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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted an annual survey, a follow-up survey and a complaint investigation on April 11, 12, and 13, 2017 with a telephone exit on April 25, 2017. The complaint investigation was initiated by the Alexander Department of Social Services on April 4, 2017.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the home in a clean manner free from hazards related to a pile of cigarette butts, cigarette ashes, dirt and paper trash swept up and left in a corner of the smoking porch and an ashtray/trash receptacle on the screened porch overflowing with flammable trash and cigarette butts. The findings are: Observations of the facility's screened porch at the end of the building on 4/11/17, 4/12/17 and 4/13/17 revealed:	D 079		

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D 079	Continued From page 1 -The floor was concrete. -The porch contained several chairs and multiple round tables, one with an ashtray containing old cigarette butts and one with a small tin can containing cigarette butts. -There was a pile of trash approximately 2 and one half feet wide and approximately 4 inches deep that had been swept into the corner by a large metal garbage can on the right side of the porch and was in the same location for three days. -The pile of trash consisted of cigarette ashes, dirt, cellophane wrappers, small pieces of paper, a wadded up paper towel and a large number of cigarette butts. -There was a metal ashtray/trash receptacle approximately 3 feet tall and 10 inches square beside a wooden bench along the wall of the facility. -The top of the receptacle, the ashtray, was approximately 2 inches deep with several areas where the original finish had peeled away and was rusted, and contained several cigarette butts. -Approximately 6 inches below the ashtray, there was a circular opening approximately 6 inches in diameter on each side of the receptacle. -Cigarette butts mixed in with, and on top of, empty cigarette packs, cellophane wrappers, paper and facial tissue filled the receptacle and spilled out onto the floor. Interviews with six residents 4/11/17 between 10:30am and 12:15pm revealed: -Some of the residents who smoked, threw their cigarette butts on the floor of the screened porch when they were done smoking. -"We need more ashtrays out there and maybe they wouldn't throw the butts on the floor." -The metal trash can on the screened porch was for trash.	D 079		

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D 079	Continued From page 2 -"It was dangerous to use the tall ashtray for trash. It could catch on fire." -There had not been a fire on the screened porch that anyone was aware of. -The housekeeper was the one who cleaned the porch. Interview on 4/11/17 at 12:30pm with the Administrator revealed: -He was not aware there were cigarette butts in with the paper trash in the ashtray/trash receptacle on the screened porch. -He was not aware of the pile of trash and cigarette butts in the corner of the screened porch by the metal trash can. -He would put more ashtrays on the porch and remove the ashtray/trash receptacle. -He would have the pile of trash etc. remove from the porch.	D 079		
D 101	10A NCAC 13F .0309(b)(c) Plan For Evacuation 10A NCAC 13F .0309 Plan For Evacuation (b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on interviews and record reviews the	D 101		

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D 101	Continued From page 3 facility failed to assure rehearsals of the fire plan were performed quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. The findings are: Confidential interviews with four employees revealed there had not been a fire drill on either shift since before October 2016. Interviews on 4/11/17 between 10:30am and 2:30pm with eight residents revealed: -One resident who had not been at the facility very long stated, "I don't know what the fire alarm sounds like and I don't know what to do or where to go if it goes off." -Several residents said the last fire drill was in the summer. -One resident said the last facility he was at, "They had fire drills all the time. We even had them during the night." -One resident had worked in healthcare and was concerned no fire drill had been held in the past four months. -"One resident is blind and in a wheelchair. She wouldn't know what to do." -"If the alarm went off and it was raining, would we have to go outside?" -"They would tells us it was a fire drill so we wouldn't be scared, right?" Interview on 4/11/17 at 2:15pm with the Resident Care Coordinator revealed: -She was not aware of any fires at the facility. -Fire drills are held every quarter and on both shifts. -She thought the last fire drill had been in January 2017.	D 101		

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D 101	Continued From page 4 Interview on 4/12/17 at 3:05pm with the Administer revealed: -The facility had not had any fires. -He thought the facility's last fire drill had been in September 2016 or October 2016. -He did not know why fire drills had not been conducted quarterly on both shifts. -There were resident's at the facility who had not experienced a fire drill. -There was one resident who was blind, in a wheelchair, and a two person assist who would need help exiting the building. -He would hold a fire drill on both shifts as soon as possible.	D 101		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the building and all electrical equipment in the home in a safe and operating condition related to exposed wires in the cord of a bug light on the wall of the resident hallway, ceiling fans/lights missing 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 and/or covers leaving the switch boxes exposed. The findings are: Observations of the facility on 4/11/17 revealed:	D 105		

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D 105	Continued From page 5 -There was a two bulb ceiling fan/light fixture on the screened porch missing one light bulb and a globe. -The wall light beside the entry/exit door to/from the facility from the screened porch did not have a globe. -The two ceiling fan/light fixtures on the resident hallway had a build-up of dust on the blades and motors and needed cleaning. -Three of four common shower/tub rooms had dimmer switches without dials and/or covers exposing the stems and/or the switch boxes. There were no wires visible. -The switch boxes were labeled, "CAUTION HIGH VOLTAGE. DISCONNECT POWER SUPPLY BEFORE SERVICING." -There was a bug light hanging on the wall and plugged into an electrical outlet on the resident hallway closest to the screened porch. -The white cover over the wires was cracked and had curled away from where the cord entered the wall plug and the wires inside the cord were exposed. Interviews with six residents on 4/11/17 from 1:00pm through 3:40pm, 4/12/17 from 9:00am through 12:00pm and 4/13/17 from 11:00am 12:15pm revealed: -They had never noticed the ceiling fan/light fixture on the screened porch was missing a light bulb and a globe. -They had never noticed the wall light beside the entry/exit door to/from the facility from the screened porch did not have a globe. -Two residents had wondered what the [dimmer] switches were for in the bathrooms but had never touched them. -One of the female residents, in a wheelchair, could not see very well and "she bumped into everything. That might be how the cord [to the	D 105		

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D 105	Continued From page 6 bug light] got broken". Interview on 4/11/17 at 12:30pm with the Administrator revealed: -He was in the facility several times each week. -He was not aware the two bulb ceiling fan/light fixture on the screened porch was missing one light bulb and a globe. -He was not aware the wall light beside the entry/exit door to/from the facility from the screened porch did not have a globe. -He was not aware the two ceiling fan/light fixtures on the resident hallway had a build-up of dust on the blades and motors and needed cleaning. -He was not aware three of four common shower/tub rooms had dimmer switches without dials and/or covers leaving the dial stems and switch boxes exposed. -He was not aware the white cover over the wires of the bug light, hanging on the wall and plugged into an electrical outlet on the resident hallway closest to the screened porch, was cracked and had curled away from where the cord entered the wall plug and the wires inside the cord were exposed. -He would work on getting those things cleaned and/or repaired by the maintainenace man as soon as possible.	D 105		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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

Based on observations, interviews and record reviews, the facility failed to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 2 sampled residents with physical decline and history of falls, resulting in the potential for serious injury when Resident #2 fell down outside steps in her wheelchair in December 2016 and in March 2017 when another fall resulted in medical treatment at the emergency room (ER) for a closed head injury and Resident #7 who fell in October 2016 requiring medical treatment in the ER for a closed head injury and left wrist injury and and another fall in April 2017 resulted in a compound fracture of the first lumbar vertebra with stabilization of the fracture in the Emergency Room.

The findings are:

A. Review of Resident #2's current FL2 dated 2/8/17 revealed:
-Diagnoses included dementia, chronic kidney disease, Type II diabetes, high blood pressure and chest pain.
-Medication orders included memantine HCL 10mg, twice a day (for dementia associated with Alzheimer's disease) and sertraline 50mg daily (for depression and anxiety).
-The resident was noted to be semi-ambulatory with a wheelchair and incontinent of bowel and bladder.
-The resident required extensive assistance with eating, toileting and ambulation.
-The resident was totally dependent on staff for

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bathing, dressing, grooming and transfer.
-There was no indication the resident was disorientated or exhibited inappropriate behavior.

Review of Resident #2's current care plan dated 2/12/16 revealed:
-The resident required extensive assistance with eating, toileting and ambulation/locomotion.
-She was totally dependent on staff for bathing, dressing, personal hygiene and transferring.
-There was no indication the resident was wandering, verbally or physically abusive, resisting care, or exhibiting disruptive or socially inappropriate behavior.

Based on record review and observation, Resident #2 was determined not to be interviewable.

Review of a Physician's note in Resident #2's record dated 8/12/16 revealed the resident had functional decline with decreased mobility, generalized weakness, decreased strength and unsteady gait with falls and dementia.

Review of Incident and Accident Reports for Resident #2 revealed:
-On 12/21/16 at 3:10am, the resident's roommate came to staff and stated Resident #2 was on the floor. Assessment revealed no injury. Resident had been dressed and brought taken by wheelchair to the Living Room with staff.
-There was no documentation of interventions put in place to safeguard the resident post-fall .
-On 12/21/16 at 8:00am, the resident had been up all of the night, had been agitated and going in and out of other resident rooms as she made her way down the hallway saying she was "going home".
-The Personal Care Aide (PCA) and the

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Medication Aide (MA) were busy in the dining room and passing medications.
-A door alarm sounded and the MA, PCA and Maintenance person went checking doors.
-The resident had made her way down the hall to the office area, had opened the door to the back yard, fallen down the stairs in her wheelchair and had been found laying on the ground up against the chain link fence.
-The staff had checked the resident and noted no injury, put her back in her wheelchair, took her into the facility and put her to bed.
-Documentation of 30 minute checks the staff stated had been done were not located.
-There was no documentation interventions had been put in place to safeguard the resident post-fall.
-There was no documentation the resident's physician had been notified.

Review of Resident #2's record revealed:
-A staff note dated 3/13/17 which stated, "Still has purple, black, yellow colored contusions that are healing from her fall. ER (Emergency Room) doctor stated may take several weeks for healing due to her age".
-No documentation regarding the date and time of the fall.
-No notes from the ER regarding the fall.

Review of a Physician's note in Resident #2's record dated 3/23/17 revealed:
-Diagnoses included dementia with behavioral disturbances, cognitive loss, anxiety state/depression, abnormal gait and dysuria (discomfort when urinating).
-The resident needed constant monitoring due to her trying to walk unassisted and being too frail and weak to stand alone.
-The resident had poor vision, limited strength,

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was wheelchair bound and a 2 person assist.
-The resident had fallen attempting to get out of her wheelchair unassisted, and sustained a bruise to her forehead and left eye approximately one week prior to this visit.
-She had been evaluated and treated at the Emergency Room (ER). Xrays were negative.
-Staff had told the physician Resident #2 needed a higher level of care than facility could provide and requested a SNF (skilled nursing facility) referral.
-The physician felt the resident was appropriate for palliative care, possibly hospice. The family declined.
-An order dated 3/23/17, to transfer the resident to skilled nursing as "care exceeds the ALF (Assisted Living Facility) capabilities and increased risk for falls and need for supervision throughout the day to assist with all aspects of her care".

Review of Incident and Accident Reports for Resident #2 revealed:
-There was no Incident/Accident Report regarding a fall referred to in staff notes dated 3/13/17 and in a physician's note dated 3/23/17.
-There was no documentation of interventions put in place to safeguard the resident post-fall.

Review of Physician's notes in Resident #2's record dated 4/10/17 revealed:
-Several changes were made to the resident's medication, "Hopefully this will help her sleep at night and still control behaviors during the day without being so sedated in the afternoon".
-These medication changes included: Ativan 0.25mg twice a day as needed was discontinued, Vistaril 12.5mg at 2pm and 6pm were prescribed to assist with behaviors, and Remeron 7.5mg at bedtime was continued.

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D 270	Continued From page 11 -The Namenda (memantine HCL) would "continue, however its benefits are unlikely at this stage of disease progression". Interview on 4/12/17 at 11:45am with Staff E, PCA revealed: -She had worked at the facility since January 4, 2017. -"[Resident #2] is a heavy care resident. She has changed a lot since I came to work here. She is dead weight and is always falling. She needs 24/7 care and we just can't do that." -The facility has an old lift but the staff had been told not to use it. -"Resident #2 falls several times a week, out of her wheelchair when she leans forward and reaches for the floor, and when she tries to get up and walk." -"Last week [Resident #2] fell twice and this week once so far. About 4 weeks ago, I came back to work and the left side of her face was all bruised from a fall." -"Sometime before I stated working here, [Resident #2] opened the back door by the office and fell down the steps in her wheelchair." -She was not aware of interventions put in place to safe-guard Resident #2 after her falls. -The door alarms were always on and it was difficult to check every door every time an alarm went off. Interview on 4/13/17 at 9:30am with Staff I, MA, revealed: -Resident #2 cannot see very well and requires a lot of assistance from the staff. -On 12/21/16, Resident #2 had been awake most of the night and was pretty agitated at breakfast. -Resident #2 was in her wheelchair, went down the hall to the exit door at the end of the hallway, by the office, and opened the door.	D 270		

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-The PCA was in the dining room and the MA was giving medications when the door alarm went off.
-Resident #2 had fallen down the back stairs in her wheelchair and was found laying on the ground up against the chain link fence.
-Resident #2 was checked for injury, none was noted, taken to her room and put to bed.
-The staff had Resident #2 on thirty minute checks.
-She was not aware of any other falls for Resident #2.

Observations on 4/12/17 at 3:30pm of the entry/exit door by the facility office revealed:
-The door was approximately 32 to 34 inches wide and contained a large window.
-The door knob was located on the right side of the door and the door opened outward to the left onto a concrete porch.
-An alarm sounded while the door was open.
-The threshold was flush to the concrete porch.
-Behind the door, when it was open, was the outer wall and window to an unoccupied resident room.
-The concrete porch had a full double handrail on the right side and a single handrail attached to the building, below the resident room window, curving down and attached to a half concrete slab at the base of the porch by the chain link fence.
-From handrail to handrail, the porch was approximately 36 inches wide and from threshold to the end of the porch was approximately 40 inches long.
-A chain link fence was flush to the outer wall of the unoccupied resident room at the bottom of the porch stairs.
-At the base of the stairs, looking toward the door, was a slab of concrete on the right and bare ground on the left.
-A step up from the ground and another to the

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porch each had a height of approximately 8 inches.
-Upon re-entry to the facility, the alarm had sounded and then was quiet.
-It was noted the door had not closed completely and daylight could be seen around it on three sides.
-The latch touching the metal tee-strike had silenced the alarm but the door remained unlatched.

Interview on 4/12/17 at 3:15pm with the Administrator revealed:
-He was not aware Resident #2's physician had written an order to transfer the resident to skilled nursing as "care exceeds the ALF (Assisted Living Facility) capabilities and increased risk for falls and need for supervision throughout the day to assist with all aspects of her care".
-Resident #2 had fallen several times but did not fall "all the time".
-The staff knew to keep an eye on her because she tried to get up and walk.
-He was not aware of other interventions put in place to safeguard the resident.
-He was aware the resident had opened the back door by the office and fallen down the stairs in her wheelchair.
-He was not aware the entry/exit door by the office did not always latch when it closed.
-He was not aware the alarm on the door would not sound if the latch was making contact with the tee-strike.
-He would have the door checked as soon as possible.

Interview on 4/12/17 at 3:40pm with the Resident Care Coordinator (RCC) revealed:
-She was not aware Resident #2's physician had written an order to transfer the resident to skilled

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nursing as "care exceeds the ALF (Assisted Living Facility) capabilities and increased risk for falls and need for supervision throughout the day to assist with all aspects of her care".
-She did not know why Resident #2's physician had not been informed of the fall on 12/21/16.
-She 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 person assist.
-Resident #2 often leaned over in her wheelchair and had fallen out trying to pick up things she thought were on the floor but didn't get hurt.
-Resident #2 tried to walk in her room and had fallen several times without injury.
-She did not know why reports had not been filled out for each fall.
-The facility had an old lift but it was not in use.
-Resident #2 could weight bear and walks a few steps but it was not safe for her to do that without help.
-She was not aware the entry/exit door by the office did not always latch when it closed.
-She was not aware the 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 resident's physician since 1/21/17.
-She had seen a gradual decline in the resident abilities and felt she was appropriate for palliative care, possibly Hospice however the family did not want either one.
-The resident could walk but was extremely unsteady on her feet and her vision was impaired.
-She was aware Resident #2 had fallen once in March 2017.
-She was not aware Resident #2 had gone out of

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the back door of the facility and fallen down the stairs in her wheelchair on 12/21/16.
-She had written an order on 3/23/17 for the facility to look for a skilled nursing facility because she felt the Resident #2 needed more care and more supervision than this facility could provide.
-She was not aware the facility had not been looking for placement for the resident.

B. Review of Resident #7's current FL2 dated 11/4/16 revealed:
-Diagnoses included major neurocognitive disorder (previously known as dementia) and bipolar disorder.
-Medications included donepezil 10mg daily (for Alzheimer's Disease), mirtazapine 30mg at bedtime (antidepressant) and Invega Sustenna 78mg injection every month (for bipolar disorder).
-She was ambulatory with no assistive devices and continent of bowel and bladder.
-There was no indication the resident was disorientated or exhibited inappropriate behavior.

Review of the Resident Register for Resident #7 revealed an admission date of 10/24/16.

Review of Resident #7's current care plan dated 11/4/16 revealed:
-The resident required limited assistance with all activities of daily living and had limited range of motion in her upper extremities.
-The resident resisted care at times and was limited in her ability with locomotion.
-The resident was sometimes disoriented, forgetful and needing reminders and her speech was slurred.

Review of a hospital discharge summary dated 10/28/16 in Resident #7's record revealed:
-Resident #7 had been brought in by EMS "full

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syncope" (temporary loss of consciousness).
-She had been on the smoking porch at the facility when she passed out, awakened and passed out again.
-When she fell, she hit the left side of her face and injured her left wrist. Xrays were negative for fractures.
-At discharge on 10/30/16, the cause of her syncope had not been identified. The hospital physician wrote, "I recommend supervision with ambulation."
-Resident #7 had returned to the facility with a splint on her left wrist due to pain and swelling.

Review of physican notes in Resident #7's record revealed:
-On 10/28/16, the resident had an episode of syncope, had fallen on the screened porch, hit her face and injured her left wrist. She had been taken to the hospital for treatment and admitted.
-The reason for the syncope was not determined and the resident had been discharged back to the facility.
Review of physican notes in Resident #7's record revealed:
-On 11/4/16, "Functional decline with decreased mobility, generalized weakness, decreased strength and unsteady gait."
-On 12/13/16, the resident "has had recent falls and is at risk for falls".

Review of Incident and Accident Reports provided by the facility for Resident #7 revealed there was no documentation Resident #7 had fallen on 10/28/16 or of interventions put in place to increase the safety of the resident post-fall.

Review of a hospital discharge summary dated 4/3/17 in Resident #7's record revealed:
-Resident #7 had fallen at the facility, complained

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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: -She had worked at the facility since January 4, 2017. -Resident #7 had been getting weaker, was more unsteady on her feet and needed more care than the facility could provide. -The resident had fallen in the bathroom the week before and fractured her back and had been in a lot of pain. -She was not aware of interventions put in place to increase the safety of the resident after her fall.	D 270		

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D 270	Continued From page 18 Interview on 4/13/17 at 9:30am with Staff I, Medication Aide (MA) revealed: -Resident #7 had been in a lot of pain after falling and fracturing her back. -The staff had been transporting the resident to the dining room in a wheelchair or she would eat in her room. -"She is alert and orientated but seems depressed. I think she's given up." Interview on 4/12/17 at 3:15pm with the Administrator revealed: -He was aware Resident #7 had fallen and been sent to the hospital for treatment of injuries from those falls. -He stated the resident was watched more closely by the staff but was not aware of interventions put in place to increase Resident #7's safety post-falls. Interview on 4/12/17 at 3:40pm with the Resident Care Coordinator (RCC) revealed: -She stated Resident #7 had fallen twice since she was admitted and is alert, orientated and very independent. -She takes her own showers and ambulates in her room and in the hallway. -She was not aware of interventions put in place to increase Resident #7's safety post falls. The facility's failure to provide supervision for 2 of 2 sampled residents with a history of physical decline and falls, resulted in the potential for serious injury when Resident #2 fell down outside steps in her wheelchair in December 2016 and in March 2017 when another fall resulted in medical treatment at the emergency room (ER) for a closed head injury and Resident #7 who fell on 10/28/16 requiring medical treatment in the ER for a closed head injury and left wrist injury and a	D 270		

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D 270	Continued From page 19 fall on 4/3/17 which resulted in a compound fracture of the first lumbar vertebra with stabilization of the fracture in the Emergency Room. The facility's failure to supervise Resident #2 and Resident #7 resulted in serious physical harm and substantial risk that death or serious injury could occur and constitutes a Type A2 Violation. A Plan of Protection was provided by the facility and included the following: -Staff will check on Resident #2 and Resident #7 every 30 minutes and offer help as needed. -Staff will encourage use of assistive devices as appropriate for all residents. -Staff will ensure call bells are within reach of the residents. -Staff will encourage residents to use call bells to summon staff. -All residents will be assessed quarterly and on an as needed basis for falls. -New residents will be assessed for falls upon admission. -If a resident becomes/is a potential risk for falls, the physician, responsible party and DSS will be notified and a new plan of care developed. -If appropriate, the resident will be discharged to a higher level of care. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 25, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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

Based on interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 3 of 3 sampled residents regarding Resident #2's transfer to a higher level of care due to falls and care and supervision exceeding the ALF (Assisted Living Facility) capabilities, Resident #3, with a history of chronic pain being without Endocet pain medications for 24 hours, and Resident #7 with a physician's order to schedule an appointment with an orthopedic surgeon post-fall with a compound fracture of the first lumbar vertebra and a vetebroplasty performed in the Emergency Room.

The findings are:

A. Review of Resident #2's current FL2 dated 2/8/17 revealed:
-Diagnoses included dementia, chronic kidney disease, Type II diabetes, high blood pressure and chest pain.
-The resident was noted to be semi-ambulatory with a wheelchair and incontinent of bowel and bladder.
-The resident required extensive assistance with eating, toileting and ambulation.
-The resident was totally dependent on staff for bathing, dressing, grooming and transfer.
-There was no indication the resident was disorientated or exhibited inappropriate behavior.

Review of Resident #2's current care plan dated 2/12/16 revealed:

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D 273	Continued From page 21 -The resident required extensive assistance with eating, toileting and ambulation/locomotion. -She was totally dependent on staff for bathing, dressing, personal hygiene and transferring. -There was no indication the resident was wandering, verbally or physically abusive, resisting care, or exhibiting disruptive or socially inappropriate behavior. Review of a Physician's note in Resident #2's record dated 8/12/16 revealed the resident had functional decline with decreased mobility, generalized weakness, decreased strength and unsteady gait with falls and dementia. Review of a Physician's note in Resident #2's record dated 3/23/17 revealed: -Diagnoses included dementia with behavioral disturbances, cognitive loss, anxiety state/depression, abnormal gait and dysuria (discomfort when urinating). -The resident needed constant monitoring due to her trying to walk unassisted and being too frail and weak to stand alone. -The resident had poor vision, limited strength, was wheelchair bound and a 2 person assist. -The resident had fallen attempting to get out of her wheelchair unassisted, and sustained a bruise to her forehead and left eye approximately one week prior to this visit. -She had been evaluated and treated at the Emergency Room (ER). Xrays were negative. -Staff had told the physician Resident #2 needed a higher level of care than facility could supply and requested a SNF (skilled nursing facility) referral. -The physician felt the resident was appropriate for palliative care, possibly hospice. The family declined. -An order, dated 3/23/17, to transfer the resident	D 273		

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to skilled nursing as "care exceeds the ALF (Assisted Living Facility) capabilities and increased risk for falls and need for supervision throughout the day to assist with all aspects of her care".

Interview on 4/12/17 at 11:45am with Staff E, Personal Care Aide, (PCA) revealed:
-She had worked at the facility since 1/4/17.
-"[Resident #2] is a heavy care resident. She has changed a lot since I came to work here. She is dead weight and is always falling. She needs 24/7 care and we just can't do that."
-The facility has an old lift but the staff had been told not to use it.
-"Resident #2 falls, several times a week, out of her wheelchair when she leans forward and reaches for the floor, and when she tries to get up and walk."
-"Last week [Resident #2] fell twice and this week once so far. About 4 weeks ago, I came back to work and the left side of her face was all bruised from a fall."
-"Sometime before I stated working here, [Resident #2] opened the back door by the office and fell down the steps in her wheelchair."
-The door alarms were always on and it was difficult to check every time one went off.

Interview on 4/12/17 at 3:15pm with the Administrator revealed:
-He felt the facility could meet the care needs of Resident #2.
-He thought the RCC had contacted several skilled facilities regarding moving Resident #2 to a higher level of care.

Interview on 4/12/17 at 3:40pm with the Resident Care Coordinator (RCC) revealed:
-She was not aware of the physician's order

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written 3/23/17 to transfer the resident to skilled nursing due to "care exceeds the ALF (Assisted Living Facility) capabilities and increased risk for falls and need for supervision throughout the day to assist with all aspects of her care".
-She would contact several skilled nursing facilities regarding Resident #2 need for a higher level of care.

Interview on 4/13/17 at 9:52am with Resident #2's physician revealed she was not aware the facility had not contacted skilled nursing facilities regarding the transfer order written 3 weeks ago.

B. Review of Resident #7's current FL2 dated 11/4/16 revealed:
-Diagnoses included major neurocognitive disorder (previously known as dementia) and bipolar disorder.
-Medications included donepezil 10mg daily (for Alzheimer's Disease), mirtazapine 30mg at bedtime (antidepressant) and Invega Sustenna 78mg injection every month (for bipolar disorder).
-She was ambulatory with no assistive devices and continent of bowel and bladder.
-There was no indication the resident was disorientated or exhibited inappropriate behavior.

Review of Resident #7's register dated 10/24/16 revealed an admission date of 10/24/16.

Review of Resident #7's current care plan dated 11/4/16 revealed:
-The resident required limited assistance with all activities of daily living and had limited range of motion in her upper extremities.
-The resident resisted care at times and was limited in her ability with locomotion.
-The resident was sometimes disoriented, forgetful and needing reminders and her speech

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D 273	Continued From page 24 was slurred. Review of a hospital discharge summary dated 4/3/17 in Resident #7's record revealed: -Resident #7 had fallen at the facility, complained 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. Interview on 4/12/17 at 3:15 with the Administrator revealed: -He was not aware the ER physician had sent Resident #7 back to the facility on 4/3/17 with instructions to call [Name of orthopedic surgeon] to schedule an appointment. -He would have the Resident Care Coordinator (RCC) schedule an appointment. Interview on 4/12/17 at 3:40pm with the RCC revealed: -She was not aware the ER physician had sent Resident #7 back to the facility on 4/3/17 with instructions to call [Name of orthopedic surgeon] to schedule an appointment. -She would call and schedule an appointment as soon as possible. C. Review of Resident #3's current FL2 dated 1/2/2017 revealed: -Diagnoses included chronic pain and enlarged prostate. -A physician order for Endocet 10/325mg, 1 tablet 3 times a day at 7am, 12 noon, and 9pm (used	D 273		

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D 273	Continued From page 25 for chronic pain). Interview with Resident #3 on 4/12/2017 at 2:00pm revealed: -He received his last dose of Endocet "yesterday" at 12 noon. -If he did not receive his pain medication, his pain level was at a "10 or over" on a pain scale 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. Interview with the Resident Care Coordinator (RCC) on 4/11/17 at 2:20pm revealed she had contacted the pain clinic for a prescription and the Endocet would be "in tonight." Interview with the RCC 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 prescription, but that it would be in today. Interview with the RCC on 4/13/17 at 9:45am revealed the Endocet came in the tote "last night." Review of the Resident #3's Endocet controlled drug sheet labeled as 90 count dispensed on 3/15/17 revealed staff began documentation of administration on 3/15/17 at 7:00am and ended with a 0 balance on 4/11/17 at 12:00pm. documented as administered or wasted for at least 16 times. Comparison of the physician order for 3 Endocet per day to the 90 Endocet listed on the controlled drug sheet label which were dispensed on 3/15/17, revealed the Endocet should have been a sufficient supply through 4/13/17 at 9:00pm.	D 273		

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ALEXANDER ASSISTED LIVING	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 26 Interview with Resident #3's family member on 4/13/2017 at 11:00am revealed they went to the pain clinic on 4/12/17 and asked for Resident #3's prescription for the Endocet because Resident #3 ran out. Interview with director of the pain clinic on 4/18/2017 at 9:00am revealed: -The facility staff did not notify the pain clinic that Resident #3 ran out of Endocet on 4/11/17, but his family member came by their office on 4/12/17 for a new prescription. -The director stated the 90 Endocet dispensed on 3/15/17 should have been a sufficient supply to last until 4/15/17. -They do not usually prescribe narcotics when they know the last delivery should not be out, but they made an exception in this case. Review of the Endocet controlled drug sheet which ended on 4/11/17 at 12:00pm and the controlled sheet for the Endocet which began on 4/12/17 at 9:00pm, and the interview with the director of the pain clinic revealed Resident #3 missed 3 doses of Endocet because there were none available for administration and there was a delay in reordering the Endocet. Based on interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 3 of 3 sampled residents regarding Resident #2's transfer to a higher level of care due to care and supervision exceeding the ALF (Assisted Living Facility) capabilities, Resident #3 with a history of chronic pain being without Endocet pain medications for 24 hours, and Resident #7 with a physician's order to schedule an appointment with an orthopedic surgeon post-fall with a compound	D 273		

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D 273	Continued From page 27 fracture of the first lumbar vertebra and a vetebroplasty performed in the Emergency Room. The failure of staff to assure all referrals and follow-ups were completed in a timely manner was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 4/13/17 revealed: -The facility will assure all referrals are handled as quickly as possible such as scheduling any appointments immediately. -Follow-up appointments will be made in a timely manner to assure residents are safe and secure. -The doctors appointment notes will be double checked to assure all referrals are made. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 9, 2017.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or	D 280		

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D 280	Continued From page 28 current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Licensed Health Professional Support (LHPS) evaluations were completed quarterly for 2 of 3 sampled residents (Resident #5 and #6) and included a physical assessment, evaluation of the residents' care being provided, or needed recommendations for changes in the care of the resident. The findings are: A. Review of Resident #5's current FL2 dated 6/17/16 revealed: -Diagnoses included mild mental retardation, major depression, schizoaffective disorder, seizure disorder and diabetes mellitus. -An order for finger stick blood sugar checks every morning. Review of Resident #5's most recent LHPS revealed: -An evaluation date of 2/1/16. -The task listed was FSBS (finger stick blood sugar).	D 280		

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D 280	Continued From page 29	D 280		

Interview on 4/12/17 at 3:00pm with Resident #5 revealed the medication aides did his finger sticks.

B. Review of Resident #6's current FL-2 dated 7/29/16 revealed:
-Diagnoses included altered mental status, hyperplasia of prostate, hypertension and atrial fibrillation.
-An order for compression hose, wheel chair, and oxygen.

Review of Resident #6's Resident Register revealed an admission date of 6/25/15.

Review of Resident #6's most recent Licensed Health Professional Support (LHPS) revealed:
-An evaluation date of 11/28/16.
-The date of last evaluation of 11/4/16.
-The tasks listed were Ted hose, transferring non-ambulatory resident, ambulation using assistive devices, inhalation medication by machine, and oxygen administration and monitoring.
-Changes and follow up recommendations listed 'continue all orders and hospice services'.

Interview on 4/13/17 at 2:45pm with Resident #6 revealed:
-The staff put on his "stockings" in the morning and take them off when he goes to bed.
-The staff help him when he has to go to the bathroom.
-The staff set his oxygen where it needs to be, he does not adjust his oxygen.

Interview on 4/13/17 at 3:45pm with the LHPS coordinator for the facility pharmacy revealed:
-He assigned the LHPS nurses to the facilities.
-He gave the LHPS nurses the autonomy to

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D 280	Continued From page 30 complete and schedule with the facilities what LHPS tasks needed to be completed. Attempted telephone interview with the facility LHPS Nurse on 4/13/17 at 1:15pm and 4:30pm was unsuccessful.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all therapeutic diets for 2 of 4 sampled residents (Resident #5 and #8) were served as ordered related to puree and no concentrated sweets diet orders. The findings are: A. Review of Resident #8's FL2 dated 7/29/16 revealed: -Diagnoses included mental retardation. -A physician order for a diabetic puree diet. Observation of the noon meal on 4/11/17 at 12:00pm revealed Resident #8 received pureed chicken, squash, sweet potatoes and applesauce. Review of the facility therapeutic menus revealed residents on a puree diet should also have received a roll.	D 310		

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D 310	Continued From page 31 Interview with the cook on 4/11/17 at 12:45pm revealed: -He had been taught that residents on a puree diet were not to be served bread. -He was not aware the puree therapeutic menus stated residents were to be served pureed bread. Refer to interview with the Administrator on 4/12/17 at 2:45pm. B. Review of Resident #5's FL2 dated 6/17/16 revealed: -Diagnoses included mild mental retardation, and schizoaffective disorder. -Physican orders for a No Concentrated Sweets diet. -Finger Stick Blood Sugars in the mornings. -Metformin 500mg three times per day. Review of a physician note dated 6/17/16 in Resident #5's record revealed she wanted to continue with the diabetes medications and finger stick blood sugars because of a slightly elevated A1C. Observation of the noon meal on 4/11/17 at 12:00pm revealed Resident #5 received chicken, squash, sweet potatoes and chocolate pudding. Review of the facility's therapeutic menus revealed residents on a No Concentrated Sweets diet should have received sugar free pudding. Interview with the cook on 4/11/17 at 12:45pm revealed: -He thought the chocolate pudding was sugar free. -He would assure in the future the residents on No Concentrated Sweets diet were served	D 310		

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D 310	Continued From page 32 according to the menu. Review of the label on the chocolate pudding can revealed it was not sugar free. Observation on 4/11/17 at 12:15pm revealed the label on the chocolate pudding container had caloric sweetener. Interview with Resident #5 on 4/11/17 at 10:30am when questioned about his diet and the food revealed he did not like the food. Refer to interview with the Administrator on 4/12/17 at 2:45pm. Interview with the Administrator on 4/12/17 at 2:45pm revealed: -All the cooks had been trained to follow the therapeutic menus. -He would assure they served according to the menus in the future.	D 310		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by:	D 315		

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D 315	Continued From page 33 Based on observations and interviews, the facility failed to develop a program of activities designed to promote the residents' active involvement with each other, their families and the community. The findings are: Observations on 4/11/17 at 10:45am of a large wooden activity calendar hanging on the wall in the facility's main hallway revealed: -The top of the calendar had an area for the month and year and was labeled April 2017. -Below the month and year, the board had been divided into seven sections, each containing a different day of the week. -Below each day of the week there were 6 additional boxes for a total of 42 sections. -Twelve of the sections were empty. The remaining 30 sections each contained a numbered piece of colored paper approximately 3 inches by 5 inches had been arranged to represent the activity calendar for April 2017. -Activities listed on the calendar included musical chairs on 4/3, card game day on 4/6, decorate cookies day on 4/8, fingerpainting on 4/9, bubble blowing day on 4/14, random act of kindness day on 4/15, wacky sock day on 4/21, color a picture day on 4/23, and musical train on 4/30. Continued observations in the facility on 4/11/17, 4/12/17/ and 4/13/17 revealed: -The activity listed on the activity calendar for 4/11/17, Movie Day, did not take place. -The activity listed for 4/12/17, Music Day, did not take place. -The activity listed for 4/13/17, Ice Cream Party, did not take place. -There were no alternative activities provided in their place.	D 315		

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D 315	Continued From page 34 Interviews with six residents on 4/11/17 between 10:30am and 12:15pm revealed: -One resident said there were no activities, "You watch TV or walk the halls to keep from going crazy. We never go on outings". -A second resident stated she had played corn hole and made a necklace "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 wasn't where all the smokers went to smoke. -The third resident stated he loved to read but one of the lenses had fallen out of his glasses. He wished he could get books on tape but didn't think the library would bring them to the facility and if they did he would have no way of getting them returned. -A fourth resident stated, "There wasn't any activities and it got pretty boring. Some of the residents can walk to the store but I can't and I don't trust them with 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 resident stated they loved to read magazines but there wasn't any to read. Interviews on 4/12/17 between 9:05 am and 3:55pm and 4/13/17 at 9:30am with four staff revealed: -There had not been an Activity Director in several months. -Some of the activities on the activity calendar were pretty childish. -They had not seen the residents having movies and popcorn, blowing bubbles or frosting cookies. -There was nothing special planned for Easter. -The residents went in the van to appointments but not on fun outings. -It can get pretty boring for most of these residents.	D 315		

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D 315	Continued From page 35 Interview on 4/13/17 at 3:15pm with the Administrator revealed: -The facility did not have an Activity Director but was in the process of looking for one. -He felt the calendar provided at least 14 hours of activities each week. -In the absence of an Activity Director his expectation was for all of the staff to pitch in and help with the activities. -He was not aware of the activities scheduled for 4/11/17, 4/12/17 and 4/13/17 and that the activities had not taken place. -The facility had not taken residents on an outing in several months.	D 315		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the 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	D 352		

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D 352	Continued From page 36 (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure all medications administered to 1 of 3 sampled residents (Resident #3) were dispensed from the pharmacy and properly labeled resulting in a Medication Aide administering 2 Endocet, prescribed for Resident 3's family member, from an unlabeled container the family member had brought to the facility from home. The findings are: Review of Resident #3's current FL2 dated 1/2/2017 revealed: -Diagnoses included chronic pain and enlarged prostate -A physician order for Endocet 10/325mg, 1 tablet 3 times a day at 7am, 12 noon, and 9pm (used for chronic pain). Observations of medication on hand for Resident #3 on 4/11/17 at 2:20pm revealed Endocet was not available in the medication cart. Interview with Resident #3 on 4/12/2017 at 2:00pm revealed: -He was currently out of Endocet and received his last dose "yesterday" at 12 noon. -He stated he also ran out of Endocet sometime in March, 2017, date not known, but the family brought in 2 tablets and the medication aides administrated them to him. -His family was aware the Endocet was unavailable, so they brought Endocet tablets for him that were prescribed for another family member.	D 352		

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D 352	Continued From page 37 -If he did not receive his pain medication, his pain level was at a "10 or over" on a pain scale ranging 1-10. Interview with Resident #3's family member on 4/13/2017 at 11:00am revealed: -In the past, about "2-3 weeks ago," Resident #3's family was notified of missing Endocet. -In March 2017, the family reported the Resident Care Coordinator (RCC) asked the family, in a roundabout way, to bring in Endocet because Resident #3 "was running out." -The family stated Resident #3 had run out of medication 3-4 times within the last 6 months. -The family also stated Resident #3 had been at the facility before, about 5 years ago, and had the same issues. Interview with the RCC on 4/13/17 at 11:15am revealed: -Resident #3 did run out of Endocet in March, date not known. -The RCC denied that she requested the family to bring in Endocet but that it was the family's idea. -The family member brought in 2 Endocet in a small white container. -The Endocet was in a container without a label. -She knew it was Endocet because she "looked it up online." -She did not keep a record of the 2 Endocet which the family brought in. -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 not know the date and times they were administered. -She could not find the controlled drug sheet for March which showed when Resident #1 ran out of Endocet. -She documented the administration of the 2	D 352		

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D 352	Continued From page 38 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 #3 for staff to administer. -Their policy did not allow for unlabeled medications to be administered to the residents. -They could not find the pharmacy delivery sheets and all of the residents' controlled drug sheets because "they were scattered all around."	D 352		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 4 sampled residents (Resident #3), received Endocet as prescribed. The findings are: Review of Resident #3's FL2 dated 1/2/2017 revealed: -Diagnoses included chronic pain and enlarged prostate.	D 358		

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D 358	Continued From page 39 -A physician order for Endocet 10/325 3 times a day 7am, 12 noon, and 9pm (used for chronic pain). -A physician order for methadone 10 mg at 8am 12 noon, 4 pm and 8 pm. Interview with Resident #3 on 4/12/2017 at 2:00pm revealed: -He received his last dose of Endocet "yesterday" at 12 noon. -He stated he also ran out of Endocet sometime in March, 2017, date not known, but the family brought in 2 tablets and the medication aides administered them to him. -If he does not receive his pain medication, his pain level is at a "10 or over" on a pain scale ranging 1-10. Observations of medications on hand for Resident #3 on 4/11/17 at 2:20pm revealed no Endocet available in the medication cart. Interview with the Resident Care Coordinator (RCC) on 4/11/17 at 2:20pm revealed the Endocet had been ordered and would be "in tonight." Interview with the RCC on 4/12/17 at 9:00am revealed the Endocet did not come in on 4/11/17 because the physican had to send in a prescription, but that it would be in "today." Interview with the RCC 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 revealed 90 Endocet 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.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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D 358	Continued From page 40 Review of the March and April 2017 electronic Medication Administration Records on 4/11/17 at 2:00pm revealed: -Transcriptions for Endocet 10/325 to be administered three times per day, at 7:00am, 12:00pm and 9:00pm. -Endocet 10/325 was documented as administered routinely. Interview with Resident #3's family member on 4/13/2017 at 11:00am revealed: -They went to the pain clinic on 4/12/17 and asked for a new prescription for Resident #3's Endocet because he ran out on 4/11/17. -In the past, about "2-3 weeks ago," Resident #3's family was notified of missing Endocet. -In March 2017, the family reported the RCC had asked family in a roundabout way to bring in Endocet because Resident #3 was running out. -Family stated that Resident #3 has ran out of medication 3-4 times within the last 6 months. Family stated that Resident has been at the facility before about 5 years ago and has had the same issues. Interview with director of the pain clinic on 4/18/2017 at 9:00am revealed: -The facility staff did not notify the pain clinic that Resident #3 ran out of Endocet on 4/11/17, but his family member came by their office on 4/12/17 for a new prescription. -The director stated the 90 Endocet dispensed on 3/15/17 should have been a sufficient supply to last until 4/15/17. -They do not usually prescribe narcotics when they know the last delivery should not be out, but they made an exception in this case.	D 358		

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D 367	Continued From page 41	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: TYPE B VIOLATION 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 related to as needed medications documented on	D 367		

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D 367	Continued From page 42 a controlled drug sheet but with no justification or effectiveness documented on the eMARs. The findings are: A. Review of Resident #1's Resident Register revealed he was admitted to the facility on 3/6/17. Review of Resident #1's FL2 dated 3/6/17 revealed: -Diagnoses included dementia, mixed type, hepatitis C, major depressive disorder, history of traumatic brain injury, and chronic obstructive pulmonary disease. -Order for ativan 1 mg three times per day. -Physician orders for oxycodone 10 mg three times daily (a pain medication). -"Insulin sliding scale" (used to lover blood sugar). -Finger stick blood sugars (FSBS) three times per day. 1. Review of physician order dated 3/8/17 revealed ativan 1.0 mg twice daily on 3/8/17. Review of a physician visit dated 3/27/17 revealed: -An order to discontinue ativan 1 mg and begin Vistaril 25 mg twice daily. -"... years ago [Resident #1] had an accident where a steel beam landed on top of head resulted in a TBI (traumatic brain injury) and chronic head aches." 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." -Oxycodone and ativan helped him "deal with" the pain which included his "head, neck, hip, and a	D 367		

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D 367	Continued From page 43	D 367		

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 anxiety.

Review of the controlled drug sheet for Resident #1's ativan 1 mg revealed:
-28 tablets were dispensed on 3/23/17 with documentation of administration from 3/24/17 through 4/06/17.
-No other controlled sheets for ativan 1 mg.
-The staff documented administering ativan 1 mg to Resident #1 for 11 days after it was discontinued.
-No controlled drug sheet was available for the count down from 3/8/17 through 3/23/17.

Review of the Resident #1's March 2017 electronic Medication Records (eMARs) revealed:
-Transcription of entry for ativan 1 mg twice daily as needed for anxiety with documentation of administration of ativan 1 mg from 3/8/17 through 3/12/17 with 1 ativan administered on 3 days and 2 ativan administered on 2 days.
-Transcription of another entry for ativan 1 mg twice daily at 8:00am and 8:00pm with documentation of administration from 8:00pm on 3/1517 through 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 entries.
-A total of 31 ativan 1 mg were documented on the eMAR.
-No documentation of administration of ativan 1 mg after 8:00am on 3/27/17.

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D 367	Continued From page 44 -Documentation the administration of Vistaril 25mg began on 3/27/17 and continued through 4/13/17am when the eMARs. Review of the March and April 2017 eMARs and review of the ativan 1 mg controlled drug sheets revealed 31 ativan 1 mg were documented on the eMARs and 28 were documented on the controlled drug sheets. Interview with the RCC on 4/13/17 at 3:10pm revealed: -She did not know why staff continued to administer ativan after it was discontinued on the eMAR. -It was the responsibility of the medication aide on duty when the discontinue order came in to remove the controlled drug sheet and the medication off the cart when it was discontinued. Interview with the Administrator on 4/13/17 at 2:30pm revealed: -He was not aware the ativan was administered after it was discontinued. -The computer would not allow a medication to be documented as administered after it was entered as "discontinued" so the medications aides should have known it had been discontinued. -He would monitor the controlled drug sheets. -They could not find the pharmacy delivery sheets and all of the residents' controlled drug sheets because "they were scattered all around." Telephone call on 4/13/17 at 9:30am to the mental health provider who prescribed the Vistaril and discontinued the Ativan was not successful. Telephone interview with the pharmacist on 4/13/17 at 4:10pm revealed 60 ativan 1 mg were dispensed on 3/13/17 and 21 ativan 1 mg were	D 367		

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D 367	Continued From page 45 dispensed on 3/8/17 for a total of 81 Ativan. Comparison of the March and April 2017 eMARS with the 81 ativan 1 mg dispensed and with the ativan 1mg on the controlled drug sheets revealed: -Of of the 81 ativan 1mg dispensed, only 31 were documented on the eMARs. -28 ativan 1mg were documented on the only controlled drug sheet for Resident #1's ativan 1 mg. -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 eMARs. 2. Review of a physician order dated 3/6/17 revealed Resident #1's oxycodone 10mg routinely scheduled three times daily was changed to 1/2 tablet every 4 hours as needed for pain not to exceed 30 mg per day. Review of a physician order dated 3/23/17 revealed the oxycodone 10 mg was changed to 10 mg 1/2 tablet every 4 hours as needed for mild-moderate pain and 1 tablet every 4 hours as needed for severe pain not to exceed 30 mg per day. Telephone interview with the pharmacy on 4/12/17 at 4:10pm revealed: -21 oxycodone 10 mg were dispensed on 3/8/17. -69 oxycodone 10 mg were dispensed on 3/9/17. -90 oxycodone 10 mg were dispensed on 3/23/17. Review of the March and April 2017 electronic Medication Administration Records (eMARs) revealed only 19 oxycodone 10 mg were documented as administered to Resident #1 which were from 3/10/17 to 4/5/17.	D 367		

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D 367	Continued From page 46 Review of Resident #1's oxycodone 10 mg controlled drug sheets revealed: -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. -The second sheet had a handwritten label and staff documented the administration of 30 oxycodone from 3/42/17 at 8:00am through 4/6/17 8:00am. -No other controlled drug sheets were available. Comparison of the March and April 2017 eMARs with the 180 oxycodone 10 mg dispensed 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 eMARs and there was no documentation why the oxycodone 10 mg was not administered three times per day. -Of the 60 oxycodone 10 mg documented on the controlled drug sheet only 19 were documented on the eMARs and therefore there was no reason and justification for the as needed narcotic for 41 doses. -Of the 180 oxydodone 10 mg dispensed, 120 oxycodone 10 mg were not accounted for on a controlled drug sheet and 161 oxycodone 10 mg were not accounted for on the eMAR. Interview with the Administrator on 4/13/17 at 2:30pm revealed: -Resident #1's physician's assistant notified him on a Thursday afternoon, that some of Resident #1's oxycodone was missing. -The Administrator also said some of the controlled drug sheets were discovered missing after Staff A, medication aide left after work on that Thursday, date not stated.	D 367		

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D 367	Continued From page 47 -Staff A never returned to work and would not answer her telephone calls. 3. Review of physician order dated 3/6/17 revealed Novolog 100 units Flexpen Sliding Scale before meals and at bedtime as follows: -150-200: 2 units -201-250: 4 units -251-300: 6 units -301-350: 8 units -351-400: 10 units -401-450: 12 units ->450: 12 units and recheck in 1 hour. Review of the electronic Medication Administration Record (eMAR) for 3/7/17 through 3/31/17 revealed: -FSBS at 7:00am, 11:30am, 4:30pm and 8:00pm were transcribed on the eMAR. -No documentation of any sliding scale insulin administered during that time. -At 7:00am: 11 opportunities out of 21, SS insulin should have been administered. -At 11:30am: 21 opportunities out of 22, SS insulin should have been administered. -At 4:30pm: 17 opportunities out of 21, SS insulin should have been administered. -At 8:00pm: 15 opportunities out of 24, SS insulin should have been administered. Review of the eMAR for 4/1/17 through 4/13/17 revealed: -FSBS at 7:00am, 11:30am, 4:30pm and 8:00pm were transcribed on the eMAR. -No documentation of any sliding scale insulin administered during that time. -At 7:00am: 6 opportunities out 12, SS insulin should have been administered. -At 11:30am: 10 opportunities out of 10, SS insulin should have been administered.	D 367		

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D 367	Continued From page 48 -At 4:30pm: 7 opportunities out of 8, SS insulin should have been administered. -At 8:00pm: 11 opportunities out of 12, SS insulin should have been administered. Interview with the Resident Care Coordinator (RCC) on 4/12/17 at 3:20pm revealed: -The eMARs would not allow for her to enter the amount of insulin administered for sliding scale (SS) and she did not document the administration of SS insulin on paper. -There was no paper documentation any medication aide had documented that SS insulin was administered to Resident #1 since admission. -She knew what she had administered for SS insulin but she did not know what other medication aides had administered. -She said she reported the inability to document the SS insulin to the pharmacy but the staff person she spoke to was no longer there. -They had another resident on sliding scale insulin and the eMAR would allow for the documentation of the administration of SS insulin for that resident. Telephone interview with Staff B, medication aide, revealed she also could not document the administration of SS insulin on the eMAR and there was no paper MAR in place to document in SS insulin. Telephone interview with the pharmacy on 4/13/17 at 4:10pm revealed: -They were not aware the facility could not document SS insulin for Resident #1 until 4/12/17 during the survey. -The facility does have to call them to make changes to the eMAR system for entering SS insulin.	D 367		

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D 367	Continued From page 49 Interview with the Administrator on 4/13/17 at 2:30pm revealed: -He was not aware medication aides were not documenting the administration of SS insulin for Resident #1. -The RCC was responsible for assuring all medications could be and were documented on the eMARs. -The RCC should have called the pharmacy to assure the eMAR was set up to document SS insulin for Resident #1. Interview with Resident #1 on 4/14/17 at 11:25am revealed: -He was getting his FSBSs and the staff had been administering the SS insulin. -He did not know if the amounts of SS insulin administered were according to the physician orders. B. Review of Resident #3's FL2 dated 1/2/2017 revealed: -Diagnoses included chronic pain and enlarged prostate. -A physician order for Endocet 10/325 3 times a day 7am, 2:00pm, and 9pm (used for chronic pain). -A physician order for methadone 10 mg at 8am, 12 noon, 4 pm, and 8 pm. -A physician order for Flexeril 10mg three times per day. Interview with Resident #3 on 4/12/2017 at 2:00pm revealed: -He received his last dose Endocet "yesterday" at 12 noon. -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	D 367		

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D 367	Continued From page 50	D 367		

Coordinator (RCC) administered them to him.
-His family was aware the Endocet was out and they brought Endocet tablets for him that had been prescribed. prescribed for another family member.
-If he does not receive his pain medication, his pain level is at a "10 or over" on a pain scale ranging 1-10.
-He was scared to take the medication the Medication Aides are giving him because he was not always sure what they were giving him, but he took the medication anyway.
-He had ran out of both medications in the past but did not know the dates.

Interview with Resident #3's family member on 4/13/2017 at 11:00am revealed:
-In the past, about "2-3 weeks ago," Resident #3's family was notified of missing Endocet.
-In March 2017, the family reported the RCC had asked family, in a roundabout way, to bring in Endocet because Resident #3 was running out.
-The family stated Resident #3 had run out of both pain medications 3-4 times within the last 6 months but the dates were not known.
-The family also stated Resident #3 had been at the facility before, about 5 years ago, and had the same issues with his medications.

1. Observations of medications on hand for Resident #3 on 4/11/17 at 2:20pm revealed no Endocet 10/325 available in the medication cart.

Interview with the RCC on 4/11/17 at 2:20pm revealed the Endocet had been ordered and would be "in tonight."

Interview with the RCC 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

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D 367	Continued From page 51 prescription, but that it would be in today. Interview with the RCC 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 revealed: -There were no controlled drug sheets for Endocet from 2/11/17 at 7:00am through 3/14/17 at 9:00pm. -One controlled drug sheet documented 90 Endocet were dispensed on 3/15/2017 with documentation that 76 Endocet were administered from 3/15/17 at 7:00am to 4/11/17 at 12:00pm with 0 balance. -One controlled drug which revealed 10 Endocet 10/325 were dispensed on 4/12/17 and first documented as administered on 4/12/17 at 9:00pm. -No documentation of any Endocet administered from 2/11/7 at 7:00am through 3/14/17 at 9:00pm for a total of 96 doses not documented as administered. -Endocet 10/325 controlled drug sheet labeled as 90 count dispensed on 3/15/17 which began with documentation of administration on 3/15/17 at 7:00am and ended with a 0 balance on 4/11/17 at 12:00pm and a total of 10 Endocet 10/325 tablets were documented as wasted on the sheet. -On the controlled drug sheet which began with documentation of administration on 3/15/17, staff did not document the administration of Endocet to Resident #3 on 6 occasions when they were documented as wasted. Telephone interview with the RCC on 4/24/17 at 2:29pm revealed: -She did not know why Resident #3 was not administered Endocet at least 4 times when one was wasted.	D 367		

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ALEXANDER ASSISTED LIVING	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 52 -She said Staff A, medication aide, who used to work there, wasted 6 Endocet. Review of the February, March and April 2017 electronic Medication Administration records (eMARs) revealed: -Endocet 10/325 was transcribed to be administered three times daily, at 7:00am, 12:00pm and 9:00pm. -Documentation Resident # 3 was administered his Endocet 10/325 as ordered. Telephone call on 4/20/17 at 1:24pm to Staff A, a medication aide who no longer worked at the facility, was not successful. Interview with the RCC on 4/13/17 at 11:15am revealed: -Resident #3 did run out of Endocet in March, date not known. -A family member brought in 2 Endocet which she administered to Resident #3. Interview with the Administrator on 4/13/17 at 2:15pm revealed: -He was not aware staff were not documenting the administration of Endocet correctly on the eMAR. -He was not aware staff had wasted 10 Endocet. -He would monitor the controlled drug sheets and assure the eMARs were accurate 2. Review of the January 2017 electronic Medication Administration Records (eMARs) revealed: -Methadone 10 mg was transcribed to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Methadone 10 mg was not documented as administered on 1/15/17 at 12:00pm, 4:00pm and	D 367		

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D 367	Continued From page 53 7:00pm and on 1/17/17 at 8:00am. Review of Resident #3's methadone 10 mg controlled drug sheet which had 120 methadone 10 mg dispensed on 12/16/16 revealed: -Documentation as methadone 10 mg administered from 12/18/17 at 8:00am through 1/15/17 at 9pm with 8 remaining. -Staff documented the administration of methadone 10 mg on 1/15/17 at 12:00pm, 4:00pm, and 7:00pm and on 1/16/17 at 7:00am, although all 4 doses were not documented on the MAR. 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. Review of methadone 10 mg controlled drug sheets revealed: -No sheet for the administration of methadone 10 mg from 2/24/17 at 7:00am through 3/23/17 at 7:00pm for a total of 87 doses not accounted for. -One sheet had 120 methadone dispensed on 3/16/17 but documented the administration of 30 beginning on 3/24/17 at 8:00am through 4/10/17 at 8:00am with a balance of 0. -On 3/24/17 there was no documentation of methadone 10 mg administered at 12 noon. -On 3/25/17 there were no methadone 10 mg documented as administered at 7:00am, at 12 noon and at 4:00pm. -No documentation for any administration of methadone 10 mg on 3/26/17 through 4/2/17 at 4:00pm. -A total of 35 doses were not documented as administered on the controlled drug sheets from 3/24/17 through 4/10/17. -A current controlled drug sheet with a	D 367		

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D 367	Continued From page 54 handwritten label revealed a beginning quantity of 16 methadone 10 mg with documentation of administration on 4/11/16 at 11:50am with quantity of 11 on 4/12/17. Review of the methadone 10 mg controlled drug sheets compared to the March and April 2017 eMARs, 122 doses were documented on the eMAR with no documentation of administration on a controlled drug sheet. Telephone interview with the pharmacy on 4/17/17 at 3:15pm revealed the following methadone were dispensed as follows: -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. Interview with the RCC on 4/13/17 at 11:15am revealed: -She did not know why Resident #3 was not administered methadone as ordered. -She did not know why the methadone was not documented on the eMARs but was documented on the controlled drug sheet. Interview with the Administrator on 4/13/17 at 2:15pm revealed: -He would monitor the controlled drug sheets and assure the MARs were accurate. -He was not aware methadone was not documented as ordered on the controlled drug sheets. 3. Review of the March and April 2017 electronic Medication Administration Records (eMARs) revealed: -Transcription of Flexeril 10 mg to be	D 367		

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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.
-To prevent staff administering Flexeril too frequently, she just told the next shift medication aide when she administered Flexeril.

Interview with the Administrator on 4/13/17 at 2:15pm revealed:
-He was not aware before the survey there was a problem with documenting Flexeril.
-The RCC should have call the pharmacy if there was a problem with entry on the eMAR.
-He understood the eMAR would not allow for the documentation of Flexeril if it was ordered at 12 noon and the medication aides attempted to enter it on the MAR earlier than 12 noon.

Comparison of the number of Flexeril which were dispensed per pharmacist interview compared to the number documented on the March and April MARs and the 10 Flexeril on hand revealed of the 106 Flexeril dispensed, 43 Flexeril were not

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D 367	Continued From page 56 accounted for. Confidential interview with 2 medication aides revealed they were not aware of the problem with entering Flexeril into the eMARs and had never had any problems entering the documentation of Resident #3's prn Flexeril on the eMAR. Interview with Resident #3 on 4/13/17 at 4:45pm revealed he did receive Flexeril but did not know how often. Telephone interview with the pharmacist on 4/18/17 at 10:20am revealed: -The eMAR would not allow documentation of Flexeril if the medication aides were attempting to administer it before the time of order allowed it. -The facility had never contacted the pharmacy to notify them the Flexeril could not be documented on the eMAR. -A total of 106 Flexeril were dispensed from 3/14/17 to 4/6/17. -On 3/14/17, 16 Flexeril were dispensed. -On 3/20/16, 30 Flexeril were dispensed. -On 3/27/17, 30 Flexeril were dispensed. -On 4/6/17, 30 Flexeril were dispensed. -The Flexeril were dispensed only when the facility requested them and was not on automatic refill. -The facility had never returned any Flexeril to the pharmacy for Resident #3. _____ The failure to document sliding scale insulin, ativan, and oxycodone on Resident #1's electronic Medication Administation Records (eMARs) and the failure to maintain all controlled drug sheets placed Resident #1's administration of medications in question. No documentation of any sliding scale insulin was on the eMARs for	D 367		

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D 367	Continued From page 57 the 5 weeks Resident #1 was in the facility. Out of 81 ativan 1 mg dispensed, only 31 were documented as administered on the eMAR and only 28 were on the controlled drug sheet. Of the 180 oxydodone 10 mg dispensed, 120 oxycodone 10 mg were not accounted for on a controlled drug sheet and 161 oxycodone 10 mg were not accounted for on the eMAR. There was no reason and justification documented for the as needed oxycodone for 41 times when it was documented as administered from the controlled drug sheet. The e MARs are designed to only allow the documentation of as needed medications within the allowed time frame. Resident #3's Endocet 10/325 was documented as administered routinely on the eMARs but the controlled drug sheets did not account for 123 doses for 2 and 1/2 months. The methadone for Resident #3's controlled drug sheets had no documentation for the administration of methadone for 126 doses for 13 weeks but they were documented on the eMARs, 43 Flexeril 10 mg were not accounted for on the eMARs. This failure to assure accuracy for the documentation of administration of medications for Resident #1 and #3 was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 4/12/17 revealed: -The facility will review the medication cart for discontinued orders, remove them and return them to the pharmacy. -A medication cart review will be completed by the pharmacy. -A medication cart review and comparisons of the residents' charts will be completed and monitored by the Adminsitrator/Director on a weekly basis. -Discontinued medications will be pulled off the	D 367		

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D 367	Continued From page 58 cart as soon as the discontinued orders are received. -The residents' charts will be reviews to assure we are not giving medications without an order and will be monitored by the Administrator on a weekly basis. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 9, 2017.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION 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 reconciliation of those controlled substances for 3 of 3 sampled residents (Resident #1, #3 and #6). The findings are: A. Review of Resident #6's current FL-2 dated 7/29/16 revealed:	D 392		

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D 392	Continued From page 59 -Diagnoses included altered mental status, hyperplasia of prostate, hypertension and atrial fibrillation. -Medications included Hydromorphone 2mg tablet (a narcotic medication used to treat severe pain), take 1 tablet three times per day (TID). Interview on 4/13/17 at 2:30pm with Resident #6 revealed: -"I have lots of pain all the time." -He was unaware of what medications he was taking. -He was in pain even after taking his pain medication. -There were times that he was pain free, but not often. -He could not tell if he was getting the medications the way he was supposed to. Interview with a personal care aide on 4/13/17 at 3:00pm revealed: -Resident # 6 "has been smiling and in a better mood since his got his pain medications." -When he was out of medications, he said, "he was hurting all over," and he got "irritable." Review of a physician's order for Resident #6 dated 11/7/16 revealed: -Dilaudid 2mg (hydromorphone is a generic form used for Dilaudid). -One tablet three times daily (TID) for pain, scheduled. -Quantity ordered 42. 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 needed for pain. -Quantity ordered 56.	D 392		

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D 392	Continued From page 60 Review of a physician's order for Resident #6 dated 1/21/17 which documented: -Hydromorphone 2mg. -One tablet three times per day scheduled and may have one tablet every 6 hours as needed for pain. -Quantity 105 tablets (45 tabs) (60 tabs). Interview on 4/13/17 at 10:00am with the Resident Care Coordinator (RCC) revealed: -She did not know if there were any additional orders for Resident #6's Hydromorphone. -The Hospice Nurse gets the hospice doctor to order the medications and they send the order to the pharmacy. Telephone interview with the facility pharmacy on 4/13/17 at 2:15pm revealed: -The facility received 30 Hydromorphone 2mg for Resident #6 on 2/3/17. -The facility received 75 Hydromorphone 2mg for Resident #6 on 2/6/17. -The facility received 105 Hydromorphone 2mg for Resident #6 on 2/15/17. -The facility received 60 Hydromorphone 2mg for Resident #6 on 2/28/17. -The facility received 60 Hydromorphone 2mg for Resident #6 on 3/9/17. -The facility received 45 Hydromorphone 2mg for Resident #6 on 3/13/17. -The facility received 105 Hydromorphone 2mg for Resident #6 on 3/22/17. -The facility received 105 Hydromorphone 2mg for Resident #6 on 4/7/17. Review of the February 2017 pharmacy generated Medication Administration Record (MAR) for Resident #6 revealed: -Hydromorphone 2mg tablet one tablet three	D 392		

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times daily.
-The scheduled administration times were documented as 8:00am, 2:00pm and 8:00pm.
-Documentation showed 84 times administered out of 84 opportunities for the scheduled Hydromorphone.
-Hydromorphone 2mg tablet 1 tablet every 6 hours PRN for pain.
-The Hydromorphone 2mg PRN was documented 44 times as administered.
-The total number of Hydromorphone 2mg tablets documented as administered were 128 tablets.

Review of the March 2017 pharmacy generated MAR for Resident #6 revealed:
-Hydromorphone 2mg, 1 tablet three times daily.
-The scheduled administration times were documented as 8:00am, 2:00pm and 8:00pm.
-Documentation showed 55 times administered out of 93 opportunities for the scheduled Hydromorphone.
-Hydromorphone 2mg tablet 1 tablet every 6 hours PRN for pain.
-The Hydromorphone 2mg PRN was documented 9 times as administered.
-The total number of Hydromorphone 2mg tablets documented as administered were 64 tablets.

Review of the April 2017 pharmacy generated MAR for Resident #6 revealed:
-Hydromorphone 2mg tablet on tablet three times daily.
-The scheduled administration times were documented as 8:00am, 2:00pm and 8:00pm.
-Documentation showed 24 times administered out of 35 opportunities for the scheduled Hydromorphone.
-Documentation showed 10 times the medication was not administered because 'Med Not on Cart'.
-Hydromorphone 2mg, 1 tablet every 6 hours

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D 392	Continued From page 62 PRN for pain. -The Hydromorphone 2mg PRN was documented 1 time as administered. -The total number of Hydromorphone 2mg tablets documented as administered 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 amount indicated 77 tablets on hand. Review of the Hydromorphone 2mg for Resident #6 on the medication cart revealed 77 tablets were available. Interview on 4/13/17 at 11:15am with Resident #6's Hospice Nurse revealed: -[Resident #6 Name] appeared to be in pain when she came into the facility. -She had "recently" started to count the narcotics for Resident #6 because he had been out of his morphine. Review of a hospice nursing note dated 3/31/17 documented: -No complaint of pain at this time. -Patient does not verbalize pain, no nonverbal signs or symptoms. Review of a hospice nursing note dated 4/5/17 documented: -Patient is alert and oriented x 2, forgetfulness, confusion and verbalizes some anxiety. -Medications in place and seems effective. Review of a hospice nursing note dated 4/7/17	D 392		

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documented:
-Resident denies pain.
-Resident states 'I want to be transferred'.
-Patient's pain medication to arrive today.

Review of the facility and pharmacy information revealed:
-The pharmacy sent 270 Hydromorphone tablets in February, 128 were administered which leaves 142 unaccounted for.
-The pharmacy sent 210 Hydromorphone tablets in March 2017, 64 were administered which leaves 146 unaccounted for.
-The Pharmacy sent 105 Hydromorphone tablets in April 2017, 28 were administered and 77 were on hand which leaves 3 unaccounted for.
-The total amount of missing Hydromorphone 2mg tablets was 288.

B. Review of Resident #3's FL2 dated 1/2/2017 revealed:
-Diagnoses included chronic pain and enlarged prostate.
-A physician order for Endocet 10/325 3 times a day 7am, 12 noon, and 9pm (used for chronic pain).
-A physician order for methadone 10 mg at 8am 12 noon, 4 pm and 8 pm.

Interview with Resident #3 on 4/12/2017 at 2:00pm revealed:
-He received his last dose Endocet "yesterday" at 12 noon.
-He stated he also ran out of Endocet sometime in March, 2017, date not known, but a family member brought in 2 tablets Endocet that was prescribed for that family member and the Resident Care Coordinator (RCC) administered them to him.
-If he does not receive his pain medication, his

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pain level is at a "10 or over" on a pain scale ranging 1-10.
-He was scared to take the medication that the aides are giving him because he was not always sure what they were giving him, but he took the medication anyway.

1. Observations of medications on hand for Resident #3 on 4/11/17 at 2:20pm revealed no Endocet 10/325 available in the medication cart.

Interview with the RCC on 4/11/17 at 2:20pm revealed the Endocet had been ordered and would be "in tonight."

Interview with the RCC 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 prescription, but that it would be in today.

Interview with the RCC 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 revealed:
-One sheet documented 90 were dispensed and documentation of administration began on 12/19/16 through 1/18/17 with a remaining balance of 0.
-Another sheet documented the 90 were dispensed on 1/14/17 and documentation of administration began on 1/18/17 through 2/10/17 at 10:00pm with a remaining balance of 18.
-There were no controlled drug sheets for Endocet 10/325 from 2/11/17 at 7:00am through 3/14/17 at 9:00pm.
-One controlled drug sheet documented 90 were dispensed on 3/15/2017 with documentation that 76 Endocet 10/325 were administered from 3/15/17 at 7:00am to 4/11/17 at 12:00pm with 0

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ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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balance.
-One controlled drug which revealed 10 were dispensed on 4/12/17 and first documented as administered on 4/12/17 at 9:00pm.
-No documentation of any Endocet 10/325 were administered from 2/11/7 at 7:00am through 3/14/17 at 9:00pm for a total of 96 doses not documented as administered.

Review of pharmacy delivery sheet revealed 90 Endocet 10/325 were delivered on 2/14/17 but the controlled drug sheet for was missing for that delivery.

Review of the controlled drug sheets with Endocet 10/325 dispensed on 1/14/17 with 18 remaining and the missing controlled drug sheet with delivery of 90 Endocet 10/325 on 2/14/17, a total of 108 Endocet 10/325 were not accounted for from 1/14/17 through 3/14/17.

Review of the Resident #3's Endocet 10/325 controlled drug sheet labeled as 90 count dispensed on 3/15/17 which began with documentation of administration on 3/15/17 at 7:00am and ended with a 0 balance on 4/11/17 at 12:00pm revealed:
-A total of 10 Endocet 10/325 tablets were documented as wasted on the sheet with no reasons why 9 of the 10 Endocet were wasted.
-Staff did not document the administration of Endocet 10/325 to Resident #3 on 6 occasions when they were documented as wasted.
-At least 15 errors were made with the count down when 1 Endocet 10/325 was administered or wasted and the ending count went down by 2 from the beginning count.
-A total of 76 out of the 90 tablets dispensed were documented as administered which is 4 Endocet 10/ 325 not accounted for on the controlled drug

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D 392	Continued From page 66 sheet for this time frame. 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. Telephone call on 4/20/17 at 1:24 pm to Staff A, medication aide who no longer worked there, was not successful. 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. Telephone interview with the RCC on 4/24/17 at 2:29pm revealed: -She wasted one tablet when it dropped into another residents valproic acid. -The one Endocet documented as wasted on 3/20/17 was not wasted but administered but did not know why she had documented it was wasted. -She did not know why she changed the balance on the right side of the sheet on 3/21/17 at 8:00pm, on on 3/22/17 at 7:00am and at noon. -She could not remember why she documented on 3/25/17 at 12 noon the count dropped the balance by 2 when 1 Endocet was administered by a trainee, Staff D. -She did not know why on 3/28/17 at 12 noon through 3/30/17 at 8:00pm she changed the count on the left side of the page after she and Staff A had documented different counts. -The one Endocet documented as wasted on	D 392		

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3/31/17 at 4:00pm was because she popped it at wrong time.
-The one Endocet documented on 3/31/17 at 8:00pm with "no waste" was wasted because a second entry documented another Endocet administered at the same time and the count came down by 1 both times.
-She did not know why Staff A, medication aide, who used to work there, wasted 6 Endocet.

Review of the January through April 2017 electronic Medication Administration records (eMARs) revealed:
-Transcription of the administration of Endocet 10/325 three times daily, at 7:00am, 12:00pm, and 9:00pm.
-Documentation Resident # 3 received his Endocet 10/325 as ordered.

Review of the methadone 10 mg controlled drug sheets compared to the March and April 2017 eMARs, 122 doses were documented on the eMAR with no documentation of administration on a controlled drug sheet.

Interview with director of the pain clinic on 4/18/2017 at 9:00am revealed:
-The facility staff did not notify the pain clinic that Resident #3 ran out of Endocet on 4/11/17 but his family member came by their office on 4/12/17 for a new prescription.
-The director stated the 90 Endocet dispensed on 3/15/17 should have been a sufficient supply to last through 4/15/17.
-They do no usually prescribe narcotics when they know the last delivery should not be out.

Interview with Resident #3's family member on 4/13/2017 at 11:00am revealed:
-They went to the pain clinic on 4/12/17 and

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D 392	Continued From page 68 asked for Resident #3 a new prescription for the Endocet because he ran out. -In the past, about "2-3 weeks ago," Resident #3's family was notified of missing Endocet. -In March 2017, the family reported the RCC had asked family in a roundabout way to bring in Endocet because Resident #3 was running out. -Family stated that Resident #3 has ran out of medication 3-4 times within the last 6 months. -Family stated that Resident #3 has been at the facility before about 5 years ago and has had the same issues. Interview with the RCC on 4/13/17 at 11:15am revealed: -Resident #3 did run out of Endocet in March, date not known. -The family member brought in 2 Endocet which she administered to Resident #3 in a small white container. -She could not find the controlled drug sheet for March which showed when Resident #1 ran out of Endocet. -She documented the administration of the 2 Endocet on the MAR but not on a controlled drug sheet. Interview with the Administrator on 4/13/17 at 2:15pm revealed: -"Obviously I did not realize there was that much waste or I would have nipped it in the bud." -He did not have a written policy for staff wasting narcotics but their policy is "a common sense policy" to have a witness. -He plans to write a policy addressing staff wasting narcotics and consequences for staff who routinely waste narcotics. -He was not aware staff wasted 10 Endocet or that the counts went down by more than 1 when just 1 dose was administered.	D 392		

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D 392	Continued From page 69 -He did not have a written policy how to handle medications/documentation which were brought with the residents upon admission, but he or the RCC was responsible for assuring the medications were counted and the documentation remained on file. -He would change the medication aides procedure when they did shift count by assuring that the medication aide going off duty and the one coming on duty initialed the balance so that no changes could be made to the controlled drug sheet after a mediation aide's documented. -He would require the medication aides lock up any wasted medication for him to observe before they were wasted. -He would monitor the controlled drug sheets. -He was not aware the family brought in the 2 Endocet for Resident #3 for staff to administer. -Their policy did not allow for unlabeled medications to be administered to the residents. -They could not find the pharmacy delivery sheets and all of the residents' controlled drug sheets because "they were scattered all around." 2. Review of Resident #3's methadone controlled drug sheets revealed: -One sheet had 120 methadone 10 mg dispensed on 12/16/16 with documentation as administered from 12/18/17 at 8:00am through 1/15/17 at 9pm with 8 remaining with no documentation of any methadone 10 mg administered for 4 times of administration. -No controlled drug sheets between 1/16/17 at 8:00am through 1/18/17 at 7:00am. -One sheet had 120 methadone 10 mg dispensed on 1/18/17 but marked out and handwritten in with a "30" with documentation as administered from 1/18/17 at 7:00am through 1/24/17 at 12 noon with a balance of 4. -One sheet had 120 methadone 10 mg dispensed	D 392		

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D 392	Continued From page 70 with it marked out and 90 handwritten in with documentation of administration beginning on 1/25/17 at 12 noon and ending on 2/16/17 at 12 noon with a balance of 0. -On the controlled drug sheet with documentation of administration beginning on 1/25/17, 4 doses methadone 10 mg were not documented as administered. -On the controlled drug sheet with documentation of administration beginning on 1/25/17, 3 doses methadone were wasted. -One sheet had 120 methadone 10 mg dispensed on 2/14/17 but the 120 marked out with a "30" with documentation of administration from 2/16/17 at 4:00pm through 2/23/17 at 9:00pm with a balance of 0. -There were no methadone 10 mg controlled drug sheets from 2/24/17 am through 3/23/17 at 8:00pm for a total of 116 doses. -One sheet had 120 methadone 10 mg dispensed on 3/16/17 but documented the administration of 30 beginning on 3/24/17 at 8:00am through 4/10/17 at 8:00am with a balance of 0. -Another methadone 10 mg controlled drug sheet which had 90 methadone dispensed on 3/16/17 had documentation of administration beginning on 3/24/17 and ending on 4/10/17. -On the controlled drug sheet which documented the administration of methadone 10 mg beginning on 3/24/17 revealed 4 doses were not documented as administered and 1 dose was wasted. Telephone interview with the pharmacy on 4/17/17 at 3:15pm revealed the following methadone 10 mg were dispensed as follows: -120 on 12/16/17 -120 on 1/14/17 -120 on 2/14/17 -120 on 3/16/17	D 392		

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D 392	Continued From page 71 -12 on 4/15/17 Observation of medications on hand on 4/11/17 at 2:20pm revealed 15 methadone 10 mg was available. Review of the available controlled drug sheets for Resident #3's methadone and comparison with the documentation on the MARs revealed 163 methadone were not accounted for on controlled drug sheets: -8 remaining methadone on 1/15/17. -4 remaining methadone on 1/24/17. -116 methadone doses not documented on a controlled drug sheet from 2/24/17 at 9:00pm through 3/24/17 at 8:00am. -4 doses not documented as administered on the controlled drug sheet which began on 3/24/17. Review of the January through April 2017 Medication Administration records revealed documentation Resident # 3 received his methadone as ordered. Interview with the Administrator on 4/13/17 at 2:15pm revealed: -He did not have a written policy for staff wasting narcotics but their policy is "a common sense policy" to have a witness. -He plans to write a policy addressing staff wasting narcotics and consequences for staff who routinely waste narcotics. -He would change the medication aides procedure when they did shift count by assuring that the medication aide going off duty and the one coming on duty initialed the balance so that no changes could be made to the controlled drug sheet after a mediation aide's documented. -He would require the medication aides lock up any wasted medication for him to observe before	D 392		

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they were wasted.
-He would monitor the controlled drug sheets.
-They could not find the pharmacy delivery sheets and all of the residents' controlled drug sheets because "they were scattered all around."

C. Review of Resident #1's Resident Register revealed he was admitted to this facility on 3/6/17.

Review of Resident #1's FL2 dated 3/6/17 revealed:
-Diagnoses included dementia, mixed type, hepatitis C, major depressive disorder, history of a TBI (traumatic brain injury), and chronic obstructive pulmonary disease.
-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 anxiety.
-The female physician told him last Thursday she would write prescription for other medications to

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try to control his pain and anxiety, but they "are not working."

Interview with the RCC on 4/13/17 at 11:30am revealed that Resident #1 had gone to the hospital that morning.

Review of Resident #1's hospital discharge records from visit from 4/13/17 through 4/17/17 revealed:
-Other diagnoses included cirrhosis, acute upper abdominal pain, and chronic thrombocytopenia.
-Under hospital course: "Since they [pain medication] were stolen he was not given a refill...As result his pain level has increased. He tried to put up with for the last several days and says that he had been enduring the pain but over the last couple of days the pain has gotten a lot worse. Today he could no longer bear the pain...he also describes severe back pain in his neck back to lower extremities which is all chronic but has worsened...He was admitted for pancreatitis."

1. Review of a physician order dated 3/8/17 revealed the oxycodone 10mg routinely scheduled three times daily was changed to 1/2 tablet every 4 hours as needed for pain not to exceed 30 mg per day.

Review of physician order dated 3/23/17 revealed the oxycodone 10 mg was changed to 10 mg 1/2 tablet every 4 hours as needed for mild-moderate pain, 1 tablet every 4 hours as needed for severe pain not to exceed 30 mg per day.

Review of the pharmacy delivery sheets for Resident #1's oxycodone 10 mg revealed:
-21 oxycodone 10 mg were dispensed on 3/8/17.
-69 oxycodone 10 mg were dispensed on 3/9/17.

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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 and discontinued on 3/15 with no oxycodone 10 mg documented as administered on this entry. -A second transcription in March 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 hours as needed for mild-moderate pain with documentation of administration beginning on 3/25/17 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 for oxycodone 10 mg, 1 tablet every 4 hours as needed for pain with no documentation of any administration. -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 #3's oxycodone 10 mg controlled drug sheets revealed: -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. -The second sheet had a handwritten label and staff documented the administration of 30 oxycodone 10 mg from 3/42/17 at 8:00am	D 392		

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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, which leaves 89 oxycodone that were missing.

Telephone interview with the prescribing physician assistant on 4/13/17 at 9:30am revealed:
-She came into the facility recently on a "Thursday," date not sure because she was not currently in the office.
-The RCC asked her to write a prescription for Resident #1's oxycodone because he was almost out.
-She knew she had written a prescription for Resident #1's oxycodone "recently" for 90 tablets and he should have had at least 44 tablets left but

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D 392	Continued From page 76 the RCC said he only had 1 tablet. -She did not write another prescription for Resident #1 for the oxycodone. -She notified the primary care provider of the missing narcotics and he agreed she should not prescribe any narcotics for any residents who resided in this facility. -She called the pharmacy to tell them that she thought Resident #1 had some missing oxycodone. -The mental health physician ordered the Ativan. Interview with the Administrator on 4/13/17 at 2:15pm revealed: -When staff requested the physician assistant for a prescription for oxycodone for Resident #1, she stated she had recently written a prescription for 90 oxycodone and there should have been at least 44 more oxycodone available. -He stated the physician assistant refused to write another prescription and she reported the missing oxycodone to the prescribing pharmacy. -The facility completed an investigation for the missing oxycodone. -After shift change on Thursday evening, the medication aide discovered the oxycodone was missing after Staff A, the medication aide left. -He thought Staff A also took some controlled drug sheets with her because they were kept in the medication room after the medications were administered. -Staff A had not been back to work since the incident. -He would change the medication aides' procedure when they did shift count by assuring that the medication aide going off duty and the one coming on duty initialed the balance so that no changes could be made to the controlled drug sheet after a mediation aide's documented to assure the balance was agreed upon by both	D 392		

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medication aides.
-He would monitor the controlled drug sheets.
-They could not find the pharmacy delivery sheets and all of the residents' controlled drug sheets because "they were scattered all around."
-He was not aware that more than 44 oxycodone were missing.

Telephone call to Staff A, medication aide, on 4/20/17 at 1:24pm was not successful.

Confidential interview with a staff revealed that after Resident #1 ran out of oxycodone and Ativan, he complained as follows:
-Resident #1 "has been complaining of shakes and says he is not sleeping much."
-"He would say, 'I'm shaking and my leg hurts.'."

2. Review of physician order dated 3/8/17 revealed ativan 1 mg was changed from three times per day to two times per day.

Telephone interview with the pharmacist on 4/11/17 at 3:10pm revealed 60 ativan 1 mg were dispensed on 3/13/17 and 21 ativan 1 mg were dispensed on 3/8/17 for a total of 81 ativan.

Review of the ativan 1 mg controlled drug sheet revealed
- 28 tablets were dispensed on 3/23/17 with documentation of administration from 3/24/17 through 4/06/17.
-No other controlled sheets for ativan 1 mg.

Review of the March and April 2017 electronic Medication Administration Records (eMARs) revealed:
-Transcription of ativan 1 mg twice daily as needed for anxiety with documentation of 7 doses administered from 3/9/17 to 3/12/17.

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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 were not accounted for on the MARs. 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 entries. -No documentation of administration of Ativan after 8:00am on 3/27/17. -Documentation 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		

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D 392	Continued From page 79 order for administration of Ativan twice daily on 3/8/17 revealed 63 ativan 1 mg would have been a sufficient supply to administer 3 ativan 1 mg on 3/7/17, and 2 daily beginning on 3/8/17 through 4/6/17 at 8:00am when the balance was 0 on the controlled drug sheet, which leaves 18 ativan 1 mg that is over the amount which were needed to administer as ordered, but were not available and not accounted for. Interview with the RCC on 4/13/17 3:10pm revealed: -She did not know why staff continued to administer ativan after it was discontinued. -It was the responsibility of the medication aide on duty when the discontinue order came in to remove the controlled drug sheet and the medication off the cart when it was discontinued. -She thought Staff A, medication aide took some ativan and the missing controlled drug sheet. Interview with the Administrator on 4/13/17 at 2:15pm revealed: -He would change the medication aides procedure when they did shift count by assuring that the medication aide going off duty and the one coming on duty initialed the balance so that no changes could be made to the controlled drug sheet after a mediation aide's documented and so both medication aides agreed to the documented number. -He would monitor the controlled drug sheets. -They could not find the pharmacy delivery sheets and all of the residents' controlled drug sheets because "they were scattered all around." The facility's failure to maintain records, reconcile all narcotics delivered with records of administration, require a fail proof shift change count, and provide oversight of all narcotics and	D 392		

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D 392	Continued From page 80 narcotic waste resulted in opportunity for diversion of the residents' narcotics. The facility's investigation for drug diversion did not result in any method for reducing and/or eliminating opportunity for drug diversion. Attempted reconciliation of delivery sheets, controlled drug sheets, and medications by the survey team revealed 288 Hydromorphone 2 mg, 108 Endocet 10/325, 133 methadone 10 mg, 120 oxycodone 10 mg and 53 ativan 1 mg were not accounted for. The 3 residents went without their pain and anxiety medications because the narcotics were either not available to administer or because a physician assistant would no longer prescribe narcotics for any residents in this facility after she learned of the narcotic diversion. The failure to maintain accurate and retrievable records of receipt, administration, and disposition of controlled substances and the inability to account for 702 doses of narcotics for 3 residents was detrimental to the health, welfare and safety of the residents and constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 4/12/17 revealed: -The facility will assure all controlled substances are counted upon arrival, maintained the delivery ticket, and make certain all packs are numbered according to what was received, 1 of 3, 2 of 3, and 3 of 3. -We will put stock on the medication cart with the necessary amount and will double lock the left over until needed. -We will compare the count sheet with the empty pack and review the count sheets on a daily basis for compliance and number the controlled sheets to be sure they match them to the empty pack. -We will review the count sheet on a daily basis. -If a controlled drug is wasted, it will be witnessed	D 392		

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D 392	Continued From page 81 by a staff. -The pharmacy will do a medication cart review. -The narcotics will be checked for supply on a weekly basis. -The physician, pharmacy and DSS will be notified if there are any medications which are found to be missing. -All medication documentation will be maintained in the facility. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 9, 2017.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the administrator failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, health care referral and follow-up, pharmaceutical services, and implementation. The findings are: A. Based on observations, interviews and record reviews, the facility failed to provide supervision	D912		

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D912	Continued From page 82 of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 2 sampled residents with physical decline and falls, resulting in a fall with a closed head injury and potential for serious injury from a fall down the stairs in her wheelchair (Resident #2) and a fall with a left wrist and closed head injury and a second fall with a compound fractured of the first lumbar vertebra requiring stabilization in the Emergency Room (Resident #7). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] B. Based on interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 3 of 3 sampled residents regarding Resident #2's transfer to a higher level of care due to care and supervision exceeding the ALF (Assisted Living Facility) capabilities, Resident #3 with a history of chronic pain being without Endocet pain medications for 24 hours, and Resident #7 with a physician's order to schedule an appointment with an orthopedic surgeon post-fall with a compound fracture of the first lumbar vertebra and a vetebroplasty performed in the Emergency Room. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] C. Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained 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	D912		

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D912	Continued From page 83 presence of controlled substances, medication labels, and accurate records of the receipt, use, and disposition of controlled substances. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A2 Violation).] D. Based on observations, interviews, and record reviews, the facility failed 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).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on 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:	D914		

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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 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 reconciliation 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 B Violation).]	D914		

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D936	Continued From page 85	D936		
D936	10A NCAC 13F .1010 (d) (e) Pharmaceutical Services 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: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident ' s absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication ' s release from the facility and shall include at least: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; (C) any cautionary information from the original	D936		

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D936	Continued From page 86 prescription package if the information is not on the container released for the leave of absence; (3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and (4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications ' release from and return to the facility. (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed 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).	D936		

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D936	Continued From page 87 The findings are: A. Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances. B. Review of Resident #1's Resident Register revealed he was admitted to this facility on 3/6/17. Review of Resident #1's FL2 dated 3/6/17 revealed: -Diagnoses included dementia, mixed type, hepatitis C, major depressive disorder, history of traumatic brain injury, and chronic obstructive pulmonary disease. -Physician orders included ativan 1mg three times daily (used for anxiety) and oxycodone 10mg three times daily (used for pain). -Physician orders for 13 other medications. -This FL2 was signed by this facility's physician assistant. Interview with Resident #1 on 4/11/17 at 11:25am revealed: -He was a resident at another facility before he was admitted to this facility. -A staff from this facility came to the facility to transfer him, but he was not sure which staff. -He was having a lot of pain and anxiety because his oxycodone was "stolen." -He did not know what medications the other facility sent with this staff. Interview with the Resident Care Coordinator on 4/11/17 at 2:30pm revealed: -She picked up Resident #3 at the other facility and transferred him to this facility. -There was a "bag of medications" which the other facility sent with the resident. -When she came back to the facility she "handed" the bag of medications to Staff A, a medication	D936		

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D936	Continued From page 88 aide who no longer worked there, and asked her to write down the name and quantity of medcations. -She did not know where the list of medications was that Staff A was supposed to have documented. -She did not have any records from the other facility which stated what medications were sent by that facility. Telephone interview on 4/20/17 at 1:24 pm to Staff A, a medication aide who no longer worked at the facility, was not successful. Review of a statement dated 3/16/17 was sent to the surveyor from the facility where Resident #1 transferred from and stated, "Resident was discharged on 3/6/17 and all medications were given." Review of previous FL2 dated 9/13/16 revealed the following orders: -Physician order for Ativan 1mg three times daily. -Physician order for oxycodone 10mg three times a day. -Physician orders for 16 other medications. Interview with the Administrator on 4/13/17 at 2:35pm revealed: -It was his policy for all medications that come in with the residents be counted and listed. -The medication aides on duty upon arrival of new admissions are responsible for making a list of medications brought to the facility. -The mediation list should be maintained in the resident records. The facility's failure to accurately document and maintain readily retrievable records for review placed the residents at risk for their medications	D936		

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D936	Continued From page 89 including narcotics to be exploited and to not be administered accurately. The missing documentation for medications and maybe narcotics which came with a new admission exposed the resident to staff's ability to divert the medications/narcotics. The failure to maintain a list of medications which 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 medications was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. The Plan of Protection provided by the Adminsitrator on 4/17/17 revealed: -All medication aides will enter the administration of all medications in the electronic Medication Administration Records (eMARs). -If the eMARs will not allow documentation of the administration of medications, the Administrator will be notified and the medication aides will document the administration on paper and maintained it on file. -Any documentation on paper will be entered on the eMARs when the eMARs are back up and working. -The Administrator will monitor the documentation of all as needed medications and assure records are maintained according to rule. -All medications entering the facility will be maintained on file in the facility. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 9, 2017.	D936		

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D980	Continued From page 90	D980		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: Type A2 Violation Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained 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 presence of controlled substances, medication labels, and accurate records of the receipt, use, and disposition of controlled substances. The findings are: Interview on 4/13/17 at 3:15pm with the Administrator revealed his responsibility "as Administrator of the facility was to ensure the residents received great care and being in compliance with all rules and regulations." Non-compliance identified during the survey included: A. Based on observations, interviews and record	D980		

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D980	Continued From page 91 reviews, the facility failed to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 2 sampled residents with physical decline and falls, resulting in a fall with a closed head injury and potential for serious injury from a fall down the stairs in her wheelchair (Resident #2) and a fall with a left wrist and closed head injury and a second fall with a compound fractured of the first lumbar vertebra requiring stabilization in the Emergency Room (Resident #7). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] B. Based on interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 3 of 3 sampled residents regarding Resident #2's transfer to a higher level of care due to care and supervision exceeding the ALF (Assisted Living Facility) capabilities, Resident #3 with a history of chronic pain being without Endocet pain medications for 24 hours, and Resident #7 with a physician's order to schedule an appointment with an orthopedic surgeon post-fall with a compound fracture of the first lumbar vertebra and a vetebroplasty performed in the Emergency Room. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] C. 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	D980		

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D980	Continued From page 92 failure to document Flexeril on the eMAR, and 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).] D. 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 reconciliation 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 B Violation).] E. Based on observations, interviews, and record reviews, the facility failed to assure 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)	D980		

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D980	Continued From page 93 Pharmaceutical Services (Type B Violation).] F. Based on interviews and record reviews, the facility failed to assure after a prospective employee's controlled substance screening tested positive for oxycodone that a second examination and screening was performed, to verify the results of the prior examination and screening, or a statement provided by the prospective employee's physician which verified he had prescribed the oxycodone. [Refer to Tag 992, G.S. § 131D-45(a). Examination and Screening.] G. Based on observations and interviews, the facility failed to maintain the home in a clean manner free from hazards related to a pile of cigarette butts, cigarette ashes, dirt and paper trash swept up and left in a corner of the smoking porch and an ashtray/trash receptacle on the screened porch overflowing with flammable trash and cigarette butts. [Refer to Tag 79, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings.] H. Based on interviews and record reviews the facility failed to assure rehearsals of the fire plan were performed quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. [Refer to Tag 101,10A NCAC 13F .0909(b) Fire Prevention.] I. Based on observations and interviews, the facility failed to maintain the building and all electrical equipment in the home in a safe and operating condition related to exposed wires in the cord of a bug light on the wall of the resident hallway, ceiling fans/lights missing bulbs and globes and with dust build-up on the blades and motors, and dimmer switches in 3 of 4 resident	D980		

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D980	Continued From page 94 shower/tub rooms without dials and/or covers leaving the switch boxes exposed. [Refer to Tag 105, 10A NCAC 13F .0311(a) Other Requirements.] J. Based on observations, interviews, and record reviews, the facility failed to ensure the Licensed Health Professional Support (LHPS) evaluations were completed quarterly for 2 of 3 sampled residents (Resident #5 and #6) and included a physical assessment, evaluation of the residents' care being provided, or needed recommendations for changes in the care of the resident. [Refer to Tag 280, 10A NCAC 13F .0903(c) Licensed Health Professional Support.] K. Based on observations, interviews, and record reviews, the facility failed to assure all therapeutic diets for 2 of 4 sampled residents (Resident #5 and #8) were served as ordered related to puree and no concentrated sweets diet orders. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service.] L. Based on observations and interviews, the facility failed to develop a program of activities designed to promote the residents' active involvement with each other, their families and the community. [Refer to Tag 315 10A NCAC 13F .0909(a) Activities Program.] M. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 4 sampled residents (Resident #3), received Endocet as prescribed. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration. N. Based on interviews and record reviews, the facility failed to assure all medications administered to 1 of 3 sampled residents	D980		

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D980	Continued From page 95 (Resident #3) were dispensed from the pharmacy and properly labeled resulting in a Medication Aide administering 2 Endocet, prescribed for Resident 3's family member, from an unlabeled container the family member had brought to the facility from home. [Refer to Tag 352, 10A NCAC 13F .1003(a).] Failure of management to provide oversight and monitor the facility for all licensure rule areas resulted in a staff member working for 8 months after she tested positive for a controlled substance screening and in the position as Resident Care Coordinator who was in charge of all the medications; no coverage with a CPR certified staff on second shift for 7 of 7 sampled days; a resident in a wheel chair going out a door and rolling down outside steps because of lack of supervision; staff administering a resident unlabeled medications which were prescribed to a family member; 3 of 3 sampled residents not receiving narcotics as ordered; no system to accurately account for controlled substances; staff administering medications as needed without documenting the administration of the medications; residents not receiving referral/follow-up and labs as ordered; no fire drills to assure staff were trained in evacuation; and placing resident's nutritional status at risk when the therapeutic menu were not served as ordered. These failures by the management to provide oversight to assure the compliance of all licensure rules and regulations resulted in substantial risk that serious harm and serious neglect of the residents could occur and constitutes a Type A2 Violation. A Plan of Protection was provided by the facility and included the following: -The Administrator will hold a staff meeting with	D980		

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D980	Continued From page 96 all employees to assure they understand resident rights, medication, safety, fall risk, fire drill to assure all residents are safe and secure at all times. -All non-compliance will be monitored by the Administrator/Director weekly, then biweekly, then montly from that point on. -The Administrator will continue to have montly meetings with all staff to assure all resident are safe at all times. -The Administrator will continue to go over resident rights, medications, safety, fall risk, and fire drills. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 25, 2017.	D980		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to	D992		

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D992	Continued From page 97 the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that after a prospective employee's controlled substance screening tested positive for oxycodone that a second examination and screening was performed, to verify the results of the prior examination and screening, or a statement was provided by the prospective employee's physician which verified he had prescribed the oxycodone. The findings are: Review of the personnel file for the current Resident Care Coordinator (RCC) revealed: -A controlled substance screening had been completed on 7/19/16 with a positive result for oxycodone. -There was no documentation a second examination and screening had been completed to verify the positive results of the initial screening. -There was no documentation in the file that the	D992		

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D992	Continued From page 98 RCC's physician had provided a statement which verified he had prescribed oxycodone. -She had been hired as a Medication Aide/Supervisor on 7/19/16. Interview on 4/13/17 at 11:45am with the Administrat or revealed: -The staff with the positive drug screen was hired as a medication aide 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 negative. -He did not look at the drug screens for the new staff, but left it up to the RCC. -He depended on the RCC to make sure the drug screens for new staff were negative. -The Administrator was instructed by the surveyor that a new offsite drug test needed to be obtained immediately for the RCC. -The Administrator was also instructed by the surveyor that if the RCC could provide documentation from her treating physician that she was on the medication during the time frame she was hired that would suffice. Interview on 4/13/17 at 11:50am with the current RCC revealed: -She became the RCC in December 2016. -She had been on a medication in the past that showed up as positive on the drug screen. -The previous RCC knew that the drug screen was positive. -The current RCC had brought a "pill bottle" to show the previous RCC that she was on the	D992		

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D992	Continued From page 99 medication. -She had told the former RCC, she would bring in a note from her prescribing physician concerning the oxycodone however the former RCC never asked for a note. Telephone interview with the former RCC on 4/22/17 at 2:44pm revealed: -She had informed the Administrator the current RCC, had a positive drug screen but the Administrator had already hired her and did not require her to have another screening. -The current RCC, had more than 1 positive controlled substance screening and the results ahould have been in her personnel record. -The current RCC had told the former RCC, at the time of the initial screening, she had tested positive for oxycodone because she had a "tooth infection or something."	D992		