,			
		pers, small pieces of paper,			
		owel and a large number of			
	cigarette butts.				
		shtray/trash receptacle			
	· ·	tall and 10 inches square			
		ch along the wall of the			
	facility.				
		tacle, the ashtray, was			
		es deep with several areas			
	where the original fini	sh had peeled away and			
	was rusted, and conta	ained several cigarette butts.			
	-Approximately 6 inch	nes below the ashtray, there			
		g approximately 6 inches in			
	diameter on each side				
		d in with, and on top of,			
	•	s, cellophane wrappers,			
	paper and facial tissu				
		nd spilled out onto the floor.			
	illica tric receptacie a	nd spilled out onto the floor.			
	Interviewe with six rea	sidents 4/11/17 between			
	10:30am and 12:15pr				
		ts who smoked, threw their			
		floor of the screened porch			
	when they were done				
		rays out there and maybe			
	they wouldn't throw th				
	-The metal trash can	on the screened porch was			

Division of Health Service Regulation

for trash.

STATE FORM 6899 V1B311 If continuation sheet 2 of 100

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		3032 N C	HIGHWAY 16 SC	DUTH	
ALEXAND	ER ASSISTED LIVING	TAYLOR	SVILLE, NC 2868	31	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 079	Continued From page	: 2	D 079		
	-"It was dangerous to trash. It could catch o -There had not been a that anyone was awar -The housekeeper war porch.  Interview on 4/11/17 a Administrator revealer -He was not aware the with the paper trash in receptacle on the screen-He was not aware of cigarette butts in the coporch by the metal trashe would put more a remove the ashtray/trasherous and the contrasherous contr	use the tall ashtray for n fire." a fire on the screened porch re of. as the one who cleaned the at 12:30pm with the d: ere were cigarette butts in a the ashtray/trash eened porch. the pile of trash and corner of the screened ash can. shtrays on the porch and			
D 101	10A NCAC 13F .0309 (b) There shall be ref quarterly on each shif requirement of the loc Enforcement Official. (c) Records of reheat and copies furnished social services annual	nearsals of the fire plan it in accordance with the cal Fire Prevention Code rsals shall be maintained to the county department of lly. The records shall time of the rehearsals, the resent, and a short e rehearsal involved.	D 101		

This Rule is not met as evidenced by: Based on interviews and record reviews the

STATE FORM 6899 V1B311 If continuation sheet 3 of 100

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING: CON		TED
					R	
		hal002004	B. WING		1	5/2017
			DE00 0171/ 071	T. J.D 00D5	1 0 20	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SC			
	Г		ILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 101	Continued From page	e 3	D 101			
	were performed quart	requirement of the local Fire				
	The findings are:					
		rs with four employees ot been a fire drill on either ober 2016.				
	2:30pm with eight res -One resident who ha very long stated, "I do sounds like and I don to go if it goes off." -Several residents sa summerOne resident said the "They had fire drills a them during the night -One resident had wo concerned no fire drill four months"One resident is blind wouldn't know what to -"If the alarm went off we have to go outside	Ind not been at the facility on't know what the fire alarm it know what to do or where id the last fire drill was in the le last facility he was at, ll the time. We even had ." orked in healthcare and was it had been held in the past d and in a wheelchair. She to do." if and it was raining, would e?" it was a fire drill so we				
	Care Coordinator revi-She was not aware of -Fire drills are held evishifts.	at 2:15pm with the Resident ealed: of any fires at the facility. very quarter and on both fire drill had been in January				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 4 of 100

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			·		_	
			B. WING		R	
		hal002004	B. WING		04/25	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	ATE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286			
			OVILLE, NC 200			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
			,,,,,	DEFICIENCY)		
D 101	Continued From page	e 4	D 101			
	Interview on 4/12/17	at 3:05pm with the				
	Administer revealed:	at 0.00pm mar and				
	-The facility had not h	and any fires				
	-	y's last fire drill had been in				
	September 2016 or C					
	•	fire drills had not been				
	conducted quarterly of					
	•	s at the facility who had not				
	experienced a fire dril					
	•	ent who was blind, in a				
	need help exiting the	person assist who would				
		drill on both shifts as soon				
		driii on both shifts as soon				
	as possible.					
D 105	10A NCAC 13F .0311	(a) Other Requirements	D 105			
	10A NCAC 13F .0311	Other Requirements				
	. ,	all fire safety, electrical,				
		nbing equipment in an adult				
	care home shall be m	naintained in a safe and				
	operating condition.					
	This Rule is not met					
		ns and interviews, the facility				
		building and all electrical				
		ne in a safe and operating				
		xposed wires in the cord of a				
	bug light on the wall of	of the resident hallway,				
	ceiling fans/lights mis	sing bulbs and globes and				
	with dust build-up on	the blades and motors, and				
	dimmer switches in 3	of 4 resident shower/tub				
	rooms without dials a	nd/or covers leaving the				
	switch boxes exposed					
	The findings are:					
	Observations of the fa	acility on 4/11/17 revealed:				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 5 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					F	<b>}</b>
		hal002004	B. WING		1	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 SO	ОИТН		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 105	Continued From page	: 5	D 105			
	the screened porch miglobe.  -The wall light beside the facility from the scand globe.  -The two ceiling fan/line hallway had a build-umotors and needed contract of four common dimmer switches with exposing the stems and the switch boxes were nowing the stems and the switch boxes were high voltage. DIS SUPPLY BEFORE SENTHERE was a bug lightly plugged into an electron hallway closest to the switch cover over had curled away from the switch as a support of the switch cover over had curled away from the switch as a support of the s	on shower/tub rooms had out dials and/or covers nd/or the switch boxes. visible. ere labeled, "CAUTION CONNECT POWER ERVICING." thanging on the wall and rical outlet on the resident				
	1:00pm through 3:40p through 12:00pm and 12:15pm revealed: -They had never notice	sidents on 4/11/17 from om, 4/12/17 from 9:00am 4/13/17 from 11:00am ced the ceiling fan/light				
	bulb and a globe.	ed porch was missing a light ed the wall light beside the				
	entry/exit door to/from screened porch did no -Two residents had w	the facility from the				
	-One of the female re could not see very we	sidents, in a wheelchair, ell and "she bumped into it be how the cord [to the				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 6 of 100

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		1	B. WING		F	
		hal002004	B. WINO		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 S			
	OLIMAN DV OT		/ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 105	Continued From page	e 6	D 105			
	bug light] got broken"					
	-He was not aware the fixture on the screened light bulb and a globe -He was not aware the entry/exit door to/from screened porch did not -He was not aware the fixtures on the resider dust on the blades and cleaning.  -He was not aware the shower/tub rooms had dials and/or covers les witch boxes exposed -He was not aware the of the bug light, hanging into an electrical outled closest to the screene had curled away from wall plug and the wire exposed.  -He would work on getting the streene had curled away from wall plug and the wire exposed.	d: several times each week. e two bulb ceiling fan/light ed porch was missing one . e wall light beside the n the facility from the ot have a globe. e two ceiling fan/light nt hallway had a build-up of id motors and needed ree of four common d dimmer switches without aving the dial stems and				
D 270	10A NCAC 13F .0901 Supervision	(b) Personal Care and	D 270			
		e supervision of residents in resident's assessed needs,				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 7 of 100

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	JE. ZIP CODE	,
	NOTIBER ON OUT LIER		HIGHWAY 16 S		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 270	Continued From page		D 270		
	This Rule is not met a TYPE A2 VIOLATION  Based on observation reviews, the facility fa of residents in accord assessed needs, care symptoms for 2 of 2 sphysical decline and the potential for serior fell down outside step December 2016 and if fall resulted in medical emergency room (ER and Resident #7 who requiring medical treathead injury and left wfall in April 2017 resulted.	as evidenced by:  Ins, interviews and record iled to provide supervision ance with each resident's explan and current itempled residents with mistory of falls, resulting in us injury when Resident #2 is in her wheelchair in in March 2017 when another al treatment at the in October 2016 itement in the ER for a closed rist injury and and another ited in a compound fracture ited in a with stabilization of the			
	The findings are:  A Review of Residen	it #2's current FL2 dated			
	2/8/17 revealed: -Diagnoses included of disease, Type II diabet and chest painMedication orders including, twice a day (for Alzheimer's disease) (for depression and a -The resident was not with a wheelchair and bladderThe resident required	dementia, chronic kidney etes, high blood pressure cluded memantine HCL or dementia associated with and sertraline 50mg daily nxiety). In the details of the semi-ambulatory of the incontinent of bowel and details extensive assistance with			
	eating, toileting and a -The resident was total	mbulation. ally dependent on staff for			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 8 of 100

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			•
		hal002004	B. WING		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC			
			VILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	e 8	D 270			
	Review of Resident #					
	eating, toileting and a -She was totally depe dressing, personal hy -There was no indicat					
	wandering, verbally o resisting care, or exhi inappropriate behavio	biting disruptive or socially				
	Based on record revie Resident #2 was dete interviewable.	•				
	record dated 8/12/16 functional decline with	s, decreased strength and				
	Resident #2 revealed -On 12/21/16 at 3:10a came to staff and staff floor. Assessment revealed been dressed an wheelchair to the Livin-There was no docum in place to safeguard -On 12/21/16 at 8:00a up all of the night, had and out of other resid	am, the resident's roommate ted Resident #2 was on the realed no injury. Resident d brought taken by				

Division of Health Service Regulation

-The Personal Care Aide (PCA) and the

STATE FORM 6899 V1B311 If continuation sheet 9 of 100

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	
			HIGHWAY 16 S		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286		
			TILLE, NC 200		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	9	D 270		
	Madigation Aida (MA)	wore busy in the dining			
	room and passing me	were busy in the dining			
		ed and the MA, PCA and			
	Maintenance person				
		de her way down the hall to			
		pened the door to the back			
	·	stairs in her wheelchair and			
		g on the ground up against			
	the chain link fence.				
	-The staff had checke	ed the resident and noted no			
	injury, put her back in	her wheelchair, took her			
	into the facility and pu	ut her to bed.			
		minute checks the staff			
	stated had been done				
		nentation interventions had			
	been put in place to s post-fall.	afeguard the resident			
		nentation the resident's			
	physician had been n	otified.			
	Review of Resident #	2's record revealed:			
	-A staff note dated 3/	13/17 which stated, "Still has			
		colored contusions that are			
	~	ER (Emergency Room)			
	doctor stated may tak	te several weeks for healing			
	due to her age".				
		egarding the date and time			
	of the fall.	- " " " " " " " " " " " " " " " " " " "			
	-No notes from the El	R regarding the fall.			
	Review of a Physician	n's note in Resident #2's			
	record dated 3/23/17				
	•	dementia with behavioral			
	disturbances, cognitiv				
		ormal gait and dysuria			
	(discomfort when urin				
		constant monitoring due to			
		ssisted and being too frail			
	and weak to stand ald	one.	1		

Division of Health Service Regulation

-The resident had poor vision, limited strength,

STATE FORM 6899 V1B311 If continuation sheet 10 of 100

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		hal002004	B. WING		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΥΔΝΓ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SO	ОИТН		
ALLXAND	ZEN AGGIGTED EIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	<del>2</del> 10	D 270			
	-The resident had fall her wheelchair unass bruise to her forehead one week prior to this -She had been evalua Emergency Room (El-Staff had told the phya higher level of care and requested a SNF referralThe physician felt the for palliative care, post declinedAn order dated 3/23/to skilled nursing as "(Assisted Living Facil increased risk for falls)	ated and treated at the R). Xrays were negative. ysician Resident #2 needed than facility could provide (skilled nursing facility) e resident was appropriate ssibly hospice. The family  17, to transfer the resident care exceeds the ALF				
	Resident #2 revealed -There was no Incider a fall referred to in sta in a physician's note of -There was no docum in place to safeguard  Review of Physician's record dated 4/10/17 -Several changes we medication, "Hopefull night and still control without being so seda -These medication ch 0.25mg twice a day a Vistaril 12.5mg at 2pr	nt/Accident Report regarding aff notes dated 3/13/17 and dated 3/23/17. Identation of interventions put the resident post-fall. Is notes in Resident #2's revealed: Ire made to the resident's by this will help her sleep at behaviors during the day				

Division of Health Service Regulation

bedtime was continued.

STATE FORM 6899 V1B311 If continuation sheet 11 of 100

Division of Health Service Regulation			T		I
	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS' AN OF CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	JI CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COWIFLETED
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		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
AI FYAND	ER ASSISTED LIVING	3032 N C I	HIGHWAY 16 SC	DUTH	
ALLXAND	ER ADDIOTED EIVING	TAYLORS	/ILLE, NC 286	81	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
			-		
D 270	Continued From page	e 11	D 270		
	The Newsonds (man	antina IICI ) wawle			
	-The Namenda (mem	•			
		s benefits are unlikely at this			
	stage of disease prog	gression".			
	lata a da	-1 44.45 Ot-# E. DOA			
		at 11:45am with Staff E, PCA			
	revealed:	h - f - ::::			
		he facility since January 4,			
	2017.				
		eavy care resident. She has			
	_	came to work here. She is			
	•	ways falling. She needs 24/7			
	care and we just can'				
		ld lift but the staff had been			
	told not to use it.				
		veral times a week, out of			
		she leans forward and			
		and when she tries to get up			
	and walk."				
		t #2] fell twice and this week			
		weeks ago, I came back to			
		of her face was all bruised			
	from a fall."				
	-"Sometime before I s				
		I the back door by the office			
	and fell down the step				
		of interventions put in place			
	to safe-guard Reside				
		re always on and it was			
		y door every time an alarm			
	went off.				
	1-4	-4 0:00 :::::::::::::::::::::::::::			
		at 9:30am with Staff I, MA,			
	revealed:				
		see very well and requires a			
	lot of assistance from				
		ent #2 had been awake most			
		pretty agitated at breakfast.			
	-Resident #2 was in h	ner wheelchair, went down			

Division of Health Service Regulation

the hall to the exit door at the end of the hallway,

by the office, and opened the door.

STATE FORM 6899 V1B311 If continuation sheet 12 of 100

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					1 _	
			P WING		F	
		hal002004	B. WING		04/2	25/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		3032 N.C.I	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		/ILLE, NC 286			
			TILLE, 140 200			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
iAO		,	IAG	DEFICIENCY)		
D 270	Continued From page	e 12	D 270			
	-The PCA was in the	dining room and the MA was				
	giving medications wh	nen the door alarm went off.				
	-Resident #2 had falle	en down the back stairs in				
	her wheelchair and w	as found laying on the				
	ground up against the					
		ecked for injury, none was				
	noted, taken to her ro					
		•				
	<ul><li>-The staff had Resident #2 on thirty minute checks.</li><li>-She was not aware of any other falls for</li></ul>					
	Resident #2.	or any other rane ref				
	resident #2.					
	Observations on 4/12	:/17 at 3:30pm of the				
		facility office revealed:				
	-	ximately 32 to 34 inches				
	wide and contained a					
		ocated on the right side of				
		opened outward to the left				
	onto a concrete porch					
		hile the door was open.				
		ush to the concrete porch.				
		en it was open, was the				
		v to an unoccupied resident				
	room.	v to an unoccupied resident				
		nad a full double handrail on				
	•	ingle handrail attached to the				
		sident room window, curving				
	•	a half concrete slab at the				
	base of the porch by					
	-From handrail to handrail, the porch was approximately 36 inches wide and from threshold					
	· ·					
	· ·	h was approximately 40				
	inches long.					
		as flush to the outer wall of				
	·	ent room at the bottom of				
	the porch stairs.					
		airs, looking toward the door,				
		e on the right and bare				
	ground on the left.					

Division of Health Service Regulation

-A step up from the ground and another to the

STATE FORM 6899 V1B311 If continuation sheet 13 of 100

DIVISION	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1		R	
		hal002004	B. WING		04/25/2017	
		1.002007			1 07/20/2017	$\dashv$
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AI EVAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	DUTH		
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	$\neg$
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	:
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				22.10.2.10		$\dashv$
D 270	Continued From page 13		D 270			
	porch each had a height of approximately 8					
	inches.	gnt or approximately o				
		facility the clarm had				
	sounded and then wa	facility, the alarm had				
		r had not closed completely				
		seen around it on three				
	sides.	seen around it on timee				
	-The latch touching the metal tee-strike had silenced the alarm but the door remained unlatched.					
	dilatorica.					
	Interview on 4/12/17	at 3:15pm with the				
	Administrator reveale	-				
	-He was not aware Ro	esident #2's physician had				
		ansfer the resident to skilled				
	nursing as "care exce	eeds the ALF (Assisted				
	Living Facility) capabi	ilities and increased risk for				
	falls and need for sup	pervision throughout the day				
	to assist with all aspe	ects of her care".				
	-Resident #2 had falle	en several times but did not				
	fall "all the time".					
		ep an eye on her because				
	she tried to get up an					
		f other interventions put in				
	place to safeguard the					
		esident had opened the back				
		d fallen down the stairs in her				
	wheelchair.	o ontra/ovit door by the				
		e entry/exit door by the				
	office did not always I	iaten when it closed. he alarm on the door would				
		was making contact with the				
	tee-strike.	was making contact with the				
		loor checked as soon as				
	possible.	3001 011001100 ab 30011 ab				
	possible.					
	Interview on 4/12/17	at 3:40pm with the Resident				
	Care Coordinator (RC					

Division of Health Service Regulation

-She was not aware Resident #2's physician had written an order to transfer the resident to skilled

STATE FORM 6899 V1B311 If continuation sheet 14 of 100

Division	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED	
					1 _	_	
			B. WING		F		
		hal002004	B. WING		04/2	25/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
			, ,	,			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S				
		TAYLORS	VILLE, NC 286	81			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE	
TAG	REGULATORT OR I	ESCIDENTII TIIVO INI ORMATION)	TAG	DEFICIENCY)	MAIL	]	
				,			
D 270	Continued From page	e 14	D 270				
	nursing as "care exceeds the ALF (Assisted						
	• • • • • • • • • • • • • • • • • • • •	ilities and increased risk for					
	-	ervision throughout the day					
	to assist with all aspe						
	-She did not know why Resident #2's physician had not been informed of the fall on 12/21/16She stated Resident #2 did not fall "very often"She did not know why incident reports were not completed for each of Resident #2's falls.						
	-Resident #2 was a 2						
		aned over in her wheelchair					
		ing to pick up things she					
		loor but didn't get hurt.					
	•	walk in her room and had					
	fallen several times w						
		y reports had not been filled					
		ly reports riad not been filled					
	out for each fall.	Lat 1984 hours thousand the const					
		d lift but it was not in use.					
		eight bear and walks a few					
	•	afe for her to do that without					
	help.						
		he entry/exit door by the					
	office did not always l						
	-She was not aware t	he alarm on the door would					
	not sound if the latch	was making contact with the					
	tee-strike.						
	Interview on 4/13/17	at 9:52am with Resident #2's					
	physician revealed:						
	-She had been the re	sident's physician since					
	1/21/17.						
		lual decline in the resident					
	•	vas appropriate for palliative					
		e however the family did not					
	want either one.	5 alo lailing did flot	1				
		alk but was extremely					
		and her vision was impaired.					
		dent #2 had fallen once in					
	JUE WAS AWAIE REGI	oeor#z nao janen once in		1		1	

Division of Health Service Regulation

March 2017.

-She was not aware Resident #2 had gone out of

STATE FORM 6899 V1B311 If continuation sheet 15 of 100

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_	,
		hal002004	B. WING		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC			
	I		SVILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	e 15	D 270			
	the back door of the fistairs in her wheelchars in her wheelchars had written an of facility to look for a skishe felt the Resident more supervision than she was not aware to looking for placement.  B. Review of Resident 11/4/16 revealed: -Diagnoses included disorder (previously known bipolar disorderMedications included Alzheimer's Disease) bedtime (antidepress; 78mg injection every she was ambulatory and continent of bowersThere was no indicated disorientated or exhibits.  Review of the Resider revealed an admission Review of Resident #11/4/16 revealed: -The resident required activities of daily living motion in her upper eactivities of daily living motion in her ability we the resident resisted limited in her ability we the resident was sor forgetful and needing was slurred.	acility and fallen down the air on 12/21/16. rder on 3/23/17 for the cilled nursing facility because #2 needed more care and in this facility could provide. The facility had not been for the resident.  It #7's current FL2 dated major neurocognitive nown as dementia) and donepezil 10mg daily (for mirtazapine 30mg at ant) and Invega Sustenna month (for bipolar disorder). With no assistive devices el and bladder. Side in inappropriate behavior.  Int Register for Resident #7 in date of 10/24/16.  T's current care plan dated dimited assistance with all g and had limited range of extremities. If care at times and was ith locomotion. The metimes disoriented, reminders and her speech				
	-The resident required limited assistance with all activities of daily living and had limited range of motion in her upper extremitiesThe resident resisted care at times and was limited in her ability with locomotionThe resident was sometimes disoriented, forgetful and needing reminders and her speech					

Division of Health Service Regulation

-Resident #7 had been brought in by EMS "full

STATE FORM 6899 V1B311 If continuation sheet 16 of 100

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	<del></del>	_	
		hal002004	B. WING		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	0,2011
TVAINE OF T	NOVIDER OR GOLF EIER		HIGHWAY 16 S			
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	e 16	D 270			
D 210	syncope" (temporary -She had been on the facility when she pass passed out againWhen she fell, she h and injured her left wi fracturesAt discharge on 10/3 syncope had not been physician wrote, "I red ambulation." -Resident #7 had retu splint on her left wrist  Review of physican in revealed: -On 10/28/16, the res syncope, had fallen o her face and injured in taken to the hospital fiThe reason for the sy and the resident had facility. Review of physican in revealed: -On 11/4/16, "Function mobility, generalized in strength and unstead -On 12/13/16, the res and is at risk for falls"  Review of Incident and by the facility for Resi no documentation Re 10/28/16 or of interve increase the safety of	loss of consciousness). e smoking porch at the sed out, awakened and it the left side of her face rist. Xrays were negative for 0/16, the cause of her identified. The hospital commend supervision with a due to pain and swelling.  otes in Resident #7's record ident had an episode of in the screened porch, hit her left wrist. She had been for treatment and admitted. If yncope was not determined been discharged back to the otes in Resident #7's record onal decline with decreased weakness, decreased y gait." ident "has had recent falls of Accident Reports provided dent #7 revealed there was sident #7 had fallen on intions put in place to it the resident post-fall.				
	-The reason for the sy and the resident had facility. Review of physican norevealed: -On 11/4/16, "Function mobility, generalized strength and unstead -On 12/13/16, the resumd is at risk for falls."  Review of Incident and by the facility for Residual normal documentation Residual 10/28/16 or of intervesion and the residual normal strength and strength a	yncope was not determined been discharged back to the otes in Resident #7's record onal decline with decreased weakness, decreased y gait." ident "has had recent falls dd Accident Reports provided dent #7 revealed there was sident #7 had fallen on ntions put in place to				
	Review of a hospital of 4/3/17 in Resident #7	discharge summary dated 's record revealed:				

Division of Health Service Regulation

-Resident #7 had fallen at the facility, complained

STATE FORM 6899 V1B311 If continuation sheet 17 of 100

NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  MALEXANDER ASSISTED  MALEXANDER ASSISTED  MALEXANDER ASSI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JP CODE  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NO 28681  (XA1)D PREETX TAG  (XA1)D PREETX REQULATORY OR LSC IDENTIFYING INFORMATION)  D 270  Continued From page 17  of back and left knee pain and brought by EMS to the Emergency Room (ER) for treatmentXrays revealed a compression fracture of the first lumbar vertebra and a vertebroplasty (bone cement is injected into the cracked or broken vertebras stabilizing the fracture) had been performed in the ERResident #7 had been discharged back to the facility with instructions to call [Name of orthopedic surgeon] to schedule an appointment.  Review of incident and Accident Reports provided by the facility for Resident #7 revealed: -On 4/3/17 at approximately 9:30am, a resident reported to a Personal Care Aide (PCA) Resident #7 fad fallen in the bathroomThe PCA found Resident #7 on one knee, attempting to get upResident #7 to fit the PCA her back and her knee were hurting and she had a cut on the back of her right handThe resident abeen taken back to her room, the PCA notified the Supervisor who called Emergency Medical Services (EMS) and the resident had been taken to the ER for medical treatment.  Interview on 4/12/17 at 11:45am with Staff E, PCA (Personal Care Aide) revealed:				7. BOILDING: _			,
ALEXANDER ASSISTED LIVING  SUMMARY STATEMENT OF DEPICIENCIES  (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  D 270  Continued From page 17  of back and left knee pain and brought by EMS to the Emergency Room (ER) for treatment.  -Xrays revealed a compression fracture of the first lumbar vertebra and a vertebroplasty (bone cement is injected into the cracked or broken vertebrae stabilizing the fracture) had been performed in the ER.  -Resident #7 had been discharged back to the facility with instructions to call [Name of orthopedic surgeon] to schedule an appointment.  Review of Incident and Accident Reports provided by the facility for Resident #7 revealed:  -On 4/3/17 at approximately 9:30am, a resident reported to a Personal Care Aide (PCA) Resident #7 had fallen in the bathroom.  -The PCA found Resident #7 on one knee, attempting to get up.  -Resident #7 told the PCA her back and her knee were hurting and she had a cut on the back of her right hand.  -The resident had been taken back to her room, the PCA notified the Supervisor who called Emergency Medical Services (EMS) and the resident had been taken to the ER for medical treatment.  Interview on 4/12/17 at 11:45am with Staff E, PCA (Personal Care Aide) revealed:			hal002004	B. WING		1	
CALL   D.   PROVIDERS PLAN OF CORRECTION   CALL   DEFICIENCIES   PREED   PROVIDERS PLAN OF CORRECTION   CALL   DEFICIENCY MUST BE PRECEDED BY PULL   PREED   REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY MUST BE PRECEDED BY PULL   PREED   REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY   DEFICIENC	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
Description   Summary statement of Deficiencies   ID   PROVIDERS PLAN OF CORRECTION   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   (EACH CORRECTIVE ACTION SHOULD BE (EACH EACH CORRECTIVE ACTION SHOULD BE (EACH EACH EACH EACH EACH EACH EACH EACH	ΔΙ ΕΥΔΝΓ	ER ASSISTED I IVING	3032 N C H	IIGHWAY 16 SC	DUTH		
PREFIX TAG	ALLXANL	ER AGGIGTED LIVING	TAYLORSV	/ILLE, NC 286	81		
of back and left knee pain and brought by EMS to the Emergency Room (ER) for treatment.  -Xrays revealed a compression fracture of the first lumbar vertebra and a vertebroplasty (bone cement is injected into the cracked or broken vertebrae stabilizing the fracture) had been performed in the ER.  -Resident #7 had been discharged back to the facility with instructions to call [Name of orthopedic surgeon] to schedule an appointment.  Review of Incident and Accident Reports provided by the facility for Resident #7 revealed:  -On 4/3/17 at approximately 9:30am, a resident reported to a Personal Care Aide (PCA) Resident #7 had fallen in the bathroom.  -The PCA found Resident #7 on one knee, attempting to get up.  -Resident #7 told the PCA her back and her knee were hurting and she had a cut on the back of her right hand.  -The resident had been taken back to her room, the PCA notified the Supervisor who called Emergency Medical Services (EMS) and the resident had been taken to the ER for medical treatment.  Interview on 4/12/17 at 11:45am with Staff E, PCA (Personal Care Aide) revealed:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
the Emergency Room (ER) for treatment.  -Xrays revealed a compression fracture of the first lumbar vertebra and a vertebroplasty (bone cement is injected into the cracked or broken vertebrae stabilizing the fracture) had been performed in the ER.  -Resident #7 had been discharged back to the facility with instructions to call [Name of orthopedic surgeon] to schedule an appointment.  Review of Incident and Accident Reports provided by the facility for Resident #7 revealed:  -On 4/3/17 at approximately 9:30am, a resident reported to a Personal Care Aide (PCA) Resident #7 had fallen in the bathroom.  -The PCA found Resident #7 on one knee, attempting to get up.  -Resident #7 told the PCA her back and her knee were hurting and she had a cut on the back of her right hand.  -The resident had been taken back to her room, the PCA notified the Supervisor who called Emergency Medical Services (EMS) and the resident had been taken to the ER for medical treatment.  Interview on 4/12/17 at 11:45am with Staff E, PCA (Personal Care Aide) revealed:	D 270	Continued From page 17		D 270			
-She had worked at the facility since January 4, 2017Resident #7 had been getting weaker, was more unsteady on her feet and needed more care than the facility could provideThe resident had fallen in the bathroom the week before and fractured her back and had been in a lot of pain.		of back and left knee the Emergency Room -Xrays revealed a corfirst lumbar vertebra a cement is injected into vertebrae stabilizing the performed in the ERResident #7 had bee facility with instruction orthopedic surgeon] to the facility for Resident and by the facility for Resident and by the facility for Resident and fallen in the base of the PCA found Resident and she right handThe resident #7 told the were hurting and she right handThe resident had been taken the PCA notified the Semergency Medical Semergency	pain and brought by EMS to a (ER) for treatment. Impression fracture of the land a vertebroplasty (bone to the cracked or broken the fracture) had been the fracture of the land to call [Name of to schedule an appointment.  Ind Accident Reports provided ident #7 revealed: Imately 9:30am, a resident land Care Aide (PCA) Resident land Care Aide (PCA) Resident land a cut on the back of her land a cut on the back of her land a cut on the back of her land to the ER for medical land the land to the ER for medical land the land the land land the land land the land land land land land land land land				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 18 of 100

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	LILD
			B. WING		R	
		hal002004	B. 111110		04/2	25/2017
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	•		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO			
			/ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	e 18	D 270			
	Interview on 4/13/17 and Medication Aide (MA) -Resident #7 had been and fracturing her back -The staff had been to the dining room in a variant in her room"She is alert and oried depressed. I think she interview on 4/12/17 and Administrator revealed. He was aware Residusent to the hospital for those fallsHe stated the resident	at 9:30am with Staff I, o revealed: en in a lot of pain after falling ck. ransporting the resident to wheelchair or she would eat entated but seems e's given up."  at 3:15pm with the d: lent #7 had fallen and been or treatment of injuries from  nt was watched more closely ot aware of interventions put				
	Care Coordinator (RC-She stated Resident she was admitted and independentShe takes her own sher room and in the h-She was not aware to increase Resident  The facility's failure to 2 sampled residents decline and falls, resuserious injury when R steps in her wheelchat March 2017 when antreatment at the emer closed head injury an 10/28/16 requiring metals.	#7 had fallen twice since d is alert, orientated and very howers and ambulates in allway. of interventions put in place				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 19 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING		R	
		hal002004	B. WING		04/25/2017	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΧΔΝΩ	ER ASSISTED LIVING	3032 N C H	IGHWAY 16 S	оитн		
7(22)(11)			ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	e 19	D 270			
	fracture of the first lur stabilization of the fra Room. The facility's fa #2 and Resident #7 re harm and substantial	esulted in a compound nbar vertebra with cture in the Emergency ailure to supervise Resident esulted in serious physical risk that death or serious d constitutes a Type A2				
	and included the follo-Staff will check on Revery 30 minutes and staff will encourage of appropriate for all residentsStaff will ensure call residentsStaff will encourage of summon staffAll residents will be an as needed basis for the inclusionIf a resident becomes the physician, responnotified and a new plate of care.  CORRECTION DATE	esident #2 and Resident #7 I offer help as needed. use of assistive devices as idents. bells are within reach of the residents to use call bells to assessed quarterly and on or falls. e assessed for falls upon s/is a potential risk for falls, sible party and DSS will be an of care developed. sident will be discharged to				
D 273	10A NCAC 13F .0902	(b) Health Care	D 273			
	· ·	Health Care assure referral and follow-up and acute health care needs				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 20 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED			
AND FLAIN	O CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COWIL LETED	
		hal002004	B. WING		R <b>04/25/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΥΔΝΩ	ER ASSISTED LIVING	3032 N C I	HIGHWAY 16 S	ОИТН		
ALLXAND	EN AGGIOTED EIVING	TAYLORS	/ILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	273 Continued From page 20		D 273			
	facility failed to assure meet the routine and 3 of 3 sampled reside transfer to a higher le care and supervision (Assisted Living Facili with a history of chror Endocet pain medical Resident #7 with a phan appointment with a post-fall with a compo	and record reviews, the e referral and follow-up to acute health care needs for ints regarding Resident #2's vel of care due to falls and exceeding the ALF ity) capabilities, Resident #3, nic pain being without tions for 24 hours, and pysician's order to schedule an orthopedic surgeon bund fracture of the first a vetebroplasty performed in				
	2/8/17 revealed: -Diagnoses included	t #2's current FL2 dated dementia, chronic kidney etes, high blood pressure				
	with a wheelchair and bladder.	ted to be semi-ambulatory I incontinent of bowel and I extensive assistance with				
	eating, toileting and a -The resident was tota bathing, dressing, gro -There was no indicat disorientated or exhib	mbulation. ally dependent on staff for soming and transfer. ion the resident was ited inappropriate behavior.				
	Review of Resident # 2/12/16 revealed:	2's current care plan dated				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 21 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		hal002004	B. WING		04	R <b>I/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
AL EVANI	DED ACCICTED LIVING	3032 N (	C HIGHWAY 16 SOL	JTH		
ALEXANI	DER ASSISTED LIVING	TAYLOR	SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	eating, toileting and a -She was totally dependenced of the street was no indicated wandering, verbally or resisting care, or exhinappropriate behavior Review of a Physicial record dated 8/12/16 functional decline with generalized weakness unsteady gait with fall Review of a Physicial record dated 3/23/17	or physically abusive, ibiting disruptive or socially or.  n's note in Resident #2's revealed the resident had h decreased mobility, as, decreased strength and Is and dementia.  n's note in Resident #2's revealed:				
	disturbances, cognitive state/depression, abrown (discomfort when uring -The resident needed her trying to walk una and weak to stand allander -The resident had powas wheelchair bounder -The resident had fallander wheelchair unassibruise to her forehead one week prior to thistone -She had been evalually Emergency Room (Elenter - Staff had told the phang higher level of care and requested a SNF referral.  -The physician felt the for palliative care, power of the state o	normal gait and dysuria nating). It constant monitoring due to assisted and being too frail one. For vision, limited strength, and a 2 person assist. Iden attempting to get out of sisted, and sustained a d and left eye approximately				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 22 of 100

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			-			
					R	
		hal002004	B. WING		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	I E, ZIP CODE		
AL EVAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH		
ALLXAND	LIVASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 070			D 070			
D 273	Continued From page	22	D 273			
	to skilled nursing as "	care exceeds the ALF				
	(Assisted Living Facil					
		s and need for supervision				
		assist with all aspects of				
	her care".					
	Interview on 4/12/17	at 11:45am with Staff E,				
	Personal Care Aide, (					
		he facility since 1/4/17.				
		eavy care resident. She has				
	_ =					
		came to work here. She is				
	_	ways falling. She needs 24/7				
	care and we just can'					
	-The facility has an ol	d lift but the staff had been				
	told not to use it.					
	-"Resident #2 falls, se	everal times a week, out of				
		she leans forward and				
		and when she tries to get up				
	and walk."	and when she thes to get up				
		t #01 fall trains and this week				
		t #2] fell twice and this week				
		weeks ago, I came back to				
		of her face was all bruised				
	from a fall."					
	-"Sometime before I s	stated working here,				
	[Resident #2] opened	I the back door by the office				
	and fell down the step	os in her wheelchair."				
		e always on and it was				
	difficult to check ever					
	difficult to check ever	y time one went on.				
	Interview on 4/40/47	at 3:15pm with the	1			
	Interview on 4/12/17		1			
	Administrator reveale					
		uld meet the care needs of				
	Resident #2.		1			
	-He thought the RCC	had contacted several				
		ding moving Resident #2 to				
	a higher level of care.	-	1			
		-				
	Interview on 4/12/17	at 3:40pm with the Resident				
	Care Coordinator (RC					
	-She was not aware o	of the physician's order				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 23 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
			72025			
		hal002004	B. WING	B. WING		R 4 <b>25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATI	E, ZIP CODE		
		3032 N C	HIGHWAY 16 SO	UTH		
ALEXAND	DER ASSISTED LIVING		SVILLE, NC 2868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page written 3/23/17 to trar nursing due to "care of Living Facility) capab falls and need for sup to assist with all asperate of care.  Interview on 4/13/17 aphysician revealed shad not contacted ski regarding the transfer B. Review of Residen 11/4/16 revealed: -Diagnoses included disorder (previously known bipolar disorderMedications included disorder (antidepress 78mg injection every she was ambulatory and continent of bowed the contacted of the contacted o	e 23  Insfer the resident to skilled exceeds the ALF (Assisted illities and increased risk for pervision throughout the day octs of her care".  Inseveral skilled nursing esident #2 need for a higher eat 9:52am with Resident #2's ne was not aware the facility led nursing facilities order written 3 weeks ago.  In #7's current FL2 dated end and and lone a	D 273	DEFICIENC	Y)	
	limited in her ability was -The resident was so forgetful and needing					

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 24 of 100

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R <b>04/25/2017</b>	
NAME OF B			DDEGG OFFICE	TE 710 0005	1 04/25/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA H <b>IGHWAY 16 S</b> (			
ALEXAND	DER ASSISTED LIVING		VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLI	ETE.
D 273	Continued From page	e 24	D 273			
	was slurred.					
	4/3/17 in Resident #7 -Resident #7 had falle of back and left knee the Emergency Room -Xrays revealed a cor first lumbar vertebra a cement is injected into vertebrae stabilizing t performed in the ERResident #7 had bee facility with instruction orthopedic surgeon] t  Interview on 4/12/17 a Administrator reveale -He was not aware th Resident #7 back to t instructions to call [Na to schedule an appoin	en at the facility, complained pain and brought by EMS to in (ER) for treatment. Impression fracture of the and a vertebroplasty (bone of the cracked or broken the fracture) had been en discharged back to the instead to call [Name of its of schedule an appointment.  At 3:15 with the ed:  The ER physician had sent the facility on 4/3/17 with ame of orthopedic surgeon] intment.  Resident Care Coordinator				
	revealed: -She was not aware t Resident #7 back to t	at 3:40pm with the RCC the ER physician had sent the facility on 4/3/17 with ame of orthopedic surgeon]				
	to schedule an appoir	· · · · · · · · · · · · · · · · · · ·				
	1/2/2017 revealed: -Diagnoses included prostateA physician order for	chronic pain and enlarged  Endocet 10/325mg, 1 tablet				
	o unies a day at /am.	, 12 noon, and 9pm (used				

STATE FORM 6899 V1B311 If continuation sheet 25 of 100

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R		
		hal002004	B. WING		04/2	5/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S				
			SVILLE, NC 286				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 273	Continued From page	25	D 273				
	for chronic pain).						
	2:00pm revealed: -He received his last of at 12 noonIf he did not receive level was at a "10 or or ranging 1-10.						
	Observations of medications on hand for Resident #3 on 4/11/17 at 2:20pm revealed Endocet was not available in the medication cart.						
	(RCC) on 4/11/17 at 2	sident Care Coordinator 2:20pm revealed she had nic for a prescription and the tonight."					
		C on 4/13/17 at 9:45am came in the tote "last night."					
	drug sheet labeled as 3/15/17 revealed staff administration on 3/19 with a 0 balance on 4.	nt #3's Endocet controlled 90 count dispensed on f began documentation of 5/17 at 7:00am and ended /11/17 at 12:00pm. nistered or wasted for at					
	per day to the 90 End drug sheet label which	ysician order for 3 Endocet ocet listed on the controlled h were dispensed on Endocet should have been					

Division of Health Service Regulation

a sufficient supply through 4/13/17 at 9:00pm.

STATE FORM 6899 V1B311 If continuation sheet 26 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BOILDING.			В
		hal002004	B. WING		04	R <b>1/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE	-	
			HIGHWAY 16 SOL	,		
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 26	D 273			
	4/13/2017 at 11:00an pain clinic on 4/12/17	ent #3's family member on n revealed they went to the ' and asked for Resident #3's ndocet because Resident #3				
	4/18/2017 at 9:00am -The facility staff did	not notify the pain clinic that of Endocet on 4/11/17, but ame by their office on				
	3/15/17 should have last until 4/15/17They do not usually	he 90 Endocet dispensed on been a sufficient supply to prescribe narcotics when elivery should not be out, but ion in this case.				
	which ended on 4/11. controlled sheet for th 4/12/17 at 9:00pm, a director of the pain cl missed 3 doses of Er	et controlled drug sheet /17 at 12:00pm and the he Endocet which began on nd the interview with the inic revealed Resident #3 hdocet because there were ministration and there was a he Endocet.				
	facility failed to assur meet the routine and 3 of 3 sampled reside transfer to a higher le supervision exceedin Facility) capabilities, chronic pain being wi medications for 24 ho physician's order to s	and record reviews, the re referral and follow-up to acute health care needs for ents regarding Resident #2's evel of care due to care and ig the ALF (Assisted Living Resident #3 with a history of ithout Endocet pain ours, and Resident #7 with a schedule an appointment with on post-fall with a compound				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 27 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		l p
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
AI EYAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	ритн	
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 2868	31	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPLETE
D 273	Continued From page	27	D 273		
	The failure of staff to a follow-ups were comp	ned in the Emergency Room.  assure all referrals and olleted in a timely manner be health, safety and welfare			
	4/13/17 revealed: -The facility will assur as quickly as possible appointments immedi -Follow-up appointme manner to assure res -The doctors appointr checked to assure all CORRECTION DATE	ents will be made in a timely idents are safe and secure. nent notes will be double referrals are made.			
D 280	registered nurse, occuphysical therapist in the evaluation of the residual plan and care provide (a) of this Rule, is condays of admission or a resident develops the least quarterly thereat following:  (1) performing a physical physical provided in the provided pr	s Licensed Health assure that participation by a appational therapist or ne on-site review and dents' health status, care id, as required in Paragraph inpleted within the first 30 within 30 days from the date ne need for the task and at	D 280		

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 28 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
AL EVAND	ACCICTED LIVING	3032 N C F	HIGHWAY 16 S	ОИТН	
ALEXANL	ER ASSISTED LIVING	TAYLORS\	/ILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 280	Continued From page	28	D 280		
	current condition requ tasks specified in Par (2) evaluating the res being provided; (3) recommending characteristic resident as needed by assessment and evaluation resident; and	uiring one or more of the agraph (a) of this Rule; sident's progress to care nanges in the care of the ased on the physical uation of the progress of the activities in Subparagraphs			
	reviews, the facility fa Health Professional S were completed quari residents (Resident # physical assessment, care being provided,	ns, interviews, and record iiled to ensure the Licensed Support (LHPS) evaluations terly for 2 of 3 sampled 5 and #6) and included a evaluation of the residents'			
	The findings are:				
	6/17/16 revealed: -Diagnoses included major depression, scl seizure disorder and	nt #5's current FL2 dated mild mental retardation, hizoaffective disorder, diabetes mellitus. ick blood sugar checks			
	revealed: -An evaluation date o	5's most recent LHPS f 2/1/16. FSBS (finger stick blood			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 29 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ΔΙ ΕΥΔΝΓ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	DUTH	
ALLXAND	ER AGGIOTED LIVING	TAYLORS	SVILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 280	Continued From page 29		D 280		
		at 3:00pm with Resident #5 on aides did his finger			
	7/29/16 revealed: -Diagnoses included a				
	hyperplasia of prostate, hypertension and atrial fibrillation.  -An order for compression hose, wheel chair, and				
	oxygen.				
	Review of Resident # revealed an admissio				
	Health Professional S -An evaluation date o -The date of last evaluation date or the tasks listed were non-ambulatory residuassistive devices, inhomachine, and oxygen monitoring.	uation of 11/4/16. Ted hose, transferring ent, ambulation using alation medication by administration and up recommendations listed			
	revealed: -The staff put on his " and take them off whe -The staff help him who bathroom.	nen he has to go to the gen where it needs to be, he			
	coordinator for the factoring the coordinator for the factoring coordinates and coordinates are coordinated as a second coordinate for the factoring coordinates are coordinated as a second coordinate for the factoring coordinates are coordinated as a second coordinate for the factoring coordinates are coordinated as a second coordinate for the factoring coordinates are coordinated as a second coordinate for the factoring coordinates are coordinated as a second coordinated as a second coordinated coordinated as a second coordinated coordinated as a second coordinated as a second coordinated coordinated coordinated as a second coordinated coordinat	at 3:45pm with the LHPS cility pharmacy revealed: PS nurses to the facilities. urses the autonomy to			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 30 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 280	Continued From page	e 30	D 280		
	LHPS tasks needed to	•			
		interview with the facility 17 at 1:15pm and 4:30pm			
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310		
	<ul><li>(e) Therapeutic Diets</li><li>(4) All therapeutic die supplements and thic</li></ul>	Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.			
	reviews, the facility fa diets for 2 of 4 sample	ns, interviews, and record iled to assure all therapeutic ed residents (Resident #5 as ordered related to puree			
	The findings are:				
	revealed: -Diagnoses included i	nt #8's FL2 dated 7/29/16 mental retardation. a diabetic puree diet.			
	12:00pm revealed Re	oon meal on 4/11/17 at sident #8 received pureed et potatoes and applesauce.			
	Review of the facility residents on a puree received a roll.	therapeutic menus revealed diet should also have			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 31 of 100

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		152.1111107111011110111152111	A. BUILDING: _	A. BUILDING:		
		hal002004	B. WING		R <b>04/25/</b> 2	2017
NAME OF D			DDEEC CITY CTA	TE 7/D CODE	04/23/2	2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA HIGHWAY 16 SO			
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 310	Continued From page 31		D 310			
	revealed: -He had been taught: diet were not to be setHe was not aware the stated residents were.  Refer to interview with 4/12/17 at 2:45pm.  B. Review of Resident revealed: -Diagnoses included a schizoaffective disorderPhysican orders for a dietFinger Stick Blood States and the stick blood sugars between the stick blood sugars between the stick blood sugars between the squash, sweet potato.  Review of the facility's revealed residents on diet should have received the thought the chock the squash.	e puree therapeutic menus to be served pureed bread. In the Administrator on In #5's FL2 dated 6/17/16 In the Hamilian retardation, and der. In No Concentrated Sweets I was in the mornings. I ree times per day. In note dated 6/17/16 in revealed she wanted to be tes medications and finger cause of a slightly elevated I sesident #5 received chicken, the estand chocolate pudding.				
	free.	he future the residents on				

Division of Health Service Regulation

No Concentrated Sweets diet were served

STATE FORM 6899 V1B311 If continuation sheet 32 of 100

2	Tricaliti Cervice riega	I	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
		11000004	B WING		F	
		hal002004	B. WING		04/2	25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
		2022 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING					
		IATLORS	VILLE, NC 286	61		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEGOLATORT OR I	ESCIDENTII TING INI OKMATION)	TAG	DEFICIENCY)	MAIL	57.11.2
				,		
D 310	0 Continued From page 32		D 310			
	according to the men	u.				
		n the chocolate pudding can				
	revealed it was not su	ıgar free.				
		17 at 12:15pm revealed the				
	label on the chocolate	e pudding container had				
	caloric sweetener.					
Interview with Resident #5 on 4/11/17 at 10:30am						
	when questioned abo	out his diet and the food				
	revealed he did not lil	ke the food.				
	Refer to interview with	h the Administrator on				
	4/12/17 at 2:45pm.					
	Interview with the Adr	ministrator on 4/12/17 at				
	2:45pm revealed:					
	-All the cooks had be	en trained to follow the				
	therapeutic menus.					
		y served according to the				
	menus in the future.	,				
D 215	404 NOAO 40E 000E		D 315			
פונע	10A NCAC 13F .0905	5(a)(b) Activities Program	0315			
	404 NOAO 40E 000E	A -4:-::4: Dun				
	10A NCAC 13F .0905					
	(a) Each adult care h	·				
		designed to promote the				
		lvement with each other,				
	their families, and the					
	(b) The program sha	Il be designed to promote				
	active involvement by	all residents but is not to				
	require any individual	to participate in any activity				
		ere is a question about a				
	•	articipate in an activity, the				
		shall be consulted to obtain a				
		the resident's capabilities.				
	This Rule is not met	as evidenced by:				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 33 of 100

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		04/2	5/2017
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N C H	RESS, CITY, STA IGHWAY 16 SC ILLE, NC 286	DUTH		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 315	failed to develop a proto promote the reside each other, their familia. The findings are:  Observations on 4/11 wooden activity calenthe facility's main hallithe top of the calend month and year and vibelow the month and divided into seven seed different day of the well-below each day of the additional boxes for a top of the section remaining 30 sections numbered piece of coinches by 5 inches has represent the activity to the activities listed on the chairs on 4/3, card gas cookies day on 4/8, fill blowing day on 4/14, on 4/15, wacky sock of day on 4/23, and must continued observation 4/12/17/ and 4/13/17. The activity listed on 4/11/17, Movie Day, on the activity listed for take place.  The activity listed for did not take place.	is and interviews, the facility orgam of activities designed ints' active involvement with lies and the community.  If at 10:45am of a large dar hanging on the wall in way revealed: Idar had an area for the was labeled April 2017. If year, the board had been ctions, each containing a eek. In week there were 6 I total of 42 sections. In were empty. The is each contained a solored paper approximately 3 and been arranged to calendar for April 2017. In e calendar included musical arme day on 4/6, decorate ingerpainting on 4/9, bubble random act of kindness day day on 4/21, color a picture sical train on 4/30.  Ins in the facility on 4/11/17, revealed: I the activity calendar for	D 315			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 34 of 100

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1 100000 4	B. WING		R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		3032 N C	HIGHWAY 16 S	OUTH	
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286		
	OLIMANA DV OT		·	T	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 315	Continued From none	- 24	D 315		
טטט	Continued From page	2 34	D 313		
	Interviews with six res	sidents on 4/11/17 between			
	10:30am and 12:15pr	m revealed:			
	-One resident said the	ere were no activities, "You			
	watch TV or walk the	halls to keep from going			
	crazy. We never go o	on outings".			
		ated she had played corn			
	hole and made a nec	klace "a while back" and that			
	was fun.				
	-A third resident said	there were no activities but			
	would enjoy sitting on	the screened porch if it			
		smokers went to smoke.			
	-The third resident sta	ated he loved to read but			
	one of the lenses had	fallen out of his glasses. He			
		books on tape but didn't think			
		g them to the facility and if			
	they did he would have	ve no way of getting them			
	returned.				
	-A fourth resident stat	ted, "There wasn't any			
	activities and it got pr	etty boring. Some of the			
	residents can walk to	the store but I can't and I			
	don't trust them with r	my money. I wish we could			
	go to the store every	so often so I could get the			
	things I need."				
	-A fifth and sixth resid	dent stated they loved to			
	read magazines but t	here wasn't any to read.			
		between 9:05 am and			
		at 9:30am with four staff			
	revealed:				
	-There had not been	an Activity Director in			
	several months.				
	-Some of the activitie	s on the activity calendar			
	were pretty childish.				
		ne residents having movies			
		bubbles or frosting cookies.			
		pecial planned for Easter.			
	-The residents went in	n the van to appointments			
	but not on fun outings	S.			

residents.

-It can get pretty boring for most of these

STATE FORM 6899 V1B311 If continuation sheet 35 of 100

Division of	of Health Service Regu	lation			FURINI APPROVE
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
AL EVAND	DER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	оитн	
ALEXAND	PER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 315	Continued From page	e 35	D 315		
	was in the process of -He felt the calendar pactivities each weekIn the absence of an expectation was for a help with the activities -He was not aware of 4/11/17, 4/12/17 and activities had not take	d: ave an Activity Director but looking for one. provided at least 14 hours of Activity Director his Il of the staff to pitch in and s. Ithe activities scheduled for 4/13/17 and that the			
D 352	10A NCAC 13F .1003	nd medications shall have a following information: esident for whom the	D 352		

medication is prescribed;
(2) the most recent date of issuance;

(3) the name of the prescriber;

(4) the name and concentration of the medication, quantity dispensed, and prescription serial number;

(5) directions for use stated and not abbreviated;

- (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;
- (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
- (8) auxiliary statements as required of the medication;
- (9) the name, address, telephone number of the dispensing pharmacy; and

Division of Health Service Regulation

STATE FORM V1B311 If continuation sheet 36 of 100

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			1	<del></del>	
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
AL EVANE		3032 N C I	HIGHWAY 16 S	ОИТН	
ALEXANL	ER ASSISTED LIVING	TAYLORS'	VILLE, NC 286	81	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 352	Continued From page	e 36	D 352		
	(10) the name or initials of the dispensing pharmacist.				
	This Rule is not met	as evidenced by:			
		and record reviews, the			
	facility failed to assure	•			
	administered to 1 of 3				
		ispensed from the pharmacy			
	and properly labeled resulting in a Medication				
	Aide administering 2	Endocet, prescribed for			
	Resident 3's family m	ember, from an unlabeled			
	container the family n	nember had brought to the			
	facility from home.				
	The findings are:				
	Review of Resident # 1/2/2017 revealed:	#3's current FL2 dated			
		chronic pain and enlarged			
	l -	Endocet 10/325mg, 1 tablet			
		, 12 noon, and 9pm (used			
	Observations of medi	cation on hand for Resident			
		pm revealed Endocet was			
	not available in the m	•			
	Interview with Reside 2:00pm revealed:	nt #3 on 4/12/2017 at			
	-He was currently out	of Endocet and received his			
	last dose "yesterday"	at 12 noon. n out of Endocet sometime			
		not known, but the family			
		not known, but the family nd the medication aides			
	administrated them to				
	-His family was aware				
	•	prought Endocet tablets for			
		bed for another family			

Division of Health Service Regulation

member.

STATE FORM 6899 V1B311 If continuation sheet 37 of 100

Division o	of Health Service Requ	ulation			FORM	APPROVED
STATEMENT	r of Deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		04/2	२ 2 <b>5/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 Se SVILLE, NC 286			
0/0.15	STIMMADA ST		<u>,                                      </u>	1	NI NI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 352	Continued From page	e 37	D 352			
		his pain medication, his pain				
	level was at a "10 or or ranging 1-10.	over" on a pain scale				
		ent #3's family member on				
	4/13/2017 at 11:00an	n revealed: -3 weeks ago," Resident				
		ed of missing Endocet.				
	-In March 2017, the fa	amily reported the Resident				
	I	CC) asked the family, in a				
		oring in Endocet because				
	Resident #3 "was run	ining out. esident #3 had run out of				
	_	within the last 6 months.				
		ed Resident #3 had been at				
		out 5 years ago, and had the				
	same issues.					
	Interview with the RC revealed:	CC on 4/13/17 at 11:15am				
	-Resident #3 did run date not known.	out of Endocet in March,				
		at she requested the family to				
	_	that it was the family's idea.				
	small white container	brought in 2 Endocet in a				
		a container without a label.				
		docet because she "looked it				
	up online."					
		ecord of the 2 Endocet				
	which the family brou	ıght in.				

administered.

of Endocet.

-She kept the 2 Endocet locked in the office.
-She administered the first Endocet 1 afternoon and the second Endocet the next morning but did

-She could not find the controlled drug sheet for March which showed when Resident #1 ran out

-She documented the administration of the 2

not know the date and times they were

STATE FORM V1B311 If continuation sheet 38 of 100

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
AI FXAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SO	DUTH	
ALLXAND			SVILLE, NC 286		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 352	Continued From page	38	D 352		
	Endocet on the Medication Administration Record (MAR) but not on a controlled drug sheet.  Interview with the Administrator on 4/13/17 at 2:15pm revealed: -He was not aware the family brought in the 2				
	Endocet for Resident -Their policy did not a	#3 for staff to administer. Illow for unlabeled			
		ministered to the residents. he pharmacy delivery sheets			
	and all of the resident because "they were s	s' controlled drug sheets cattered all around."			
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358		
	(a) An adult care hor preparation and admi	Medication Administration ne shall assure that the nistration of medications,			
	by staff are in accorda				
	which are maintained	ed prescribing practitioner in the resident's record; and on and the facility's policies			
	and procedures.	,			
	reviews, the facility fa	ns, interviews, and record iled to assure 1 of 4			
	sampled residents (R Endocet as prescribe				
	The findings are:				
	Review of Resident #	3's FL2 dated 1/2/2017			

prostate.

-Diagnoses included chronic pain and enlarged

STATE FORM 6899 V1B311 If continuation sheet 39 of 100

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
					R	
		hal002004	B. WING		04/2	5/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	FE, ZIP CODE		
		3032 N C	HIGHWAY 16 SC	OUTH		
ALEXAND	ALEXANDER ASSISTED LIVING TAYLOR			31		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				,		
D 358	Continued From page	e 39	D 358			
	-A physician order for	Endocet 10/325 3 times a				
	day 7am, 12 noon, ar	nd 9pm (used for chronic				
	pain).					
		methadone 10 mg at 8am				
	12 noon, 4 pm and 8	pm.				
	Intervious with Deside	nt #3 on 4/12/2017 at				
	2:00pm revealed:	111 #3 011 4/12/2017 at				
	•	dose of Endocet "yesterday"				
	at 12 noon.	dose of Endocet yesterday				
	-He stated he also rai	n out of Endocet sometime				
	in March, 2017, date	not known, but the family				
		nd the medication aides				
	administered them to	him.				
		e his pain medication, his				
	· ·	or over" on a pain scale				
	ranging 1-10.					
	Observations of medi	cations on hand for				
		17 at 2:20pm revealed no				
	Endocet available in t					
		sident Care Coordinator				
	(RCC) on 4/11/17 at 2	· · · · · · · · · · · · · · · · · · ·				
		dered and would be "in				
	tonight."					
	Interview with the RC	C on 4/12/17 at 9:00am				
		did not come in on 4/11/17				
	because the physicar					
	prescription, but that					
		C on 4/13/17 at 9:45am				
	revealed the Endocet	came in the tote "last night."				
	Review of Resident #	3's Endocet 10/325 recent				
	controlled drug sheet					

10/325 were dispensed on 3/15/17 which were documented as administered from 3/15/17 at 7:00am to 4/11/17 at 12 noon with 0 balance.

STATE FORM 6899 V1B311 If continuation sheet 40 of 100

STATEMEN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		hal002004	B. WING		04/25/2017	
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		IGHWAY 16 S			
ALEXAND	ER ASSISTED LIVING		ILLE, NC 286			
			· ·			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	E
D 358	Continued From page	e 40	D 358			
	Medication Administra 2:00pm revealed: -Transcriptions for En administered three tin 12:00pm and 9:00pm -Endocet 10/325 was administered routinely.  Interview with Reside 4/13/2017 at 11:00am -They went to the pair asked for a new prese Endocet because he -In the past, about "2-#3's family was notified -In March 2017, the facility stated that Remedication 3-4 times Family stated that Remedication 3-4 times Family stated that Refacility before about 5 same issues.  Interview with director 4/18/2017 at 9:00am -The facility staff did resident #3 ran out on his family member ca 4/12/17 for a new pre-The director stated the 3/15/17 should have least until 4/15/17They do not usually processing the state of the sta	nes per day, at 7:00am, documented as y.  Int #3's family member on revealed: In clinic on 4/12/17 and cription for Resident #3's ran out on 4/11/17. Is weeks ago," Resident ed of missing Endocet. It amily reported the RCC had indabout way to bring in sident #3 was running out. The sident #3 has ran out of within the last 6 months. It is ident has been at the revealed: Into the pain clinic on revealed: Into the pain clinic that of Endocet on 4/11/17, but me by their office on scription. Inte 90 Endocet dispensed on the one a sufficient supply to corescribe narcotics when livery should not be out, but				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 41 of 100

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,			A. BUILDING: _		00 22.23
			D WING		R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
AL EVAND	ACCIOTED I IVINO	3032 N C	HIGHWAY 16 SC	ОИТН	
ALEXANL	DER ASSISTED LIVING	TAYLORS	SVILLE, NC 286	B1	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	
iAG		,	IAG	DEFICIENCY)	
D 367	Continued From page	e 41	D 367		
D 367			D 367		
D 307	7 10A NCAC 13F .1004(j) Medication Administration		D 307		
		Medication Administration			
		dication administration			
	following:	e accurate and include the			
	(1) resident's name;				
	` '	cation or treatment order;			
	(3) strength and dosa	ge or quantity of medication			
	administered;				
		ministering the medication			
	or treatment;	tion for the administration of			
		ents as needed (PRN) and			
		ilting effect on the resident;			
	(6) date and time of a				
	(7) documentation of				
	medications or treatmomission, including re	ents and the reason for the			
		the person administering			
		atment. If initials are used, a			
		o those initials is to be			
		ntained with the medication			
	administration record	(MAR).			
	This Bule is not mot	as syldeneed by:			
	This Rule is not met a TYPE B VIOLATION	as evidenced by.			
	THE BYIOLATION				
	Based on observation	ns, interviews and record			
		ed to assure the accuracy of			
		tion Administration Records			
	, ,	mpled residents (Resident			
		medications which were nistered on the controlled			
		ocumented as administered			
	_	d to the failure to document			

sliding scale insulin on the eMAR, related to the failure to document Flexeril on the eMAR, and related to as needed medications documented on

STATE FORM 6899 V1B311 If continuation sheet 42 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY COMPLETED	
			A. BOILDING		F	,	
		hal002004	B. WING		1	5/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC				
			VILLE, NC 286				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 367	Continued From page	42	D 367				
	a controlled drug sheet but with no justification or effectiveness documented on the eMARs.						
	The findings are:						
		t #1's Resident Register itted to the facility on 3/6/17.					
	traumatic brain injury, pulmonary disease. -Order for ativan 1 mg -Physician orders for times daily (a pain me -"Insulin sliding scale"	dementia, mixed type, pressive disorder, history of and chronic obstructive three times per day.					
	1. Review of physicial revealed ativan 1.0 m	n order dated 3/8/17 g twice daily on 3/8/17.					
	Vistaril 25 mg twice d -" years ago [Reside where a steel beam la	ue ativan 1 mg and begin aily. ent #1] had an accident					
	revealed: -In 1991, he was hit ir and injured "everythin to my thighs." -Oxycodone and ativa	nt #1 on 4/11/17 at 11:25am  In the head with a steel beaming from the top of my head  In helped him "deal with" the is "head, neck, hip, and a					

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 43 of 100

Division	of Health Service Regu	lation			_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	<u>≡</u> TED
						,
			B. WING		R	
		hal002004	D. WING	······	04/2	25/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			HIGHWAY 16 SO	,		
ALEXAND	ER ASSISTED LIVING					
		IAYLORS	VILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG		200 IDENTIFY THE INTO ON INTON	TAG	DEFICIENCY)	WAIL	1
			+			
D 367	Continued From page	e 43	D 367			1
						ı
	shoulder which was o					ı
	_	our pills have gotten gone,				1
		oxycodone had gotten gone"				ı
	and he had not been	administered any for "over a				1
	week."					ı
	-He stated he was "sh	naking and hurting."				1
	-He also stated that h	ne ran out of ativan and had				ı
	been without any ativ	an for about "a week."				ı
		ribed other medications but it				1
	was ineffective for pa					ı
						ı
	Review of the control	led drug sheet for Resident				ı
	#1's ativan 1 mg reve					1
		ensed on 3/23/17 with				ı
	I	ministration from 3/24/17				ı
		IIIIIStiation nom 5/24/17	1			ı
	through 4/06/17.	-tt-for-stives 1 mg				ı
		sheets for ativan 1 mg.				ı
		ed administering ativan 1 mg				ı
	to Resident #1 for 11	days after it was				ı
	discontinued.					ı
		heet was available for the	1			1
	count down from 3/8/	17 through 3/23/17.				ı
			1			1
	Review of the Reside	nt #1's March 2017	1			1
	electronic Medication	Records (eMARs) revealed:				ı
	-Transcription of entry	y for ativan 1 mg twice daily	1			1
		with documentation of	1			1
	_	an 1 mg from 3/8/17 through				ı
		administered on 3 days and				ı
	2 ativan administered					ı
		ther entry for ativan 1 mg				ı
	twice daily at 8:00am					ı
	_	ministration from 8:00pm on				ı
		am on 3/27/17 and a "stop				ı
			1			1
		00pm" and a "DC" in bold	1			1
	letters above the entr					ı
		mg were documented on				ı
	the eMAR.					ı
	-No documentation of	f administration of ativan 1				ı

Division of Health Service Regulation

mg after 8:00am on 3/27/17.

STATE FORM 6899 V1B311 If continuation sheet 44 of 100

	AND DLAN OF CORRECTION IDENTIFICATION NUMBER		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
AL EVAND	SED ACCIOTED I IVINO	3032 N C H	IIGHWAY 16 S	оитн	
ALEXANL	ER ASSISTED LIVING	TAYLORSV	/ILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	25mg began on 3/27/4/13/17am when the of the March are view of the ativan 1 revealed 31 ativan 1 revealed 31 ativan 1 reMARs and 28 were controlled drug sheets.  Interview with the RC revealed: -She did not know whadminister ativan after eMARIt was the responsibile duty when the disconference the controlled medication off the car.  Interview with the Adr 2:30pm revealed: -He was not aware the after it was discontinuedThe computer would documented as admiras "discontinued" so the should have known it and the would monitor the street was should make t	and April 2017 eMARs and mg controlled drug sheets mg were documented on the documented on the s.  C on 4/13/17 at 3:10pm  The was discontinued on the lity of the medication aide on tinue order came in to I drug sheet and the t when it was discontinued.  The ministrator on 4/13/17 at e ativan was administered after it was entered	D 367		
		s' controlled drug sheets			
	mental health provide	3/17 at 9:30am to the or who prescribed the Vistaril Ativan was not successful.			
	4/13/17 at 4:10pm rev	vith the pharmacist on vealed 60 ativan 1 mg were ′ and 21 ativan 1 mg were			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 45 of 100

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
					R	
		hal002004	B. WING		1	5/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΧΔΝΩ	ER ASSISTED LIVING	3032 N C H	HIGHWAY 16 S	ОИТН		
ALLXAND	EN AGGIOTED EIVING	TAYLORS	/ILLE, NC 286	81	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	<del>2</del> 45	D 367			
	dispensed on 3/8/17 f	or a total of 81 Ativan.				
	with the 81 ativan 1 m ativan 1 mg on the correvealed: -Of of the 81 ativan 1 md documented on the electron -28 ativan 1 mg were controlled drug sheet mgOf the 81 ativan 1 mg accounted for on a cowere not accounted for were not accounted for 2. Review of a physic revealed Resident #1 scheduled three times tablet every 4 hours are exceed 30 mg per day.  Review of a physician revealed the oxycodo 10 mg 1/2 tablet ever mild-moderate pain are	mg dispensed, only 31 were MARs. documented on the only for Resident #1's ativan 1  g dispensed, 53 were not ontrolled drug sheet and 50 or on the eMARs. cian order dated 3/6/17 is oxycodone 10mg routinely is daily was changed to 1/2 is needed for pain not to y. in order dated 3/23/17 in end 10 mg was changed to y 4 hours as needed for ind 1 tablet every 4 hours as				
	day.	in not to exceed 30 mg per				
		/ealed:   were dispensed on 3/8/17.   were dispensed on 3/9/17.				
	Medication Administrative revealed only 19 oxyo	and April 2017 electronic ation Records (eMARs) codone 10 mg were				

Division of Health Service Regulation

which were from 3/10/17 to 4/5/17.

STATE FORM 6899 V1B311 If continuation sheet 46 of 100

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		hal002004	B. WING		04	R <b>I/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	•	ADDRESS, CITY, STATE	: ZIP CODE	1	
TO THE OT T	NOVIDEN ON OUT FEEL		C HIGHWAY 16 SOL			
ALEXANI	DER ASSISTED LIVING		RSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From pag	e 46	D 367			
	controlled drug shee -One sheet for oxyco written label with "qu staff began documer 3/15/17 at 7:00am at -The second sheet h staff documented the oxycodone from 3/42 4/6/17 8:00amNo other controlled  Comparison of the M with the 180 oxycod with the oxycodone controlled drug shee -Of of the 180 oxycod 19 were documented was no documentation was not administered -Of the 60 oxycodon controlled drug shee on the eMARs and th and justification for th dosesOf the 180 oxydodo oxycodone 10 mg wc controlled drug shee were not accounted  Interview with the Ad 2:30pm revealed: -Resident #1's physio on a Thursday aftern #1's oxycodone was -The Administrator a controlled drug shee	and antity received as 30" and antity received as 30" and antity received as 30" and antition of administration on and ended on 3/23/17 at 8pm. ad a handwritten label and a administration of 30 2/17 at 8:00am through drug sheets were available.  March and April 2017 eMARs one 10 mg dispensed and 10 mg documented on the ts revealed: done 10 mg dispensed, only don the eMARs and there on why the oxycodone 10 mg dispensed on the tonly 19 were documented on the tonly 19 were documented nerefore there was no reason he as needed narcotic for 41 me 10 mg dispensed, 120 ere not accounted for on a trand 161 oxycodone 10 mg for on the eMAR.  Iministrator on 4/13/17 at cian's assistant notified him aloon, that some of Resident missing.  Iso said some of the ts were discovered missing tion aide left after work on				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 47 of 100

Division of	of Health Service Regul	lation			1 Ordiv	IAITROVED
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		04/2	5/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	: 47	D 367			
	-Staff A never returned answer her telephone	d to work and would not calls.				
	3. Review of physicial revealed Novolog 100 before meals and at b-150-200: 2 units -201-250: 4 units -251-300: 6 units -301-350: 8 units -351-400: 10 units -401-450: 12 units and research	o units Flexpen Sliding Scale bedtime as follows:				
	3/31/17 revealed: -FSBS at 7:00am, 11: were transcribed on the No documentation of administered during the At 7:00am: 11 opports should have been adreadded and At 4:30pm: 17 opports should have been adreadded At 8:00pm: 15 opports should have been adreadded and At 8:00pm: 15 opports should have been adreadded and At 8:00pm: 15 opports should have been adreadded.	d (eMAR) for 3/7/17 through 30am, 4:30pm and 8:00pm he eMAR. frany sliding scale insulin hat time. tunities out of 21, SS insulin ministered. rtunities out of 22, SS heen administered. tunities out of 21, SS insulin ministered. tunities out of 21, SS insulin ministered. tunities out of 24, SS insulin ministered.				
	revealed:	for 4/1/17 through 4/13/17 30am, 4:30pm and 8:00pm				

were transcribed on the eMAR.

administered during that time.

should have been administered.

-No documentation of any sliding scale insulin

-At 7:00am: 6 opportunities out 12, SS insulin

-At 11:30am: 10 opportunities out of 10, SS insulin should have been administered.

STATE FORM V1B311 If continuation sheet 48 of 100

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R	,
		hal002004	B. WING		1	5/2017
					, , , , , , ,	0.2011
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC			
• • • • • • • • • • • • • • • • • • •		TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page		D 367			
	-At 4:30pm: 7 opporti	unities out of 8, SS insulin				
	should have been add	ministered.				
		tunities out of 12, SS insulin				
	should have been ad	ministered.				
	L-4amilaw with the De	-id-at Core Coardinator				
	(RCC) on 4/12/17 at 3	sident Care Coordinator				
	` ′	ot allow for her to enter the				
		ministered for sliding scale				
		document the administration				
	of SS insulin on pape					
	-There was no paper					
		documented that SS insulin				
	was administered to F admission.	Resident #1 since				
		had administered for SS				
	insulin but she did no					
	medication aides had					
		ed the inability to document				
		pharmacy but the staff				
	person she spoke to					
	_	sident on sliding scale				
	insulin and the eMAR					
		administration of SS insulin				
	for that resident.					
	Telephone interview v	with Staff B, medication aide,				
	revealed she also cou					
		insulin on the eMAR and				1
	there was no paper M	MAR in place to document in				1
	SS insulin.					1
	l <del> </del>	20.00				1
		with the pharmacy on				1
	4/13/17 at 4:10pm rev	vealed. e the facility could not				1
		for Resident #1 until 4/12/17				1
	during the survey.	To resident // Farth 1/12/17				1
		e to call them to make				1
	changes to the eMAR	R system for entering SS				1

STATE FORM 6899 V1B311 If continuation sheet 49 of 100

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STATE	ZIR CODE	,
NAME OF T	NOVIDEN ON 3011 EIEN		HIGHWAY 16 SOL		
ALEXAND	DER ASSISTED LIVING		SVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	e 49	D 367		
	2:30pm revealed: -He was not aware m documenting the adm Resident #1The RCC was respo medications could be the eMARsThe RCC should have assure the eMAR was insulin for Resident #  Interview with Reside revealed: -He was getting his F been administering the did not know if the document of the warm of	and were documented on we called the pharmacy to s set up to document SS 1.  nt #1 on 4/14/17 at 11:25am SBSs and the staff had			
	revealed: -Diagnoses included prostateA physician order for day 7am, 2:00pm, an pain)A physician order for 12 noon, 4 pm, and 8 -A physician order for per day.  Interview with Reside 2:00pm revealed:	chronic pain and enlarged Endocet 10/325 3 times a d 9pm (used for chronic methadone 10 mg at 8am, pm. Flexeril 10mg three times ant #3 on 4/12/2017 at dose Endocet "yesterday" at			

-He stated he also ran out of Endocet sometime in March 2017, date not known, but the family brought in 2 tablets and the Resident Care

STATE FORM 6899 V1B311 If continuation sheet 50 of 100

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		hal002004	B. WING		04/25/2017
					1 0-1/20/2011
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S		
		TAYLOR	SVILLE, NC 286	81	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 367	Continued From page	. <b>E</b> O	D 367		
D 301	Continued From page	30	507		
		dministered them to him.			
		e the Endocet was out and			
		t tablets for him that had			
	I	scribed for another family			
	member.	e his pain medication, his			
		or over" on a pain scale			
	ranging 1-10.	or over on a pain scale			
	-He was scared to tak	ke the medication the			
		giving him because he was			
		they were giving him, but he			
	took the medication a				
	-He had ran out of bo	th medications in the past			
	but did not know the	dates.			
		1.1101-15-11			
	4/13/2017 at 11:00am	nt #3's family member on nrevealed:			
	-In the past, about "2-	-3 weeks ago," Resident			
	_	ed of missing Endocet.			
		amily reported the RCC had			
		ndabout way, to bring in			
		sident #3 was running out.			
		esident #3 had run out of s 3-4 times within the last 6			
	months but the dates				
		ed Resident #3 had been at			
		out 5 years ago, and had the			
	same issues with his	medications.			
		edications on hand for			
		17 at 2:20pm revealed no			
	Endocet 10/325 avail	able in the medication cart.			
	Interview with the DC	C on 4/11/17 at 2:20nm			
		C on 4/11/17 at 2:20pm had been ordered and			
	would be "in tonight."				
	Interview with the RC	C on 4/12/17 at 9:00am			

revealed the Endocet did not come in on 4/11/17

because the physician had to send in a

STATE FORM 6899 V1B311 If continuation sheet 51 of 100

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			B. WING		R	
		hal002004	B. WING	······	04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286			
			SVILLE, NC 200			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
D 367	Continued From page	e 51	D 367			
	nrescription but that i	it would be in today				
	prescription, but that it would be in today.					
	Interview with the RO	CC on 4/13/17 at 9:45am				
		came in the tote last night.				
	Tovodiod tilo Elidooot	dame in the tota last might.				
	Review of Resident #	3's Endocet 10/325				
	controlled drug sheet					
	-There were no contro					
		at 7:00am through 3/14/17				
	at 9:00pm.					
	· '	sheet documented 90				
		sed on 3/15/2017 with				
	documentation that 7					
		5/17 at 7:00am to 4/11/17				
	at 12:00pm with 0 bal					
		which revealed 10 Endocet				
		ed on 4/12/17 and first				
	documented as admir	nistered on 4/12/17 at				
	9:00pm.					
	-No documentation of	fany Endocet administered				
		n through 3/14/17 at 9:00pm				
	for a total of 96 doses	s not documented as				
	administered.					
		rolled drug sheet labeled as				
	•	n 3/15/17 which began with				
		ninistration on 3/15/17 at				
		ith a 0 balance on 4/11/17 at				
	•	of 10 Endocet 10/325 tablets				
	were documented as					
		ig sheet which began with				
		ninistration on 3/15/17, staff				
		administration of Endocet to				
		asions when they were				
	documented as waste	ed.				
		W W DOO				
		vith the RCC on 4/24/17 at				
	2:29pm revealed:	D :1 1 //0 :				
	-She did not know wh	y Resident #3 was not				

was wasted.

administered Endocet at least 4 times when one

STATE FORM 6899 V1B311 If continuation sheet 52 of 100

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		h = 1000004	B. WING		R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			HIGHWAY 16 S		
ALEXAND	ER ASSISTED LIVING				
		IAYLURS	VILLE, NC 286	81	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-1-)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	NEGOLATORT OR L	ESCIDENTIF TING IN CINIATION)	TAG	DEFICIENCY)	MAIL SINE
			+	,	
D 367	Continued From page	e 52	D 367		
		dication aide, who used to			
	work there, wasted 6	Endocet.			
	Review of the Februa	ry, March and April 2017			
	electronic Medication	Administration records			
	(eMARs) revealed:				
	-Endocet 10/325 was	transcribed to be			
	administered three tin	nes daily, at 7:00am,			
	12:00pm and 9:00pm				
	-Documentation Resid	dent # 3 was administered			
	his Endocet 10/325 as	s ordered.			
	Telephone call on 4/2	0/17 at 1:24pm to Staff A, a			
		no longer worked at the			
	facility, was not succe	•			
	radinty, was not succe	, oct al.			
	Interview with the RC	C on 4/13/17 at 11:15am			
	revealed:	0 011 4/ 10/ 17 at 11.10am			
		out of Endocet in March,			
	date not known.	out of Endocet in March,			
		ought in 2 Endocet which she			
	administered to Resid	_			
	auministered to Nesic	Jent #3.			
	Intomious with the Adr	ministrator on 4/13/17 at			
		Tillistrator on 4/15/17 at			
	2:15pm revealed:	off wore not dealers atting			
		aff were not documenting			
		Endocet correctly on the			
	eMAR.				
		aff had wasted 10 Endocet.			
		e controlled drug sheets and			
	assure the eMARs we	ere accurate			
	2. Review of the Janu				
		ation Records (eMARs)			
	revealed:				
	-Methadone 10 mg wa				
	administered at 8:00a	am, 12:00pm, 4:00pm, and			
	8:00pm.				

Division of Health Service Regulation

-Methadone 10 mg was not documented as administered on 1/15/17 at 12:00pm, 4:00pm and

STATE FORM 6899 V1B311 If continuation sheet 53 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711012111	or Contraction	BENTI IO/MISINIBEN	A. BUILDING: _		0011111	_1
		hal002004	B. WING		F	
		hal002004	1		1 U4/2	25/2017
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
ALEXANDER ASSISTED LIVING			HIGHWAY 16 S VILLE, NC 286			
0/4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	.I	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	÷ 53	D 367			
	7:00pm and on 1/17/	17 at 8:00am.				
	controlled drug sheet 10 mg dispensed on -Documentation as m administered from 12 1/15/17 at 9pm with 8 -Staff documented the methadone 10 mg on 4:00pm, and 7:00pm although all 4 doses of MAR.  Review of the March revealed methadone documented to be ad the exception of 4/4/1	nethadone 10 mg /18/17 at 8:00am through 8 remaining. e administration of 1/15/17 at 12:00pm, and on 1/16/17 at 7:00am, were not documented on the and April 2017 eMARs 10 mg was transcribed and ministered 4 times daily with				
	mg from 2/24/17 at 7: 7:00pm for a total of 8 -One sheet had 120 r	ninistration of methadone 10 00am through 3/23/17 at 37 doses not accounted for methadone dispensed on				
	beginning on 3/24/17 at 8:00am with a bala -On 3/24/17 there wa	ted the administration of 30 at 8:00am through 4/10/17 unce of 0. s no documentation of ministered at 12 noon.				
	documented as adminoon and at 4:00pmNo documentation for	or any administration of 3/26/17 through 4/2/17 at				
		vere not documented as controlled drug sheets from 1/17.				

Division of Health Service Regulation

-A current controlled drug sheet with a

STATE FORM 6899 V1B311 If continuation sheet 54 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.11.2.1.2.11.1		.5	A. BUILDING: _	A. BUILDING:		
		hal002004	B. WING		R <b>04/25/20</b> 1	17
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 S			
	QUILLEN/ QT		ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 367	Continued From page	e 54	D 367			
	handwritten label reve	ealed a beginning quantity of with documentation of 1/16 at 11:50am with				
	sheets compared to the eMARs, 122 doses w	done 10 mg controlled drug he March and April 2017 ere documented on the entation of administration on et.				
	Telephone interview v 4/17/17 at 3:15pm rev methadone were disp -120 on 12/16/17. -120 on 1/14/17. -120 on 2/14/17. -120 on 3/16/17. -12 on 4/15/17.	vealed the following				
	revealed: -She did not know wh administered methade-She did not know wh	y the methadone was not MARs but was documented				
	2:15pm revealed: -He would monitor the assure the MARs wer -He was not aware m					
		ch and April 2017 electronic ation Records (eMARs) eril 10 mg to be				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 55 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				B. WING		
		hal002004	B. WING		04/25/2	2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
AL EVAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	DUTH		
ALEXAND	ER ASSISTED LIVING	TAYLOR	SVILLE, NC 2868	31		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE 0	(X5) COMPLETE DATE
D 367	7 Continued From page 55		D 367			
	administered at 7:00am, 12:00pm, and 8:00pm.  -A total of 53 Flexeril were documented as administered from 3/14/17 through 4/6/17.  Observations of medications on hand on 4/11/17 at 2:20pm revealed 10 Flexeril remaining in a cassette which were dispensed on 4/6/17.  Interview with the RCC on 4/11/17 at 2:30pm revealed:  -She had administered Flexeril to Resident #3 but sometime the eMAR would not allow her to document the administration.  -She had not kept any paper documentation of the administration of Flexeril to Resident #1.  -She did not know if the other medication aides were documenting the Flexeril on the eMAR.  -She had called the pharmacist about the eMAR not allowing the documentation of Flexeril but that staff person no longer worked at the pharmacy.					
	aide when she admin Interview with the Adr 2:15pm revealed: -He was not aware be problem with docume -The RCC should hav was a problem with e -He understood the e documentation of Fle noon and the medica it on the MAR earlier Comparison of the nu	Id the next shift medication istered Flexeril.  ministrator on 4/13/17 at efore the survey there was a inting Flexeril. We call the pharmacy if there entry on the eMAR.  MAR would not allow for the exeril if it was ordered at 12 tion aides attempted to enter than 12 noon.				
	the number documen	acist interview compared to ted on the March and April xeril on hand revealed of the				

Division of Health Service Regulation

106 Flexeril dispensed, 43 Flexeril were not

STATE FORM 6899 V1B311 If continuation sheet 56 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			E SURVEY PLETED	
		hal002004	B. WING		04	R J/ <b>25/2017</b>
					1 0-	123/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ALEXAND	ER ASSISTED LIVING		SHIGHWAY 16 SOU SVILLE, NC 28681			
(V4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 367	Continued From page	e 56	D 367			
	accounted for.					
	revealed they were n entering Flexeril into had any problems en Resident #3's prn Fle Interview with Reside	with 2 medication aides of aware of the problem with the eMARs and had never stering the documentation of exeril on the eMAR.  ent #3 on 4/13/17 at 4:45pm we Flexeril but did not know				
	4/18/17 at 10:20am r -The eMAR would no Flexeril if the medical administer it before th -The facility had never notify them the Flexe on the eMARA total of 106 Flexer 3/14/17 to 4/6/17On 3/14/17, 16 Flexer -On 3/20/16, 30 Flexer -On 3/27/17, 30 Flexer -On 4/6/17, 30 Flexer -The Flexeril were dis facility requested their	ot allow documentation of tion aides were attempting to the time of order allowed it. For contacted the pharmacy to will could not be documented all were dispensed from the time of order allowed it. For contacted the pharmacy to will were dispensed from the time of time of time of time of the time of time				
	ativan, and oxycodor electronic Medication (eMARs) and the failudrug sheets placed R of medications in que	ent sliding scale insulin, ne on Resident #1's a Administation Records ure to maintain all controlled Resident #1's administration estion. No documentation of ulin was on the eMARs for				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 57 of 100

PRINTED: 05/17/2017 FORM APPROVED

Division of Health Service Regulation

DIVISION	or riealin Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			1		1	_
					F	₹
		hal002004	B. WING	<del></del>	04/2	25/2017
NAME OF D	DOVIDED OD CURRUED	CTREET AR	DDECC CITY CTA	TE 710 CODE		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ΔΙ ΕΧΔΝΓ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH		
7122701112	211710010125 2111110	TAYLORS	VILLE, NC 286	81		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 367	Cantinuad Frame name		D 367			
D 307	Continued From page	9 57	D 307			
	the 5 weeks Resident	#1 was in the facility. Out of				
	81 ativan 1 mg disper					
		nistered on the eMAR and				
		ontrolled drug sheet. Of the				
		g dispensed, 120 oxycodone				
		unted for on a controlled				
		xycodone 10 mg were not				
	accounted for on the					
		on documented for the as				
	needed oxycodone for	r 41 times when it was				
	documented as admir	nistered from the controlled				
	drug sheet. The e MA	Rs are designed to only				
	allow the documentat	ion of as needed				
	medications within the	e allowed time frame.				
	Resident #3's Endoce	et 10/325 was documented				
		nely on the eMARs but the				
		s did not account for 123				
	_	nonths. The methadone for				
		led drug sheets had no				
	documentation for the	•				
		oses for 13 weeks but they				
		the eMARs, 43 Flexeril 10				
	_	ed for on the eMARs. This				
		racy for the documentation				
		edications for Resident #1				
	and #3 was detriment	tal to the health, safety and				
	welfare of the residen	its and constitutes a Type B				
	Violation.					
	The Plan of Protection	n provided by the facility on				
	4/12/17 revealed:					
	-The facility will review	w the medication cart for				
		remove them and return				
	them to the pharmacy					
		view will be completed by the				
		new will be completed by the				
	pharmacy.	day, and assessed to 60				
		view and comparisons of the				
		pe completed and monitored				
		Director on a weekly basis.				
	-Discontinued medica	itions will be pulled off the				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 58 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		3032 N C	HIGHWAY 16 SO	ОИТН	
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	e 58	D 367		
	receivedThe residents' charts we are not giving med and will be monitored weekly basis.  CORRECTION DATE	iscontinued orders are s will be reviews to assure dications without an order by the Administrator on a E FOR THIS TYPE B NOT EXCEED JUNE 9,			
D 392		3(a) Controlled Substances	D 392		
	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 TYPE B VIOLATION	as evidenced by:			
	reviews, the facility fa	ere available to account for trolled substances docet, methadone, n,) and to ensure an n of those controlled sampled residents			
	The findings are:				
	A. Review of Residen 7/29/16 revealed:	at #6's current FL-2 dated			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 59 of 100

Division of Health Service Regulation					
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 392	Continued From page	: 59	D 392		
	fibrillationMedications included (a narcotic medication take 1 tablet three times that the tablet three times that tablet the tablet t	de, hypertension and atrial def Hydromorphone 2mg tablet in used to treat severe pain), hes per day (TID).  at 2:30pm with Resident #6  If the time." what medications he was after taking his pain at he was pain free, but not be was getting the he was supposed to.  and care aide on 4/13/17 at the smilling and in a better as pain medications." medications, he said, "he and he got "irritable."  at order for Resident #6 and: morphone is a generic form as daily (TID) for pain,			

needed for pain.
-Quantity ordered 56.

Review of a subsequent physician's order for Resident #6 dated 11/7/16 revealed :

-Dilaudid 2mg (hydromorphone is a generic form used for Dilaudid) one tablet every 6 hours as

STATE FORM 6899 V1B311 If continuation sheet 60 of 100

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		h - 1000004	B WING		R	
		hal002004	B. WiiNO		04/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	ОИТН		
		TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 60	D 392			
	dated 1/21/17 which of all the company of the pain.  -Quantity 105 tablets  Interview on 4/13/17 are sident Care Coording of the Hospice Nurse of the pain of the pain of the pain of the pain of the pharmacy.  Telephone interview of 4/13/17 at 2:15pm reversed the pharmacy.  Telephone interview of 4/13/17 at 2:15pm reversed the pharmacy.  Telephone interview of 4/13/17 at 2:15pm reversed the pharmacy.  The facility received Resident #6 on 2/6/17 and the pharmacy.  The facility received for Resident #6 on 2/28/17 and the pharmacy.  The facility received for Resident #6 on 3/13/17 and the pharmacy of the pharmacy.	es per day scheduled and every 6 hours as needed for (45 tabs) (60 tabs).  at 10:00am with the inator (RCC) revealed: here were any additional 6's Hydromorphone. gets the hospice doctor to and they send the order to vith the facility pharmacy on vealed: 30 Hydromorphone 2mg for 7.  75 Hydromorphone 2mg for 7.  105 Hydromorphone 2mg for 17.  60 Hydromorphone 2mg for 17.  60 Hydromorphone 2mg for 17.  105 Hydromorphone 2mg for 17.  105 Hydromorphone 2mg for 17.  105 Hydromorphone 2mg 22/17.  105 Hydromorphone 2mg 7/17.				
	Review of the Februa generated Medication (MAR) for Resident #	Administration Record				

Division of Health Service Regulation

-Hydromorphone 2mg tablet one tablet three

STATE FORM 6899 V1B311 If continuation sheet 61 of 100

Division of	Division of Health Service Regulation						
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE		
			P WING		R		
		hal002004	B. WING		04/2	5/2017	
NAME OF PRO	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
ALEXANDE	R ASSISTED LIVING		HIGHWAY 16 SC				
			SVILLE, NC 2868	81			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 392 (	92 Continued From page 61		D 392				
t	imes daily. The scheduled admir documented as 8:00a. Documentation show out of 84 opportunities lydromorphone. Hydromorphone 2mg nours PRN for pain. The Hydromorphone 44 times as administed tocumented as admir Review of the March 200 MAR for Resident #6. Hydromorphone 2mg The scheduled admir documented as 8:00a. Documentation show out of 93 opportunities lydromorphone. Hydromorphone 2mg nours PRN for pain. The Hydromorphone 2mg nours PRN for pain. The total number of ledocumented as admir Review of the April 200 MAR for Resident #6. Hydromorphone 2mg daily. The scheduled admir documented as 8:00a.	mistration times were am, 2:00pm and 8:00pm. and 84 times administered as for the scheduled by tablet 1 tablet every 6  2mg PRN was documented ared. Hydromorphone 2mg tablets histered were 128 tablets.  2017 pharmacy generated revealed: a, 1 tablet three times daily. histration times were am, 2:00pm and 8:00pm. and 55 times administered as for the scheduled by tablet 1 tablet every 6  2mg PRN was documented and additional area of tablets histered were 64 tablets.  2nd pharmacy generated arevealed: a) tablet on tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three times anistration times were and a side of tablet three anistration times were and a side of tablet three anistration times were and a side of tablet three anistration times were and a side of tablet three anistration times were and a side of tablet three anistration times were and a side of tablet three anistration times were					

-Documentation showed 10 times the medication was not administered because 'Med Not on Cart'. -Hydromorphone 2mg, 1 tablet every 6 hours

STATE FORM 6899 V1B311 If continuation sheet 62 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	COMP		(X3) DATE SUF	
, and I LAW	. Controll	SEATH IS A ISIA NOMBER.	A. BUILDING: _			
		hal002004	B. WING		R <b>04/25</b> /	/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
	TAYLORSV		/ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 62	D 392			
	1 time as administere -The total number of I documented as admin	Hydromorphone 2mg tablets nistered were 25 tablets.				
	Review of a controlled substance count sheet for Hydromorphone 2mg revealed:  -The start count number was 105.  -A dispense date of 4/7/17.  -There were 28 doses documented as administered.					
	-The remaining amou hand.	nt indicated 77 tablets on				
		norphone 2mg for Resident cart revealed 77 tablets				
	#6's Hospice Nurse re -[Resident #6 Name] she came into the fac -She had "recently" st	appeared to be in pain when				
	documented: -No complaint of pain	nursing note dated 3/31/17 at this time. palize pain, no nonverbal				
	documented:					

Division of Health Service Regulation

Review of a hospice nursing note dated 4/7/17

STATE FORM 6899 V1B311 If continuation sheet 63 of 100

Dividion (	of Health Service Regu	lation			
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	V-1-01-01-
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 SC		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 392	Continued From page	<del></del>	D 392		
	_	ant to be transferred'.			
	in February, 128 were 142 unaccounted forThe pharmacy sent 2 in March 2017, 64 we leaves 146 unaccoun -The Pharmacy sent in April 2017, 28 were on hand which leaves	210 Hydromorphone tablets ere administered which sted for. 105 Hydromorphone tablets e administered and 77 were			
	2mg tablets was 288.  B. Review of Residen revealed: -Diagnoses included prostateA physician order for day 7am, 12 noon, ar pain).	nt #3's FL2 dated 1/2/2017 chronic pain and enlarged Endocet 10/325 3 times a nd 9pm (used for chronic			
	12 noon, 4 pm and 8 Interview with Reside 2:00pm revealed: -He received his last of 12 noonHe stated he also rate in March, 2017, date member brought in 2 prescribed for that far	ent #3 on 4/12/2017 at  dose Endocet "yesterday" at  n out of Endocet sometime not known, but a family tablets Endocet that was			

them to him.

-If he does not receive his pain medication, his

STATE FORM 6899 V1B311 If continuation sheet 64 of 100

Division o	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					_	,
		h-1000004	B. WING		F	
		hal002004			04/2	25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	ATE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXANDER ASSISTED LIVING TAYLORS		VILLE, NC 286	81			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ON	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
D 392	Continued From page	e 64	D 392			
	[ · · · ·	or over" on a pain scale				
	ranging 1-10.	co the a meadination that the				
		ke the medication that the				
		because he was not always				
		giving him, but he took the				
	medication anyway.					
	1 Observations of my	adjections on band for				
		edications on hand for				
		17 at 2:20pm revealed no able in the medication cart.				
	Endocet 10/323 avail	able in the medication cart.				
	Interview with the RC	C on 4/11/17 at 2:20pm				
		had been ordered and				
	would be "in tonight."					
	would be in tonight.					
	Interview with the RC	C on 4/12/17 at 9:00am				
	revealed the Endocet	did not come in on 4/11/17				
	because the physicial	n had to send in a				
	prescription, but that i					
	· · · ·	,				
	Interview with the RC	C on 4/13/17 at 9:45am				
	revealed the Endocet	came in the tote last night.				
	Review of Resident #	3's Endocet 10/325				
	controlled drug sheets					
		ted 90 were dispensed and				
	documentation of adn					
	12/19/16 through 1/18	3/17 with a remaining				
	balance of 0.					
	-Another sheet docun					
		and documentation of				
	_	on 1/18/17 through 2/10/17				
		maining balance of 18.				
	-There were no contro	<u> </u>				
	Endocet 10/325 from	2/11/17 at 7:00am through				
	3/14/17 at 9:00pm.					
		sheet documented 90 were				
	dispensed on 3/15/20	017 with documentation that				
	76 Endocet 10/325 w	ere administered from				

Division of Health Service Regulation

3/15/17 at 7:00am to 4/11/17 at 12:00pm with 0

STATE FORM 6899 V1B311 If continuation sheet 65 of 100

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
			7. BOILBING:			R
		hal002004	B. WING		04	1/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	7 IP CODE	·	
TO WILL OF T	NOVIBER OR OUT FIER		C HIGHWAY 16 SOL			
ALEXAND	DER ASSISTED LIVING		RSVILLE, NC 28681			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
D 392	Continued From pag	e 65	D 392			
	balance.					
		which revealed 10 were				
	_	7 and first documented as				
	administered on 4/12					
		of any Endocet 10/325 were				
		11/7 at 7:00am through				
		r a total of 96 doses not				
	documented as admi					
	Review of pharmacy delivery sheet revealed 90					
	Endocet 10/325 were	e delivered on 2/14/17 but the				
	controlled drug shee	t for was missing for that				
	delivery.					
	Review of the contro	olled drug sheets with				
		ensed on 1/14/17 with 18				
	-	issing controlled drug sheet				
	_	ndocet 10/325 on 2/14/17, a				
	1	10/325 were not accounted				
	for from 1/14/17 thro	ugh 3/14/17.				
	Boylow of the Boolds	ent #3's Endocet 10/325				
	controlled drug sheet					
	dispensed on 3/15/1					
	I	ministration on 3/15/17 at				
		vith a 0 balance on 4/11/17 at				
	12:00pm revealed:	mira o balance en li il il il ac				
	· •	et 10/325 tablets were				
	documented as wast	ed on the sheet with no				
	reasons why 9 of the	10 Endocet were wasted.				
	1	ent the administration of				
	Endocet 10/325 to R	esident #3 on 6 occasions				
	when they were docu					
		ere made with the count				
		et 10/325 was administered				
		nding count went down by 2				
	from the beginning of					
		he 90 tablets dispensed were				
		inistered which is 4 Endocet				
	10/ 325 not accounte	ed for on the controlled drug				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 66 of 100

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
,	o. oo	152.111.16/11.1611.1161.152.11	A. BUILDING:			
		hal002004	B. WING		04	R / <b>/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	. ZIP CODE		
			HIGHWAY 16 SOU			
ALEXAND	DER ASSISTED LIVING		SVILLE, NC 28681			
0(1) 15	CHMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 66	D 392			
	sheet for this time fra	me.				
	Review of the March and April 2017 eMARs revealed methadone 10 mg was transcribed and documented to be administered 4 times daily with the exception of 4/4/17 at 7:00am.					
		0/17 at 1:24 pm to Staff A, no longer worked there, was				
	Telephone interview with Staff B, medication aide, on 4/25/17 at 11:51 am revealed that on 3/25/17 at 12 noon when she initialed the administration of 1 Endocet administered, she was training and the RCC documented the beginning and ending balance and she only initialed the sheet as administering, and she was not aware the ending balance was off.					
	2:29pm revealed: -She wasted one tabl another residents val -The one Endocet do 3/20/17 was not wast not know why she ha wasted.	cumented as wasted on ed but administered but did d documented it was  y she changed the balance				
	8:00pm, on on 3/22/1 -She could not remen on 3/25/17 at 12 noor balance by 2 when 1 by a trainee, Staff DShe did not know wh through 3/30/17 at 8:0 count on the left side Staff A had document	7 at 7:00am and at noon.  The result of the count dropped the dropped the count dropped the count dropped the of the page after she and				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 67 of 100

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
741012741	or contraction	IDENTIFICATION TO A TOTAL TOTAL TO A TOTAL TOTAL TO A TOTAL TOTAL TO A TOTAL TOTA	A. BUILDING: _			
		hal002004	B. WING		04/2	? :5/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΥΔΝΩ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	ОИТН		
ALLXAND	EN AGGIGTED EIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 67	D 392			
	3/31/17 at 4:00pm was wrong time.  -The one Endocet do 8:00pm with "no wast second entry docume administered at the scame down by 1 both -She did not know who used to work the Review of the Januar electronic Medication (eMARs) revealed:  -Transcription of the a 10/325 three times down december and 9:00pm.  -Documentation Resistendocet 10/325 as or Review of the methad sheets compared to the emandation of the analysis of the methad sheets compared to the emandation of the eman	cumented on 3/31/17 at the was wasted because a sented another Endocet arme time and the count of times.  By Staff A, medication aide, re, wasted 6 Endocet.  The ythrough April 2017  Administration of Endocet aily, at 7:00am, 12:00pm,  Ident # 3 received his redered.  Idene 10 mg controlled drug the March and April 2017  Fiere documented on the the tentation of administration on the tentation of administration of administra				
	last through 4/15/17They do no usually p they know the last de	orescribe narcotics when livery should not be out.				

Division of Health Service Regulation

-They went to the pain clinic on 4/12/17 and

STATE FORM 6899 V1B311 If continuation sheet 68 of 100

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
744012744	or contraction	ISENTI ISATION NOMBER.	A. BUILDING: _	<del></del>	OOM ELTED
			D MANO		R
		hal002004	B. WING		04/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
AI EYAND	ED ASSISTED I IVING	3032 N C	HIGHWAY 16 SC	DUTH	
ALEXANDER ASSISTED LIVING TAYLOR			SVILLE, NC 286	81	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE DATE
D 000			D 000		
D 392	Continued From page	2 68	D 392		
		3 a new prescription for the			
	Endocet because he				
		-3 weeks ago," Resident			
		ed of missing Endocet.			
		amily reported the RCC had ndabout way to bring in			
		sident #3 was running out.			
		esident #3 has ran out of			
	•	within the last 6 months.			
	-Family stated that Re	esident #3 has been at the			
		years ago and has had the			
	same issues.				
	Interview with the RC	C on 4/13/17 at 11:15am			
	revealed:	0 011 47 107 17 at 11.10aiii			
		out of Endocet in March,			
	date not known.				
	<del>-</del>	prought in 2 Endocet which			
		Resident #3 in a small white			
	container.	a controlled drug about for			
		e controlled drug sheet for when Resident #1 ran out			
	of Endocet.	when resident #1 fair out			
		administration of the 2			
		but not on a controlled drug			
	sheet.				
	Intonvious with the Ad-	ministrator on 4/13/17 at			
	2:15pm revealed:	iiiiisuatoi oii 4/13/17 at			
	•	ealize there was that much			
	waste or I would have				
		itten policy for staff wasting			
		licy is "a common sense			
	policy" to have a with				
	-He plans to write a p	,			
		l consequences for staff			
	who routinely waste r	arcotice	1		1

-He was not aware staff wasted 10 Endocet or that the counts went down by more than 1 when

just 1 dose was administered.

STATE FORM 6899 V1B311 If continuation sheet 69 of 100

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		hal002004	B. WING		04/25/2017
					1 04/20/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
ΔΙ ΕΧΔΝΟ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH	
ALLXAND	EN AGGIOTED ENTING	TAYLORS	SVILLE, NC 286	81	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
TAG	REGOLATORY OF	is in the intervention,	TAG	DEFICIENCY)	WILL
			+		
D 392	Continued From page	e 69	D 392		
	-He did not have a wr	ritten policy how to handle			
		ntation which were brought			
		on admission, but he or the			
	RCC was responsible				
		unted and the documentation			
	remained on file.				
	-He would change the	e medication aides			
	procedure when they	did shift count by assuring			
	that the medication a	ide going off duty and the			
	one coming on duty in	nitialed the balance so that			
	no changes could be	made to the controlled drug			
	sheet after a mediation	on aide's documented.			
	-He would require the	e medication aides lock up			
	any wasted medication	on for him to observe before			
	they were wasted.				
		e controlled drug sheets.			
		e family brought in the 2			
		#3 for staff to administer.			
	-Their policy did not a				
		ministered to the residents.			
		he pharmacy delivery sheets			
		ts' controlled drug sheets			
	because "they were s	scattered all around."			
	2 Poviou of Posidor	nt #3's methadone controlled			
	drug sheets revealed				
	•	nethadone 10 mg dispensed			
		umentation as administered			
		am through 1/15/17 at 9pm			
		no documentation of any			
	_	ministered for 4 times of			
	administration.				
		heets between 1/16/17 at			
	8:00am through 1/18/				
	-One sheet had 120				
	dispensed on 1/18/17	•			
	•	"30" with documentation as			
		18/17 at 7:00am through			

1/24/17 at 12 noon with a balance of 4.

-One sheet had 120 methadone 10 mg dispensed

STATE FORM 6899 V1B311 If continuation sheet 70 of 100

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					l R	,
		hal002004	B. WING		1	5/2017
NAME OF D		CTDFFT AF	ADDESS CITY STA	TE ZID CODE	•	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ALEXANDER ASSISTED LIVING			HIGHWAY 16 SC SVILLE, NC 286			
040.15	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 392	Continued From page	e 70	D 392			
	with it marked out and	d 90 handwritten in with				
		ninistration beginning on				
		nd ending on 2/16/17 at 12				
	noon with a balance of					
	-On the controlled dru	ig sheet with documentation				
		nning on 1/25/17, 4 doses				
	•	ere not documented as				
	administered.					
		ug sheet with documentation				
	_	nning on 1/25/17, 3 doses				
	methadone were was	nethadone 10 mg dispensed				
		0 marked out with a "30"				
	with documentation o					
		ough 2/23/17 at 9:00pm				
	with a balance of 0.					
	-There were no metha	adone 10 mg controlled drug				
	sheets from 2/24/17 a	am through 3/23/17 at				
	8:00pm for a total of	116 doses.				
		nethadone 10 mg dispensed				
		nented the administration of				
		/17 at 8:00am through				
	4/10/17 at 8:00am wit					
		10 mg controlled drug sheet				
		one dispensed on 3/16/17 fadministration beginning				
	on 3/24/17 and ending					
		ig sheet which documented				
		methadone 10 mg beginning				
	on 3/24/17 revealed 4	0 0				
		nistered and 1 dose was				
	wasted.					
	Telephone interview v					
	4/17/17 at 3:15pm rev					
	methadone 10 mg we	ere dispensed as follows:				

-120 on 1/14/17 -120 on 2/14/17 -120 on 3/16/17

STATE FORM 6899 V1B311 If continuation sheet 71 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
		hal002004	B. WING		R <b>04/25</b> /	/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ΔΙ ΕΧΔΝΩ	ER ASSISTED LIVING	3032 N C F	IIGHWAY 16 S	ОИТН			
ALLXAIL	TAYLORS		/ILLE, NC 286	81			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 392	Continued From page	e 71	D 392				
	-12 on 4/15/17						
		ations on hand on 4/11/17 at nethadone 10 mg was					
	Resident #3's methad the documentation or methadone were not drug sheets: -8 remaining methado -4 remaining methado -116 methadone dose controlled drug sheet through 3/24/17 at 8:0 -4 doses not docume controlled drug sheet	one on 1/24/17. es not documented on a from 2/24/17 at 9:00pm 00am. nted as administered on the which began on 3/24/17.  y through April 2017 ation records revealed ent # 3 received his					
	2:15pm revealed: -He did not have a wr narcotics but their pol policy" to have a with -He plans to write a p wasting narcotics and who routinely waste r -He would change the procedure when they that the medication ai one coming on duty in no changes could be	olicy addressing staff I consequences for staff parcotics.					

Division of Health Service Regulation

-He would require the medication aides lock up any wasted medication for him to observe before

STATE FORM 6899 V1B311 If continuation sheet 72 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI E	CONSTRUCTION	(X3) DATE SI	IRVEV		
	OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		COMPLETED		
			A. BUILDING: _	A. BUILDING:			
			2 14416		R		
		hal002004	B. WING		04/2	5/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		3032 N C	HIGHWAY 16 S	ОИТН			
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 392	Continued From page	e 72	D 392				
D 392	they were wastedHe would monitor the -They could not find the and all of the resident because "they were s  C. Review of Resident revealed he was adm  Review of Resident # revealed: -Diagnoses included of hepatitis C, major deg a TBI (traumatic brain obstructive pulmonary -Physician orders for	e controlled drug sheets. he pharmacy delivery sheets is' controlled drug sheets cattered all around."  It #1's Resident Register itted to this facility on 3/6/17.  I's FL2 dated 3/6/17  dementia, mixed type, pressive disorder, history of a injury), and chronic y disease. ativan 1 mg three times	5392				
	-Physician orders for ativan 1 mg three times daily (used for anxiety)Physician orders for oxycodone 10 mg three times daily (pain medication).  Interview with Resident #1 on 4/11/17 at 11:25am revealed: -In 1991, he was hit in the head with a steel beam and injured "everything from the top of my head to my thighs." -He "hurts all the time" and oxycodone and the ativan helped him deal with the pain which included his "head, neck, hip, and a shoulder which was out of socket." -The RCC told him "your pills have gotten gone, two weeks supply of oxycodone had gotten gone" and he had not been administered any for "over a week." -He stated he was "shaking and hurting." -He also stated that he ran out of Ativan and had been without any Ativan for about "a week." -The physician prescribed other medications but it was ineffective for pain and anxietyThe female physician told him last Thursday she would write prescription for other medications to						

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 73 of 100

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:		
		hal002004	B. WING		04	R <b>//25/2017</b>
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N (	ADDRESS, CITY, STATE	JTH	·	
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	try to control his pain not working."  Interview with the RC revealed that Resider hospital that morning  Review of Resident # records from visit from revealed:  -Other diagnoses included abdominal pain, and defined the last course medication] were stol refillAs result his pattried to put up with for says that he had been the last couple of day worse. Today he coul painhe also describ neck back to lower expound that worsenedH pancreatitis."  1. Review of a physic revealed the oxycodos scheduled three times tablet every 4 hours a exceed 30 mg per day.  Review of physician of the oxycodone 10 mg tablet every 4 hours a pain, 1 tablet every 4 pain not to exceed 30.  Review of the pharma Resident #1's oxycodos.	and anxiety, but they "are  C on 4/13/17 at 11:30am  It #1 had gone to the  It's hospital discharge It	D 392			
	-21 oxycodone 10 mg	one 10 mg revealed: g were dispensed on 3/8/17. g were dispensed on 3/9/17.				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 74 of 100

NAME OF PROVIDER OR SUPPLIER  NAME OF PROVIDER OR SUPPLIER  SIRVEY SOLD AT SUPPLIER  SIRVEY ADDRESS. CITY. STATE. ZIP CODE  3032 N C HIGHWAY 16 SOUTH  TATLORSVILLE, NC 28881  DEATH OF PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCES  (PACH INFICIENCY MUST BE PRECEIVED BY FULL)  PREFER (PACH PROVIDER OR MUST BE PROVIDER ACTION SHOULD SE CROSS PREFERENCE) OR FULL  PREFER (PACH PROVIDER OR MUST BE PRECEIVED BY FULL)  PREFER (PACH PROVIDER OR MUST BE PRECEIVED BY FULL)  PREFER (PACH PROVIDER OR MUST BE PRECEIVED BY FULL)  PREFER (PACH PROVIDER OR MUST BE PROVIDER ACTION SHOULD SE CROSS PREFERENCE)  PREFER (PACH PROVIDER OR MUST BE PROVIDER ACTION SHOULD SE CROSS PREFERENCE)  PREFER (PACH PROVIDER ACTION SHOULD SE CROSS PACH PROVIDER ACTION SHOULD	Division of	Division of Health Service Regulation					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28861  PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEPICIENCY MUST BE PRECEDED BY PLIL PREFIX TAG  ON CONTINUED FROM PAGE 15.0 IDENTIFYING NEGRAMTION)  D 392  Continued From page 74  90 oxycodone 10 mg were dispensed on 3/23/17.  Review of the March and April 2017 electronic Medication Administration Records (eMARs) revealed: - Transcription in March for oxycodone 10 mg documentation of administration of 10 mg. 1/2 tablet every 4 house as needed for pain and discontinued on 3/25/17.  A transcription in March and April for oxycodone 10 mg 3/10/17 and ending on 3/25/17 through 4/5/17 A transcription in March and April for oxycodone 10 mg. 1/2 tablet every 4 house as needed for mild-moderate pain with documentation of administration of administration beginning on 3/25/17 through 4/5/17 A transcription in March and April for oxycodone 10 mg. 1/2 tablet every 4 hours as needed for mild-moderate pain with documentation of administration of any administration Only 19 oxycodone 10 mg were documented as administered to Resident #1 which were from 3/10/17 to 4/6/17.  Review of Resident #3/s oxycodone 10 mg controlled drug sheets revealed: - One sheet for oxycodone 10 mg with a hand written label with 'quality received as 30° and staff began documentation of administration on 3/15/17 at 7/00am and entend on 3/23/17 at 8/9m.			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVID  SUMMAYOR PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVID  SUMMAYOR DEPENDING SUMMAYOR DEPENDENCY OF RESCRIPTIONS AND PROVIDERS RIVED OR SUMMAYOR DEPENDENCY OF RESCRIPTIONS AND PROVIDERS RIVED RESCRIPTION (PAGE 10 AM OF CORRECTION AND IS VALUE OR PROVIDERS RIVED RESCRIPTIONS AND RESCRIPTIONS	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVID  SUMMAYOR PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVID  SUMMAYOR DEPENDING SUMMAYOR DEPENDENCY OF RESCRIPTIONS AND PROVIDERS RIVED OR SUMMAYOR DEPENDENCY OF RESCRIPTIONS AND PROVIDERS RIVED RESCRIPTION (PAGE 10 AM OF CORRECTION AND IS VALUE OR PROVIDERS RIVED RESCRIPTIONS AND RESCRIPTIONS				_			
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES  (PAY) 10  PRECITA TAG  CROSS SUMMARY STATEMENT OF DEFICIENCIES I DEFICIENCY MUST BE PRECEDED BY PULL PRECITA TAG  CROSS REFERENCES TO THE ARPROPRIATE D 392  Continued From page 74  90 oxycodone 10 mg were dispensed on 3/23/17.  Review of the March and April 2017 electronic Medication Administration Records (eMARS) revealed: - Transcription in March for oxycodone 10 mg documented as administered on this entry A second transcription in March for oxycodone 10 mg documented as administered on this entry A transcription in March and April for oxycodone 10 mg, 1/2 tablet every 4 house as needed for pain with maximum 30 mg per day with documentation of administration beginning on 3/10/17 and ending on 3/24/17 A transcription in March and April for oxycodone 10 mg, 1/2 tablet every 4 house as needed for mild-moderate pain with documentation of administration beginning on 3/26/17 through 4/5/17 A transcription in March and April for oxycodone 10 mg, 1 tablet every 4 hours as needed for severe pain with documentation of administration 1 time on 3/26/17 and none in April A transcription in March and April for oxycodone 10 mg, 1 tablet every 4 hours as needed for severe pain with documentation of administration 1 time on 3/26/17 and none in April A transcription in March for oxycodone 10 mg, 1 tablet every 4 hours as needed for severe pain with documentation of administration 1 time on 3/26/17 and none in April A transcription in March for oxycodone 10 mg, 1 tablet every 4 hours as needed for severe pain with documentation of administration 1 time on 3/26/17 and none in April A transcription in March for oxycodone 10 mg, 1 tablet every 4 hours as needed for pain with no documentation of amministration Only 19 oxycodone 10 mg were documented as administered to Resident #1 which were from 3/10/17 to 4/5/17.  Review of Resident #2/5 oxycodone 10 mg controlled drug sheets revealed: - One sheet for oxycodone 10				R WING		1	
ALEXANDER ASSISTED LIVING   3032 N C HIGHWAY 16 SOUTH TAYLORS/ILLE, NC 28811			nal002004	B. WING		04/25	/2017
TAYLORSVILLE, NC 28681  (CM4) ID PREFIX IND  SUMMARY STATEMENT OF DEFICIENCIES  FREETX IND  CROSS-REFERENCE ACTION SHOULD BE CHOSEN FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 392  Continued From page 74  -90 oxycodone 10 mg were dispensed on 3/23/17.  Review of the March and April 2017 electronic Medication Administration Records (eMARS) revealed:  -Transcription in March for oxycodone 10 mg 10 mg, 1/2 tablet every 4 hours as needed for pain with maximum 30 mg per day with documentation of administration beginning on 3/10/17 and ending on 3/24/17.  -A transcription in March and April for oxycodone 10 mg, 1/2 tablet every 4 hours as needed for mild-moderate pain with documentation of administration	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
TAYLORSVILLE, NC 28681  (CA) ID SUMMARY STATEMENT OF DEFICIENCIES PER PROVIDERS PLAN OF CORRECTION EACH DEVILLATION ON THE PRECEED BY FULL PREFIX TAG.  D 392  Continued From page 74  -90 oxycodone 10 mg were dispensed on 3/23/17.  Review of the March and April 2017 electronic Medication Administration Records (eMARs) revealed: -1-Transcription in March for oxycodone 10 mg 10 mg, 1/2 tablet every 4 hours as needed for pain with maximum 30 mg per day with documentation of administration beginning on 3/10/17 and ending on 3/24/17A transcription in March and April for oxycodone 10 mg, 1/2 tablet every 4 hours as needed for mild-moderate pain with documentation of administration beginning on 3/26/17 through 4/5/17A transcription in March and April for oxycodone 10 mg, 1/2 tablet every 4 hours as needed for mild-moderate pain with documentation of administration beginning on 3/26/17 and none in AprilA transcription in March and April for oxycodone 10 mg, 1/2 tablet every 4 hours as needed for severe pain with documentation of administration 1 time on 3/26/17 and none in AprilA transcription in March and April for oxycodone 10 mg, 1 tablet every 4 hours as needed for pain with no documentation of administration 1 time on 3/26/17 and none in AprilA transcription in March and April for oxycodone 10 mg, 1 tablet every 4 hours as needed for pain with no documentation of aministration 1 time on 3/26/17 and none in AprilA transcription in March pain with documentation of 3 ministration 1 time on 3/26/17 and none in AprilA transcription in March pain with documentation of 3 ministration 1 time on 3/26/17 and none in AprilA transcription in March pain with the second of 3 ministration 1 time on 3/26/17 and none in AprilA transcription in March pain with the second of 3 ministration 1 time on 3/26/17 and none in AprilA transcription in March pain with a the second of 3 ministration 1 march for oxycodone 10 mg with a hand written label with 1 quantity received as 30° and staff began documentation o			3032 N C	HIGHWAY 16 S	OUTH		
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-One sheet for oxycodone 10 mg with a hand written label with "quantity received as 30" and staff began documentation of administration on 3/15/17 at 7:00am and ended on 3/23/17 at 8pm.							
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staff began documentation of administration on 3/15/17 at 7:00am and ended on 3/23/17 at 8pm.		-	•				
3/15/17 at 7:00am and ended on 3/23/17 at 8pm.							
· I I I I I I I I I I I I I I I I I I I		•					
The decent sheet had a nanawitten label and							
staff documented the administration of 30							

Division of Health Service Regulation

oxycodone 10 mg from 3/42/17 at 8:00am

STATE FORM 6899 V1B311 If continuation sheet 75 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		JOWN LETED	
		hal002004	B. WING		R <b>04/25/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AI EYAND	ER ASSISTED LIVING	3032 N C H	IGHWAY 16 SC	ОИТН		
ALEXAND	EN ASSISTED LIVING	TAYLORSV	ILLE, NC 286	81		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	÷ 75	D 392			
	through 4/6/17 at 8:00am.  -No other controlled drug sheets were available.  -A total of 60 oxycodone 10 mg were accounted for on available controlled drug sheets.					
	Comparison of the March and April 2017 eMARS with the 180 oxycodone 10 mg and with the oxycodone 10 mg documented on the controlled drug sheets revealed:  -Of of the 180 oxycodone 10 mg dispensed, only					
	19 were documented on the MARs.  -Of the 60 oxycodone 10 mg documented on the controlled drug sheet only 19 were documented on the MARs.					
	-Of the 180 oxycodone 10 mg dispensed, 120 oxycodone 10 mg were not accounted for on a controlled drug sheet and 161 were not accounted for on the MARs.					
	Comparison of the pharmacy delivery sheets for 180 oxycodone 10 mg with the physician order for administration of three times per day revealed 91 oxycodone 10 mg would have been a sufficient supply to administer from 3/7/17, his first full day at the facility through to 4/6/17 at 8:00am when the balance was 0 on the controlled drug sheet,					
		odone that were missing.				
	Telephone interview v physician assistant or revealed: -She came into the fa	n 4/13/17 at 9:30am				
	"Thursday," date not scurrently in the office.	sure because she was not				
	out.	one because he was almost ritten a prescription for				
	Resident #1's oxycod	one "recently" for 90 tablets ad at least 44 tablets left but				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 76 of 100

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					Ь В
		h-1002004	B. WING		R
		hal002004	1		04/25/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		3032 N C	HIGHWAY 16 S	оитн	
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286		
	OUR MAR DV OT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - )
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 392	Continued From page	76	D 392		
D 002			5 002		
	the RCC said he only				
	-She did not write and	·			
	Resident #1 for the ox				
	-	ary care provider of the			
	missing narcotics and	I he agreed she should not			
	prescribe any narcotic	cs for any residents who			
	resided in this facility.				
	-She called the pharn	nacy to tell them that she			
	thought Resident #1 h	nad some missing			
	oxycodone.				
	-The mental health ph	nysician ordered the Ativan.			
	Intonvious with the Adr	ministrator on 4/12/17 at			
	2:15pm revealed:	ministrator on 4/13/17 at			
		d the physician assistant for			
	-	codone for Resident #1, she			
		tly written a prescription for			
		ere should have been at			
	least 44 more oxycod				
		ian assistant refused to write			
		and she reported the missing			
	oxycodone to the pre-				
	•	d an investigation for the			
	missing oxycodone.	d an investigation for the			
		Thursday evening, the			
	•	overed the oxycodone was			
		the medication aide left.			
	_	so took some controlled			
		because they were kept in			
		after the medications were			
	administered.	and the medicalions were			
		back to work since the			
		DACK TO WOLK SHICE THE			
	incident.	modication aides!			
	-He would change the				
		did shift count by assuring			
		ide going off duty and the			
	-	nitialed the balance so that			
		made to the controlled drug			
	sneet atter a mediation	on aide's documented to			

Division of Health Service Regulation

assure the balance was agreed upon by both

STATE FORM 6899 V1B311 If continuation sheet 77 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			7.1. 20.25.110.			R
		hal002004	B. WING		04	1/25/2017
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AI EYANE	DED ASSISTED I IVING	3032 N C	HIGHWAY 16 SOL	ІТН		
ALEXANI	DER ASSISTED LIVING	TAYLOR	SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	-They could not find to and all of the resident because "they were sold -He was not aware the were missing.  Telephone call to Sta 4/20/17 at 1:24pm was confidential interview after Resident #1 ran Ativan, he complaine -Resident #1 "has be and says he is not sleet". He would say, 'I'm sold - "He would say, 'I'm sold - Review of physicial and says of physicial says were sold - Review of physicial says he is not sleet.	off A, medication aide, on as not successful.  If with a staff revealed that a out of oxycodone and d as follows: en complaining of shakes eeping much." Ishaking and my leg hurts.'."				
	Telephone interview 4/11/17 at 3:10pm redispensed on 3/13/17 dispensed on 3/8/17  Review of the ativan revealed - 28 tablets were dispended at through 4/06/17No other controlled serview of the March Medication Administrative revealed: -Transcription of ativa	with the pharmacist on vealed 60 ativan 1 mg were 7 and 21 ativan 1 mg were for a total of 81 ativan.  1 mg controlled drug sheet pensed on 3/23/17 with ministration from 3/24/17 sheets for ativan 1 mg.  and April 2017 electronic ation Records (eMARs)  an 1 mg twice daily as ith documentation of 7 doses				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 78 of 100

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 392  Continued From page 78  -Transcription of ativan 1 mg twice daily routinely at 8:00am and 8:00pm with administeration documented from 3/15/17 through 3/27/17.  -31 ativan 1 mg were documented as administered in April.  Comparison of the March and April 2017 eMARS with the 81 ativan 1 mg dispensed and with the ativan 1 mg dispensed on the controlled drug sheets revealed:  -Of of the 81 ativan 1 mg dispensed, 53 were not accounted for on a controlled drug sheet and 50 were not accounted for on the MARS.  -Very through 3/25 were not accounted for on the MARS.  -Very through 3/25 were not accounted for on the MARS.  -Very through 3/25 were not accounted for on the MARS.  -Very through 3/25 were not accounted for on the MARS.  -Very through 3/25 were not accounted for on the MARS.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ALEXANDER ASSISTED LIVING  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 392  Continued From page 78  -Transcription of attivan 1 mg twice daily routinely at 8:00am and 8:00pm with administration documented from 3/15/17 through 3/27/17.  -31 ativan 1 mg were documented as administered in March and no ativan 1 mg was documented as administered in March and April 2017 eMARS with the 81 ativan 1 mg dispensed and with the ativan 1 mg documented on the controlled drug sheets revealed:  -Of of the 81 ativan 1 mg dispensed, only 31 were documented on the MARs.  -28 ativan 1 mg were documented on the only controlled drug sheet for Resident #1's Ativan.  -Of the 81 ativan 1 mg dispensed, 53 were not accounted for on a controlled drug sheet and 50	74101 12744	or dorace mon	ibertii io, itiori io iiberti	A. BUILDING: _	A. BUILDING:		
ALEXANDER ASSISTED LIVING  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681    (X4) ID PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY PILL TAG   (EACH DEFICIENCY MUST BE PRECEDED BY PILL TAG   (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)   D 392   Continued From page 78			hal002004 B. WING				
TAYLORSVILLE, NC 28681  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 392  Continued From page 78  -Transcription of ativan 1 mg twice daily routinely at 8:00am and 8:00pm with administration documented from 3/15/17 through 3/27/1731 ativan 1 mg were documented as administered in April.  Comparison of the March and April 2017 eMARS with the 81 ativan 1 mg dispensed and with the ativan 1 mg documented on the controlled drug sheets revealed: -Of of the 81 ativan 1 mg dispensed, only 31 were documented on the MARs28 ativan 1 mg were documented on the only controlled drug sheet for Resident #1's AtivanOf the 81 ativan 1 mg dispensed, 53 were not accounted for on a controlled drug sheet and 50	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 392  Continued From page 78  -Transcription of ativan 1 mg twice daily routinely at 8:00am and 8:00pm with administration documented from 3/15/17 through 3/27/17.  -31 ativan 1 mg were documented as administered in March and no ativan 1 mg was documented as administered in April.  Comparison of the March and April 2017 eMARS with the 81 ativan 1 mg dispensed and with the ativan 1 mg documented on the controlled drug sheets revealed:  -Of of the 81 ativan 1 mg dispensed, only 31 were documented on the MARs.  -28 ativan 1 mg were documented on the only controlled drug sheet for Resident #1's Ativan.  -Of the 81 ativan 1 mg dispensed, 53 were not accounted for on a controlled drug sheet and 50	ALEXAND	ER ASSISTED LIVING					
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Review of a physician visit dated 3/27/17 revealed: -An order to discontinue ativan and begin Vistaril 25 mg bid -" years ago [Resident #1] had an accident where a steel beam landed on top of head. Resulted in TB I and chronic head aches."  Review of the March 2017 eMAR revealed: -Documentation of administration of ativan ended on 8:00am on 3/27/17 and a "stop date on 3/27/17 at 3:00pm" and a "DC" in bold letters above the entriesNo documentation of administration of Ativan after 8:00am on 3/27/17Documentation of Vistaril administered beginning on 3/27/17 through 4/13/17, the date the eMARs were printed.  Comparison of the pharmacist interview that 81 ativan 1 mg were dispensed with the physician	D 392	-Transcription of ativa at 8:00am and 8:00pr documented from 3/1 -31 ativan 1 mg were administered in March documented as admin Comparison of the Mawith the 81 ativan 1 mativan 1 mg documented on the March -28 ativan 1 mg were controlled drug sheet -Of the 81 ativan 1 mg accounted for on a cowere not accounted for on a cowere not accounted for Review of a physician revealed: -An order to discontin 25 mg bid -" years ago [Residum where a steel beam land Resulted in TB I and and Review of the March -Documentation of accounted for the March -Documentation of accounted for 8:00am on 3/27/17 at 3:00pm" and above the entriesNo documentation of vision 3/27/17 through 4/1 were printed.	an 1 mg twice daily routinely m with administration 5/17 through 3/27/17. documented as and no ativan 1 mg was nistered in April.  arch and April 2017 eMARS and dispensed and with the atted on the controlled drug mg dispensed, only 31 were MARs. documented on the only for Resident #1's Ativan. g dispensed, 53 were not controlled drug sheet and 50 for on the MARs.  In visit dated 3/27/17  are ativan and begin Vistaril  anded on top of head. chronic head aches."  2017 eMAR revealed: Iministration of ativan ended of and a "stop date on and a "bC" in bold letters  administration of Ativan  177. staril administered beginning 1/13/17, the date the eMARs	D 392			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 79 of 100

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		h = 1000004	B. WING		F	
		hal002004	D. 11110		04/2	25/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
	OUR MAR DV OT		· ·			1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 000			<b>—</b>			
D 392	Continued From page	e 79	D 392			
	order for administration	on of Ativan twice daily on				
		ivan 1 mg would have been				
		administer 3 ativan 1 mg on				
		ginning on 3/8/17 through				
	_	en the balance was 0 on the				
		, which leaves 18 ativan 1				
	_	nount which were needed to				
		d, but were not available and				
	not accounted for.	.,				
	Interview with the RC	C on 4/13/17 3:10pm				
	revealed:					
	-She did not know wh	v staff continued to				
	administer ativan afte	· <del>-</del>				
		lity of the medication aide on				
		tinue order came in to				
	remove the controlled					
		t when it was discontinued.				
		medication aide took some				
	•	g controlled drug sheet.				
	auvair and the inicon	g controlled drug officet.				
	Interview with the Adr	ministrator on 4/13/17 at				
	2:15pm revealed:					
	-He would change the	e medication aides				
	_	did shift count by assuring				
		ide going off duty and the				
		nitialed the balance so that				
		made to the controlled drug				
		on aide's documented and				
	so both medication ai					
	documented number.					
		e controlled drug sheets.				
		he pharmacy delivery sheets				
		ts' controlled drug sheets				
	because "they were s					
	because they were s	callered all arourid.				
	The facility's failure to	maintain records, reconcile				
	all narcotics delivered					
		e a fail proof shift change				
		e a rail proof still change rersight of all narcotics and				
	Count, and provide ov	craight of all harcolles and	1			1

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 80 of 100

Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		hal002004	B. WING		F	
		hal002004			04/2	25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	== 40010 <b>=</b> == 1 11 //110	3032 N C F	IIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING	TAYLORS\	/ILLE, NC 286	81		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
D 392	Continued From page 80		D 392			
	narcotic waste resulte	ed in opportunity for				
		ents' narcotics. The facility's				
		diversion did not result in				
	any method for reduc					
	opportunity for drug d					
		ery sheets, controlled drug				
		ons by the survey team				
		orphone 2 mg, 108 Endocet				
	-	ne 10 mg, 120 oxycodone				
		1 mg were not accounted				
	_	ent without their pain and				
		pecause the narcotics were				
	·	administer or because a				
		ould no longer prescribe				
		dents in this facility after she				
	-	c diversion. The failure to				
	maintain accurate and	d retrievable records of				
	receipt, administration					
		s and the inability to account				
		otics for 3 residents was				
		alth, welfare and safety of				
		estitutes a Type B Violation.				
	The Plan of Protection	n provided by the facility on				
	4/12/17 revealed:					
	-The facility will assur	e all controlled substances				
	are counted upon arri	ival, maintained the delivery				
	ticket, and make certa	ain all packs are numbered				
	according to what wa	s received, 1 of 3, 2 of 3,				
	and 3 of 3.					
	-We will put stock on	the medication cart with the				
	necessary amount an	d will double lock the left				
	over until needed.					
	-We will compare the	count sheet with the empty				
	· · · · · · · · · · · · · · · · · · ·	count sheets on a daily basis				
	=	umber the controlled sheets				
		them to the empty pack.				
	-	ount sheet on a daily basis.				

Division of Health Service Regulation

-If a controlled drug is wasted, it will be witnessed

STATE FORM 6899 V1B311 If continuation sheet 81 of 100

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		
			71. 501251110.			П
		hal002004	B. WING		04	R / <b>25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
ΔΙ ΕΧΔΝΓ	DER ASSISTED LIVING	3032 N C	HIGHWAY 16 SO	DUTH		
ALLXAIL	PER AGGIGTED EIVING	TAYLORS	SVILLE, NC 2868	<b>1</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	81	D 392			
	-The narcotics will be weekly basisThe physician, pharm notified if there are ar found to be missingAll medication docum in the facility.  CORRECTION DATE	ny medications which are nentation will be maintained				
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate	ration of Residents' Rights ave the following rights:				
	reviews, the administration resident received care adequate, appropriate relevant federal and saregulations related to supervision, health capharmaceutical service.  The findings are:  A. Based on observation	ns, interviews, and record rator failed to assure every e and services which were e, and in compliance with state laws and rules and				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 82 of 100

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		hal002004	B. WING		04/2	₹ 25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SC			
			ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D912	Continued From page	82	D912			
D912	of residents in accord assessed needs, care symptoms for 2 of 2 sphysical decline and closed head injury an from a fall down the se (Resident #2) and a fictored head injury an compound fractured or requiring stabilization (Resident #7). [Refer .0901(b) Personal Cat Violation).]  B. Based on interview facility failed to assume the routine and 3 of 3 sampled reside transfer to a higher less supervision exceeding Facility) capabilities, I chronic pain being wire medications for 24 hophysician's order to sean orthopedic surgeofracture of the first lur vetebroplasty perform	ance with each resident's e plan and current sampled residents with falls, resulting in a fall with a d potential for serious injury tairs in her wheelchair all with a left wrist and d a second fall with a of the first lumbar vertebra in the Emergency Room to Tag 270 10A NCAC 13F and Supervision (Type A2 ws and record reviews, the e referral and follow-up to acute health care needs for ents regarding Resident #2's evel of care due to care and g the ALF (Assisted Living Resident #3 with a history of thout Endocet pain purs, and Resident #7 with a chedule an appointment with in post-fall with a compound inbar vertebra and a need in the Emergency Room.  A NCAC 13F .0902(b)	D912			
	reviews, the administ total operation of the rules and regulations					
	rules and regulations related to personal care and supervision, health care housekeeping and furnishings, fire rehearsals for evacuation, licensed health profession support, pharmaceutical services, other requirements, activities, nutrition and food service, medication administration, examination and screening for the					

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 83 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	
		hal002004	B. WING		04/25/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SC ILLE, NC 286			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D912	Continued From page	e 83	D912			
	labels, and accurate rand disposition of corto Tag 980, G.S. 131LA2 Violation).]  D. Based on observarreviews, the facility fa	d substances, medication records of the receipt, use, atrolled substances. [Refer D-25 Implementation (Type tions, interviews, and record iled to assure that accurate				
	records of the receipt, use, and disposition of medications which included pharmacy delivery sheets, controlled drug sheets, medication administration records, and medications brought into the facility were maintained in the facility and available upon request for review for 3 of 4 sampled residents (Resident #1, #3, and #6). [Refer to Tag 936,10A NCAC 13F .1010(d) Pharmaceutical Services (Type B Violation).]					
D914	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.		D914			
This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free from neglect and exploitation related to failure to maintain accurate medication administration records and the failure to assure readily retrievable records and accurate reconciliation of controlled substances which resulted in three residents who were not administered their medications and narcotics as ordered.  The findings are:						

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 84 of 100

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH  TAYLORSVILLE, NC 28681   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D914  Continued From page 84  A. Based on observations, interviews and record review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the controlled drug sheets but not documented as administered on the eMARs, related to the failure to document sliding scale insulin on the eMAR, related to the failure to document Flexeril on the eMAR, and	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681   (X4) ID PREFIX TAG  CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D914  Continued From page 84  A. Based on observations, interviews and record review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the eMARs, related to the failure to document sliding scale insulin on the eMAR, related to the failure to document Flexeril on the eMAR, and				_		R	
ALEXANDER ASSISTED LIVING  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681    Continued From page 84   Description of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the eMARs, related to the failure to document Flexeril on the eMAR, and			hal002004	B. WING		1	017
ALEXANDER ASSISTED LIVING  TAYLORSVILLE, NC 28681    Continued From page 84   A. Based on observations, interviews and record review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the eMARs, related to the failure to document Flexeril on the eMAR, and	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAYLORSVILLE, NC 28681  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D914  Continued From page 84  A. Based on observations, interviews and record review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the controlled drug sheets but not documented as administered on the eMARs, related to the failure to document sliding scale insulin on the eMAR, related to the failure to document Flexeril on the eMAR, and	AL EVAND	NED ASSISTED LIVING	3032 N C H	IGHWAY 16 SC	ОИТН		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D914  Continued From page 84  A. Based on observations, interviews and record review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the controlled drug sheets but not documented as administered on the eMARs, related to the failure to document sliding scale insulin on the eMAR, and  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  D914  D914  D914  D914  D915  COMPLETE DATE  COMPLETE DATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DATE  DATE  OATH  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DATE  OATH  OAT	ALEXAND	PER AGGISTED LIVING	TAYLORSV	ILLE, NC 286	81		
A. Based on observations, interviews and record review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the controlled drug sheets but not documented as administered on the eMARs, related to the failure to document sliding scale insulin on the eMAR, related to the failure to document Flexeril on the eMAR, and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE CC	OMPLETE
review, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 sampled residents (Resident #1 and #3) related to medications which were documented as administered on the controlled drug sheets but not documented as administered on the eMARs, related to the failure to document sliding scale insulin on the eMAR, related to the failure to document Flexeril on the eMAR, and	D914	Continued From page	e 84	D914			
related to as needed medications documented on a controlled drug sheet but with no justification or effectiveness documented on the eMARs. [Refer to Tag 367, NCAC 13F .1004(j) Medication Administration (Type B Violation).]  B. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records were available to account for the disposition of controlled substances (hydromorphone, Endocet, methadone, oxycodone and Ativan.) and to ensure an accurate reconcililation of those controlled substances for 3 of 3 sampled residents (Resident #1, #3 and #6) which resulted in three residents who were not administered their narcotics as ordered because the narcotics were not in the facility and could not be accounted for or because a physician assistant refused to prescribe anymore narcotics after she discovered narcotics were missing. The 3 sampled residents included Resident #1 with chronic pain from a (TBI) traumatic brain injury with the diagnoses of chronic pain, Resident #3 with a history of chronic pain and Resident #6 with diagnosis of hyperplasia of prostate. [Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type	D914	A. Based on observat review, the facility fail the electronic Medica (eMARs) for 2 of 4 sa #1 and #3) related to documented as admit drug sheets but not don the eMARs, relate sliding scale insulin of failure to document Frelated to as needed a controlled drug sheeffectiveness documented Tag 367, NCAC 13 Administration (Type B. Based on observat reviews, the facility faretrievable records with the disposition of concoveration (hydromorphone, Encoveration of the disposition of concoveration of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because a physicial prescribe anymore nation of the facility and or because anymore nation of the facility and or because anymore nation of the facility and or because anymore nation of the	tions, interviews and record ed to assure the accuracy of tion Administration Records impled residents (Resident medications which were instered on the controlled ocumented as administered d to the failure to document in the eMAR, related to the lexeril on the eMAR, and medications documented on et but with no justification or ented on the eMARs. [Refer F .1004(j) Medication B Violation).]  tions, interviews, and record illed to assure readily ere available to account for trolled substances docet, methadone, in, and to ensure an in of those controlled sampled residents #6) which resulted in three of administered their because the narcotics were could not be accounted for an assistant refused to arcotics after she discovered and injury with the diagnoses of the table of tabl	D914			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 85 of 100

Division of	Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		hal002004	B. WING		04/25/2017		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
			HIGHWAY 16 SO				
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 2868				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
D936	Continued From page 85		D936				
D936	10A NCAC 13F .1010 (d) (e) Pharmaceutical Services		D936				
	10A NCAC 13F .1010(d) Pharmaceutical Services						
	(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:						
	cover the duration of the purposes of this F necessary means the administered during the administered during the acurrent dose pack, camedication for the plate (2) Written and verbal medication to be released absence shall be proviperson accompanying medication 's released include at least:  (A) the name and street.	icient and necessary to the resident 's absence. For Rule, sufficient and amount of medication to be ne leave of absence or only card, or container if the rd, or container has enough nned absence; instructions for each					

by the resident's physician;

(C) any cautionary information from the original

STATE FORM 6899 V1B311 If continuation sheet 86 of 100

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D936	Continued From page	e 86	D936			
	prescription package the container released (3) The resident's me a capped or closed comedications from con (4) Labeling of each of medication containers shall be legible, including resident and the name medication, and be at The facility shall main resident's record of microsident's record of microsident's leave of aboreleased from the facility quantities of medication to the facility absence shall be verifacility staff and reside accompanying the resident's release from and refusion to the facility shall a of the receipt, use, and	if the information is not on d for the leave of absence; dication shall be provided in ontainer that will protect the tamination and spillage; and of the resident's individual is for the leave of absence de at least the name of the e and strength of the effixed to each container. In the indications provided for the sence, including the quantity in the documentation of the cons released from and of or a resident's leave of fied by signature of the ent or the person sident upon the medications turn to the facility. In the documentation of medications that accurate records and disposition of medications facility and available upon				
	Based on observation reviews, the facility farecords of the receipt medications which incompletely sheets, controlled dru administration records into the facility were navailable upon requesting the sheets.	s, and medications brought naintained in the facility and				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 87 of 100

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AL EVAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	ОИТН		
ALEXAND	TAYLORS			81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D936	Continued From page	e 87	D936			
	The findings are:					
	<ul> <li>A. Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances.</li> <li>B. Review of Resident #1's Resident Register revealed he was admitted to this facility on 3/6/17.</li> <li>Review of Resident #1's FL2 dated 3/6/17 revealed:</li> <li>-Diagnoses included dementia, mixed type,</li> </ul>					
	hepatitis C, major dep	pressive disorder, history of and chronic obstructive				
	-Physician orders incl	uded ativan 1mg three anxiety) and oxycodone				
	10mg three times dail	* · · · · · · · · · · · · · · · · · · ·				
	-Physician orders for -This FL2 was signed assistant.	by this facility's physician				
	Interview with Reside revealed:	nt #1 on 4/11/17 at 11:25am				
	-He was a resident at was admitted to this fa	another facility before he acility.				
		ty came to the facility to				
		as not sure which staff. of pain and anxiety because				
	his oxycodone was "s	stolen."				
	<ul> <li>-He did not know what facility sent with this s</li> </ul>	at medications the other staff.				
	Interview with the Res 4/11/17 at 2:30pm rev	sident Care Coordinator on				
		ent #3 at the other facility				
	and transferred him to	o this facility.				
	<ul> <li>There was a "bag of other facility sent with</li> </ul>	medications" which the the resident.				

Division of Health Service Regulation

-When she came back to the facility she "handed" the bag of medications to Staff A, a medication

STATE FORM 6899 V1B311 If continuation sheet 88 of 100

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 S			
		TAYLORS	VILLE, NC 286	81 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D936	Continued From page 88 D936					
	aide who no longer we to write down the name medications.  -She did not know who was that Staff A was a documented.  -She did not have any facility which stated we by that facility.  Telephone interview of Staff A, a medication at the facility, was not at the facility, was not Review of a statement the surveyor from the transferred from and a discharged on 3/6/17 given."  Review of previous FI the following orders: -Physician order for A-Physician order for a dayPhysician orders for Interview with the Adr 2:35pm revealed: -It was his policy for a with the residents be a medication aides new admissions are not medications brought.	rorked there, and asked her ne and quantity of here the list of medications supposed to have by records from the other what medications were sent on 4/20/17 at 1:24 pm to aide who no longer worked at successful.  In dated 3/16/17 was sent to acfacility where Resident #1 stated, "Resident was and all medications were  L2 dated 9/13/16 revealed between the times daily. Expression of the times daily. Expression of the times daily. Expression of the times daily and the times daily. Expression of the times daily and the times daily of the times				
	-	o accurately document and				

Division of Health Service Regulation

placed the residents at risk for their medications

STATE FORM 6899 V1B311 If continuation sheet 89 of 100

	or riealth Service Regu		I			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
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		hal002004	B. WING		04/2	5/2017
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		3032 N C H	IIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING	TAVI ORSI	ILLE, NC 286	81		
		TATEORS	TLLL, NC 200	01		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				DEI IGIENGT)		
D936	Continued From page	. 00	D936			
D930	Continued From page	: 09	D930			
	including parcetics to	be exploited and to not be				
	•	•				
	administered accurate	-				
	documentation for me	•				
		with a new admission				
	exposed the resident	to staff's ability to divert the				
	medications/narcotics	. The failure to maintain a				
	list of medications wh	ich entered the facility and				
	belonged to Resident #1 placed the facility in a					
	position where they could not prove the resident's					
	medications were accounted for. This system of					
	failing to maintain records of receipt, use, and					
	disposition of medicat	tions was detrimental to the				
	health safety and welf	fare of the residents and				
	constitutes a Type B					
	conocitation a Type B	violation.				
	The Dies of Destaction	- manyided by the				
	The Plan of Protection					
	Adminsitrator on 4/17					
	-All medication aides	will enter the administration				
	of all medications in the	ne electronic Medication				
	Administration Record	ds (eMARs).				
		allow documentation of the				
		ications, the Administrator				
		e medication aides will				
	document the adminis	stration on paper and				
	maintained it on file.					
	-Any documentation of	on paper will be entered on				
	the eMARs when the	eMARs are back up and				
	working.	·				
		Il monitor the documentation				
		cations and assure records				
	are maintained accord					
	-All medications enter	-				
	maintained on file in t	he facility.				
	CORRECTION DATE	FOR THIS TYPE B				
		IOT EXCEED JUNE 9,				
		IO I EXOLLE JOINE J,				
	2017.					
			I .	İ		

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 90 of 100

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74427 2744	or contraction	IDENTIFICATION NO.	A. BUILDING: _			
		hal002004	B. WING		R 04/25/2	017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SO ILLE, NC 286			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N I	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	COMPLETE DATE
D980	Continued From page	90	D980			
D980	G.S. § 131D-25 Imple	ementation	D980			
	G.S. 131D-25 Implem	nentation				
	this Article shall rest v facility. Each facility s	lementing the provisions of with the administrator of the shall provide appropriate element the declaration of ded in G.S. 131D-21.				
	This Rule is not met a Type A2 Violation	as evidenced by:				
	reviews, the administration of the rules and regulations supervision, health cafurnishings, fire reheallicensed health profesion pharmaceutical service activities, nutrition and administration, examination presence of controlled	esion support, ces, other requirements, d food service, medication nation and screening for the d substances, medication records of the receipt, use,				
	The findings are:					
		d his responsibility "as acility was to ensure the eat care and being in				
	Non-compliance identification included:	tified during the survey				
	A. Based on observat	tions, interviews and record				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 91 of 100

Division of Health Service Regulation

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		hal002004	B. WING		R <b>04/25/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE	
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC		
		TAYLORS	SVILLE, NC 2868	11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D980	of residents in accord assessed needs, care symptoms for 2 of 2 sphysical decline and follosed head injury and from a fall down the second head injury and compound fractured or requiring stabilization (Resident #7). [Refer .0901(b) Personal Ca Violation).]  B. Based on interview facility failed to assure meet the routine and a 3 of 3 sampled reside transfer to a higher lessupervision exceeding Facility) capabilities, For chronic pain being with medications for 24 hophysician's order to sea an orthopedic surgeon fracture of the first lunivetebroplasty perform [Refer to Tag 273, 10/Health Care (Type B V)  C. Based on observative review, the facility failed to documented as admir drug sheets but not do on the eMARs, related	iled to provide supervision ance with each resident's e plan and current ampled residents with falls, resulting in a fall with a d potential for serious injury tairs in her wheelchair all with a left wrist and d a second fall with a of the first lumbar vertebra in the Emergency Room to Tag 270 10A NCAC 13F and Supervision (Type A2) are and Supervision (Type A2) are and record reviews, the ereferral and follow-up to acute health care needs for ints regarding Resident #2's well of care due to care and go the ALF (Assisted Living Resident #3 with a history of thout Endocet pain urs, and Resident #7 with a chedule an appointment with an post-fall with a compound inbar vertebra and a fined in the Emergency Room. A NCAC 13F .0902(b) Violation).]  Tions, interviews and record and to assure the accuracy of tion Administration Records mpled residents (Resident medications which were instered on the controlled occumented as administered do to the failure to document	D980		
	documented as admir drug sheets but not do on the eMARs, related	nistered on the controlled ocumented as administered			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 92 of 100

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_
		hal002004	B. WING	<del> </del>	04	R // <b>25/2017</b>
NAME OF D	ROVIDER OR SUPPLIER	CTDEET VI	DDRESS, CITY, STATE	= ZIR CODE	, ,	
NAME OF T	NOVIDEN ON 3011 EIEN		HIGHWAY 16 SOI			
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 28681			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
D980	Continued From page	92	D980			
D980	failure to document F related to as needed a controlled drug she effectiveness docume to Tag 367, NCAC 13 Administration (Type D. Based on observar reviews, the facility far retrievable records with disposition of con (hydromorphone, Encoxycodone and Atival accurate reconciliation substances for 3 of 3 (Resident #1, #3 and residents who were not in the facility and or because a physicial prescribe anymore national resident with the facility and or because a physicial prescribe anymore national resident #1 (TBI) traumatic brain chronic pain, Resident #1 (TBI) traumatic brain chronic pain, Resident #6 hyperplasia of prostation NCAC 13F .1008(a) (B Violation).]  E. Based on observative reviews, the facility farecords of the receipt	lexeril on the eMAR, and medications documented on et but with no justification or ented on the eMARs. [Refer F .1004(j) Medication B Violation).]  tions, interviews, and record illed to assure readily ere available to account for trolled substances docet, methadone, n.) and to ensure an n of those controlled sampled residents #6) which resulted in three of administered their because the narcotics were could not be accounted for an assistant refused to arcotics after she discovered in the sampled residents with chronic pain from a injury with the diagnoses of at #3 with a history of chronic with diagnosis of the [Refer to Tag 392, 10A Controlled Substances (Type tions, interviews, and record illed to assure accurate , use, and disposition of cluded pharmacy delivery	D980			
	administration record into the facility were r available upon reques	s, and medications brought maintained in the facility and st for review for 3 of 4 esident #1, #3, and #6).				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 93 of 100

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		hal002004	B. WING			R <b>1/25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	-	
ALEXAND	DER ASSISTED LIVING		C HIGHWAY 16 SOU			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D980	Pharmaceutical Services F. Based on intervier facility failed to assure employee's controlled tested positive for one examination and sort verify the results of the screening, or a state prospective employed he had prescribed the 1992, G.S. § 131D-45 (Screening.)  G. Based on observices facility failed to main manner free from had cigarette butts, cigar trash swept up and I porch and an ashtran screened porch over and cigarette butts. [13F.0306(a)(5) Hourstreet House of the prevention Code Entag 101,10A NCAC Prevention.]  I. Based on observate facility failed to main electrical equipment operating condition in the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway, ceiling fansing lobes and with dusting the cord of a bug light hallway.	ws and record reviews, the re after a prospective of substance screening expodone that a second eening was performed, to the prior examination and ement provided by the ee's physician which verified the oxycodone. [Refer to Tag 5(a). Examination and eations and interviews, the tain the home in a clean eater as related to a pile of ette ashes, dirt and paper eft in a corner of the smoking efforming with flammable trash efforming with flammable trash efforming and Furnishings.]  ws and record reviews the re rehearsals of the fire plan efforcement Official. [Refer to Tog 19, 10cal Fire forcement Official. [Refer to Tog 19].	D980			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 94 of 100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			
		hal002004	B. WING		04	R // <b>25/2017</b>
	ROVIDER OR SUPPLIER	3032 N C	DDRESS, CITY, STATE HIGHWAY 16 SOL	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D980	leaving the switch bor 105, 10A NCAC 13F Requirements.]  J. Based on observat reviews, the facility far Health Professional Swere completed quar residents (Resident # physical assessment, care being provided, recommendations for resident. [Refer to Tag. 0903(c) Licensed He K. Based on observat reviews, the facility fadiets for 2 of 4 sample and #8) were served and no concentrated to Tag 310 10A NCAC and Food Service.]  L. Based on observat facility failed to developed to promote involvement with each the community. [Refe 13F .0909(a) Activities M. Based on observat reviews, the facility fasampled residents (Rendocet as prescribe NCAC 13F .1004(a) N. Based on interviews N. Based On	thout dials and/or covers are exposed. [Refer to Tag .0311(a) Other  ions, interviews, and record illed to ensure the Licensed support (LHPS) evaluations terly for 2 of 3 sampled 5 and #6) and included a evaluation of the residents' or needed changes in the care of the g 280, 10A NCAC 13F alth Professional Support.]  tions, interviews, and record illed to assure all therapeutic ed residents (Resident #5 as ordered related to puree sweets diet orders. [Refer C 13F .0904(e)(4) Nutrition  ions and interviews, the op a program of activities the residents' active the other, their families and er to Tag 315 10A NCAC is Program.]  tions, interviews, and record illed to assure 1 of 4 esident #3), received d. [Refer to Tag 358, 10A Medication Administration.	D980			
	facility failed to assure administered to 1 of 3					

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 95 of 100

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BOILBING.			_
		hal002004	B. WING		04	R / <b>25/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
			HIGHWAY 16 SOU			
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 28681			
0(1) 15	CHMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	DDECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D980	Continued From page	95	D980			
	and properly labeled Aide administering 2 Resident 3's family m container the family n	ispensed from the pharmacy resulting in a Medication Endocet, prescribed for ember, from an unlabeled nember had brought to the efer to Tag 352, 10A NCAC				
	monitor the facility for resulted in a staff men after she tested positis substance screening Resident Care Coord all the medications; no certified staff on secondays; a resident in a and rolling down outs supervision; staff adminished medication a family member; 3 or receiving narcotics as accurately account for staff administering medications; resident referral/follow-up and drills to assure staff when the therapeutic ordered. These failure provide oversight to a licensure rules and resident referensure rules and resident resident referensure rules and resident res	and in the position as inator who was in charge of o coverage with a CPR nd shift for 7 of 7 sampled wheel chair going out a door ide steps because of lack of ninistering a resident s which were prescribed to f 3 sampled residents not s ordered; no system to r controlled substances; edications as needed the administration of the s not receiving labs as ordered; no fire vere trained in evacuation; a nutritional status at risk menu were not served as es by the management to assure the compliance of all egulations resulted in erious harm and serious its could occur and				
	and included the follo	vas provided by the facility wing: Il hold a staff meeting with				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 96 of 100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
hal		hal002004	B. WING		R <b>04/25/2017</b>	
1101002004				TE, ZIP CODE	04/2	5/2017
			IGHWAY 16 SC			
ALEXAND	DER ASSISTED LIVING	TAYLORSV	ILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D980	Continued From page 96		D980			
	rights, medication, sa assure all residents a timesAll non-compliance v Administrator/Director montly from that point-The Administrator wi meetings with all staff safe at all timesThe Administrator wi resident rights, medic fire drills.  CORRECTION DATE	Il continue to have montly to assure all resident are Il continue to go over ations, safety, fall risk, and				
D992	G.S. § 131D-45. Exar the presence of contr for applicants for emphomes.  (a) An offer of employ licensed under this Ar conditioned on the apexamination and scresubstances. The exar be conducted in acco Chapter 95 of the Geprocedure that utilizes may be used for the of applicants and may the results of the applicance, the adult of substance, the adult of	ment by an adult care home ticle to an applicant is plicant's consent to an	D992			

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 97 of 100

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED	
h-1000004		h-1002004	B. WING		R	
		hal002004			04/25/2017	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO			
			/ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D992	Continued From page 97		D992			
	applicant's prescribing controlled substance examination and screphysician to treat the psychological condition physician shall include substance, the prescribed and the condition for prescribed. If the rescent employee's examinate the presence of a concare home may requi-	pening is prescribed by that applicant's medical or on. The verification from the ethe name of the controlled ribed dosage and frequency, which the substance is alt of an applicant's or ion and screening indicates atrolled substance, the adult re a second examination fy the results of the prior				
	facility failed to assure employee's controlled tested positive for oxy examination and screverify the results of the screening, or a state prospective employee he had prescribed the The findings are:  Review of the person Resident Care Coord - A controlled substar completed on 7/19/16 oxycodone.  -There was no documer of the state of the st	and record reviews, the te that after a prospective d substance screening ycodone that a second tening was performed, to the prior examination and ment was provided by the the best sphysician which verified the coxycodone.  The file for the current inator (RCC) revealed: the screening had been to with a positive result for mentation a second tening had been completed				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 98 of 100

DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:			
			7. BOILBING.			
					R	
hal002004		hal002004	B. WING		04/2	5/2017
			•			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AL EVAND	ED 40010TED 1 11/11/0	3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
	OLIMANA DV OT		<u> </u>			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
,,,,		,		DEFICIENCY)		
D992	Continued From page	98	D992			
	D001 1					
		provided a statement which				
	verified he had prescr	ibed oxycodone.				
	-She had been hired a	as a Medication				
	Aide/Supervisor on 7/	19/16.				
	·					
	Interview on 4/13/17	at 11:45am with the				
	Administrat or reveale					
		sitive drug screen was hired				
		and later became the				
	Resident Care Coordinator (RCC).					
	-He was aware that all staff must have a negative					
	drug screen or documentation from their physician which verified he had prescribed oxycodone.  -The former RCC had told him the drug screen for the current RCC was "ok".  -He had taken the previous RCC's word that the					
	drug screen was nega					
		e drug screens for the new				
		<del>-</del>				
	staff, but left it up to the					
	<ul><li>-He depended on the RCC to make sure the drug screens for new staff were negative.</li><li>-The Administrator was instructed by the surveyor</li></ul>					
	that a new offsite drug	g test needed to be obtained				
	immediately for the R	CC.				
	-The Administrator wa	as also instructed by the				
	surveyor that if the Ro					
		ner treating physician that				
		cation during the time frame				
	she was hired that wo	<u>~</u>				
	Silo wao iliica tilat we	ala camoo.				
	Interview on 4/42/47	at 11:50am with the current				
		at 11.50am with the current				
	RCC revealed:	0.5				
	-She became the RC					
		nedication in the past that				
	showed up as positive	e on the drug screen.				
		new that the drug screen				
	was positive.	3				
		d brought a "pill bottle" to				
	The content too had	a broagint a pin bottle to				

Division of Health Service Regulation

show the previous RCC that she was on the

STATE FORM 6899 V1B311 If continuation sheet 99 of 100

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		04	R	
NAME OF P	ROVIDER OR SUPPLIER			TE ZIP CODE	04	/25/2017	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH							
ALLXANL	PER ASSISTED EIVING	TAYLOR	SVILLE, NC 2868	B1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
D992	medicationShe had told the form a note from her preso the oxycodone however asked for a note.  Telephone interview where 4/22/17 at 2:44pm reverse had informed the RCC, had a positive of Administrator had alreguire her to have an arrow the current RCC, had controlled substance ahould have been in late.	ner RCC, she would bring in ribing physician concerning ver the former RCC never with the former RCC on vealed: e Administrator the current drug screen but the eady hired her and did not nother screening. Id more than 1 positive screening and the results her personnel record. d told the former RCC, at screening, she had tested e because she had a "tooth	D992				

Division of Health Service Regulation

STATE FORM 6899 V1B311 If continuation sheet 100 of 100