STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045126	A. BUILDING: _____ B. WING _____	C 06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey and complaint investigation on June 14-16, 2017. The complaint investigation was initiated by the Henderson County Department of Social Services on June 13, 2017.	D 000	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.**	
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure foods and beverages appropriate to residents' diets were offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. The findings are: Interviews with 16 residents on 6/14/17 from 9:15am to 10:45am revealed: -One resident had not seen any snacks for "months. They may have some in a room up there, but they haven't been around bringing snacks. Some people can't walk down there to get them. Snack should be something deliverable". -"They give snacks, but I don't usually take them.	D 298	**10A NCAC 13F .004(d)(2) Nutrition and Food Service** **A.) With respect to the specific resident(s) cited:** There were no specific residents cited in the statement of deficiencies. **B.) With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** See C & D below. **C.) With respect to what systemic measures have been put in place to address the stated concern:** The Executive Director conducted training with the Food Service Director on the provision of snacks at specified intervals three times per day on 6/21/17. A stationary snack and beverage station was set up in the main living room area on 7/5/17. The Executive Director notified residents of the snack station at the Resident Council meeting held on 7/3/17. A letter was also sent to all residents on 7/5/17 notifying them of the snack program. The Executive Director conducted training with the staff on 7/6/17 regarding the distribution of snacks via mobile cart to residents in their rooms routinely three times per day between meals.	

Reviewed and Accepted
Date: 7/10/17 cs

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D 298	Continued From page 1 I have my own snacks. I think they have a lot of snacks." -"They've had a fair amount of snacks, usually accompanies the efforts of the Activities Director" (indicating snacks were often given out in conjunction with an activity). -Staff occasionally brought snacks to the room, "not on a regular basis." They had snacks in the dining room, and "we can pick them up anytime." Snacks consisted of cookies and fruit. -"They have snacks for us in the dining room", staff had never brought snacks to the room. -"They (staff) used to bring snacks to the room, but they don't anymore. They stopped bringing snacks to the room months ago, but I'm not sure why." The resident was not on a special diet, and did not get hungry between meals. -Staff did not bring snacks to them (the residents), the residents could get snacks from the kitchen if they wanted. -They (the residents) had to go to the kitchen to get snacks, staff would "occasionally" bring snacks to their room. -"No snacks were offered at the facility." -"Snacks were available in the kitchen." -No one offered snacks. -They were not getting snacks. -"I think they provide snacks, I've not had any." -"I have my own snacks." -"I'm not getting snacks." -Two residents stated snacks were "offered daily" and delivered to their room. Observations of the kitchen on 6/14/17 at 7:50am revealed: -There was a dietician approved snack menu available to the kitchen staff. -Snack items listed on the menu were observed on the shelves in the pantry and in the refrigerators.	D 298	**D.) With respect to how the plan of corrective measures will be monitored:** The Executive Director/Designee will ensure compliance of snack availability and distribution by conducting random daily environmental rounds. Compliance with the snack menu and program requirements will be discussed at the quarterly Quality Assurance meetings for further review and/or corrective action.	

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D 298	Continued From page 2 Observations of the dining room on 6/14/17 at 10:49am revealed: -There were Fig Newton's, graham crackers, Moon Pies, snack bars, bananas and apples on a serving counter in the back of the dining room. -The dining room was not well-lit; all of the lights were off. Observations in the facility on 6/14/17 from 9:00am to 1:00pm and from 2:00pm to 4:45pm revealed no snacks were delivered to the residents. Interview with a Personal Care Aide (PCA) on 6/14/17 at 10:00am revealed: -Snacks are available in the dining room for residents "anytime they want them." -She had never taken a snack cart around to the residents' rooms to offer them snacks. -If residents can't come to the dining room to get snacks, "we take them to the dining room to get snacks." Interview with a second PCA on 6/14/17 at 11:05am revealed: -"At 10 o'clock and at 2 o'clock we go around to the rooms and offer them snacks." -"It's only like six residents who want snacks, but it's our responsibility to ask all of the residents." Interview with a third PCA on 6/15/17 at 4:00pm revealed "I don't know about the snacks. I've only been here a week." Interview with the Kitchen Manager on 6/14/17 at 2:55pm and on 6/15/17 at 7:45am revealed: -Snacks were provided to the residents 3 times per day, at 10:00am, 2:00pm and 8:00pm. -The Cook would prepare the snack cart and the	D 298		

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D 298	Continued From page 3 [Personal Care Aides (PCA)] would deliver the snacks to the residents in their rooms or in the common areas. -The facility had a snack menu that was followed. -He ordered snacks based on the snack menu. -He kept peanut butter crackers, cookies and other items "on-hand" at all times which were available to the residents. -Snacks were also kept in the dining room making them available to residents at all times. -For residents on a therapeutic diet, their snack was prepared, placed on the snack cart and made available to them "whether they wanted the snack or not". Interview with a Cook on 6/14/17 at 2:05pm revealed: -The Activities staff provided residents a snack "at 2:30pm". -He was not aware if residents received a 10:00am or 8:00pm snack. Telephone interview with one resident's family member on 6/15/17 at 10:15am revealed snacks were offered routinely to residents "They provide excellent care that way." Interview with an Activities staff on 6/15/17 at 10:50am revealed: -Snacks were made available to the residents during an activity. -Snacks at activities were in addition to the snacks made available to the residents by the facility because "not all residents" participated in the activities. Interview with a Medication Aide (MA) on 6/15/17 at 3:55pm revealed: -The 2pm and evening snacks were given out by the activities department.	D 298		

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D 298	Continued From page 4 -"Activities gives out the evening snacks to those that won't participate." -"Activity people handle the snacks." Observations on 6/15/17 at 10:11am and 2:41pm revealed two PCA's were going door to door throughout the facility with the snack cart, delivering snacks to residents. Interview with the Administrator on 6/15/17 at 2:05pm revealed: -Snacks were to be served at the facility 3 times per day, at 10:00am, 2:00pm and 8:00pm. -The snack menu was approved by a licensed dietician. -It was the Cook's responsibility to check the snack menu each day and prepare the snack cart. -The PCA's were responsible for "getting snacks to the residents" whether they were in their rooms, in the hallway of common areas. -It was the Medication Aide assigned as shift supervisor's responsibility to assure snacks were served to the residents.	D 298	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.** **10A NCAC 13F .1004(j) Medication Administration** **A.) With respect to the specific resident(s) cited:** Resident #10 was issued a credit on 7/7/17 to ensure proper compensation for the medications referenced in the statement of deficiencies. **B.) With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The Director of Clinical Services conducted a medication audit on 6/27/17 to ensure the availability of all prescribed medications.	
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	D 367	**C.) With respect to what systemic measures have been put in place to address the stated concern:** The community transitioned to a local pharmacy on 7/1/17 which will allow for the expedited delivery of medications in emergency situations. The Director of Clinical Services will conduct training for all medication technicians by 7/12/17on the regulations pertaining to the borrowing of medications in emergency situations, availability of medications and proper documentation related to narcotic reconciliation. The Director of Clinical Services will conduct weekly random medication audits for one month and monthly thereafter.	

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D 367	Continued From page 5 medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the electronic medication administration record (eMAR) was accurate and complete for 1 of 9 sampled residents (Resident #10). The findings are: Review of Resident #10's current FL2 dated 9/22/16 revealed: -Diagnoses included rheumatoid arthritis and chronic back pain. -A physician's order for Norco 5/325mg (used to treat moderate to severe pain) 1/2 tablet three times a day as needed for pain. Review of Resident #10's medication orders revealed: -An order dated 1/5/17 for Norco 5/325mg 1 tablet daily at 10pm and 4am, 60 tablets. -An order dated 2/9/17 to discontinue the current order for Norco 5/325 1 tablet daily at 10pm and 4am. -An order dated 2/9/17 for Norco 5/325mg 2 tablets daily at 10pm and 4am, 90 tablets. -An order dated 2/23/17 for Norco 5/325mg 2 tablets daily at 10pm and 4am, 90 tablets.	D 367	**D.) With respect to how the plan of corrective measures will be monitored:** The Director of Clinical Services will conduct weekly random medication audits for one month and monthly thereafter. The Executive Director and Director of Clinical Services will conduct a monthly narcotic count to ensure the availability of all controlled substances for three months and quarterly thereafter. The Medication Management program will be discussed at the quarterly Quality Assurance meeting for further review and/or corrective action.	

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D 367	Continued From page 6 -An order dated 2/24/17 to discontinue the current order for Norco 5/325mg. -An order dated 4/13/17 for Norco 5/325mg 1 tablet twice daily as needed for pain, 60 tablets. -An order dated 4/20/17 for Norco 5/325mg 1 tablet twice daily as needed for pain, 30 tablets. Review of Resident #10's April 2017 eMAR revealed: -An entry for Norco 5/325mg 1 tablet two times a day as needed for pain. -The Norco 5/325mg tablets were documented as administered 5 times from 4/1/17 to 4/25/17. Review of Resident #10's narcotic count sheet for Norco 5/325mg tablets Rx #2066319 revealed: -There were 30 tablets of Norco 5/325mg dispensed on 3/9/17 for Resident #10 for Rx #2066319. -All 30 tablets of the Norco 5/325mg supply were documented as administered from 3/2/17 to 4/25/17. -Seventeen tablets were documented as administered from 4/2/17 to 4/25/17. -There was no documentation of any of the tablets signed out 4/2/17 to 4/25/17 as having been "borrowed" for another resident. Review of Resident #10's record of narcotics returned for Rx# 2066319 revealed: -An entry dated 4/25/17 documented there were no tablets returned to the pharmacy. -The entry was initialed by two staff members. Based on the review of Resident #10's April 2017 eMAR and narcotic count sheet, 12 Norco 5/325mg tablets had been signed out by five different Medication Aides, however the doses were not documented as administered on the resident's eMAR	D 367		

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D 367	Continued From page 7 Observation of Resident #10's medications available on the medication cart on 6/15/17 at 4:27pm revealed there were 22 tablets of Norco 5/325mg tablets from prescription #2066636 dispensed on 4/13/17 available for resident use. Telephone interview with the facility pharmacy provider on 6/15/17 at 4:45pm revealed there had been no returns of Norco 5/325mg tablets dispensed for Rx# 2066319 returned to their pharmacy. Interview with Resident #10 on 6/15/17 at 4:00pm revealed: -"Anytime I ask for pain medication they give it to me." -"They are very good to me." -The staff brought her pain medication "quickly" when she requested it. Interview on 6/16/17 at 9:40am with a Medication Aide (MA) revealed the narcotic sheet entries for Resident #10 dated 4/2/17 to 4/25/17 which were not documented on resident's MAR may have been signed out of Resident #10's supply and then administered to "another resident." Interview with the Resident Care Services Director (RCSD) on 6/16/17 at 11:20am revealed: -The eMAR and narcotic count sheet "should match." -The Medication Aides had been trained to document the administration of a narcotic in the eMAR system and also to sign out the dose on the control sheet. -The eMAR would document administration of a medication whether the Medication Aide scanned the bubble pack or clicked on the medication. Either method used would document an	D 367		

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D 367	Continued From page 8 administration on the eMAR.	D 367		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to assure 4 of 4 sampled residents (#6, #9, #10 and #11) that received borrowed medications or had their medications borrowed, were replaced in a timely manner and properly documented. (Norco 5/325mg) The findings are: A. Review of Resident #11 current FL2 dated 9/9/16 revealed diagnoses of Alzheimer's dementia with behaviors, hypertension, and osteoarthritis. Review of Resident #11's medication orders revealed: -Orders dated 4/13/17 and 5/18/17 for Norco 5/325mg, 1 tablet twice daily, 60 tablets. (Norco 5/325mg is a combination analgesic used to treat moderate to severe pain.) -A subsequent order dated 6/9/17 to discontinue the Norco 5/325mg and start morphine extended	D 372	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.** **10A NCAC 13F .1004(o) Medication Administration** **A.) With respect to the specific resident(s) cited:** Resident #9, #10 and #11 were issued a credit on 7/7/17 to ensure proper compensation for the medications referenced in the statement of deficiencies. Resident #9 was discharged on 6/17/17. Resident #6 was discharged on 3/22/17. **B.) With respect to how the facility will identify residents with the potential for the identified concern and take corrective action:** The Director of Clinical Services conducted a medication audit on 6/27/17 to ensure the availability of all prescribed medications.	

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D 372	Continued From page 9 release 15mg, 1 tablet twice daily. (Morphine is a narcotic analgesic used to treat severe pain.) Interview with a pharmacist at the pharmacy provider on 6/16/17 at 10:05am revealed: -They had dispensed 60 tablets of Norco 5/325mg for Resident #11 on 4/13/17 and 5/22/17. -The directions for use on both refills of Norco 5/325mg were 1 tablet twice daily. -The 5/22/17 refill of Resident #11's Norco 5/325mg was delivered to the facility on 5/23/17 at 2:20am. -The facility had returned 21 tablets of Norco 5/325mg on 6/10/17 after the order was discontinued on 6/9/17. -The pharmacy relied on the facility to obtain the written scripts for narcotics from the physicians, but "we can help call the doctor if needed." Review of Resident #11's electronic Medication Administration Record (eMAR) for May and June 2017 revealed: -An entry Norco 5/325mg, take 1 tablet by mouth 2 times a day with scheduled adminstration times of 10:00am and 4:00pm. -The Norco 5/325mg had been documented as administered 34 times from 5/23/17 at 10:00am until 6/9/17 at 10:00am. -The Norco 5/325mg was documented as refused once on 6/7/17 at 10:00am. Review of the narcotic count sheet for Resident #11's Norco 5/325mg dispensed on 5/22/17 revealed: -Thirty-nine tablets were documented as administered. -One tablet was documented as "wasted" on 6/30/17. -Three tablets were documented as "borrowed,"	D 372	**C.) With respect to what systemic measures have been put in place to address the stated concern:** The community transitioned to a local pharmacy on 7/1/17 which will allow for the expedited delivery of medications in emergency situations. The Director of Clinical Services will conduct training for all medication technicians by 7/12/17 on the regulations pertaining to the borrowing of medications in emergency situations, availability of medications and proper documentation related to narcotic reconciliation. The Director of Clinical Services will conduct weekly random medication audits for one month and monthly thereafter. **D.) With respect to how the plan of corrective Measures will be monitored:** The Director of Clinical Services will conduct weekly random medication audits for one month and monthly thereafter. The Executive Director and Director of Clinical Services will conduct a monthly narcotic count to ensure the availability of all controlled substances for three months and quarterly thereafter. The Medication Management program will be discussed at the quarterly Quality Assurance meeting for further review and/or corrective action.	

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D 372	Continued From page 10 with 2 tablets on 6/5/17, and 1 tablet on 6/6/17. -One tablet was documented as refused on 6/7/17. -Four tablets were documented as administered on 6/5/17 and 6/6/17 even though the Norco 5/325mg was only ordered twice daily for Resident #11. Review of the facility's "Borrow Sheet" located in the front of the narcotic count sheet notebook revealed: -Four consecutive doses of Norco 5/325mg were documented as borrowed for Resident #11, from Resident #9. -Only one of the 4 doses had a date beside the borrowed entry. -The date of that one entry was 6/6/17. -There was no documentation Resident #9 was paid back for the borrowed doses. Interview with the Resident Care Services Director (RCSD) on 6/15/17 at 11:55am revealed: -Residents were paid back for medications borrowed from them. -She believed the documentation on the borrow sheet was wrong and Resident #9 was the one borrowed for and Resident #11 was the one borrowed from. -"Unless the (resident's) physician was standing right in front of you" it was hard to get a written script for narcotics when residents ran out of their medications, and "it would take a while to get them." Interview with a Medication Aide (MA) on 6/15/17 at 3:15pm revealed: -They documented on the facility's "borrow sheet" which residents they borrowed medications for and who they borrowed medications from.	D 372		

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D 372	Continued From page 11 -They paid back residents that were borrowed from by using the bubble pack from the residents borrowed for when their medications came in from the pharmacy. -The MAs tried to order narcotic medications a week or two in advance to keep residents from running out of their medications. -It was difficult to obtain a hard (written) script for narcotics from some resident's physicians. -The MA did not document when residents are "paid back" from borrowed medications. -If a resident were in pain, and we could not get the medication, that would be an emergency. -"We try not to run out." Based on the number of tablets of Norco 5/325mg documented as sent from the pharmacy for Resident #11, and the number of tablets of Norco 5/325mg documented as returned to the pharmacy, if Resident #11 had been paid back for the Norco 5/325mg tablets borrowed from her, 4 more tablets would have been returned to the pharmacy on 6/10/17. Interview with Resident #11's family member and power of attorney on 6/16/17 at 9:32am revealed: -There was a "universal concern" about residents getting their medications properly. -He wasn't necessarily concerned about the facility, but more about the resident refusing her medications. -The resident could not remember taking her medications from one administration time to the next. -She was very resistant to taking her medications, especially when she was in her room. -He was not aware of Resident #11 running out of her medications or having medications borrowed from her for other residents.	D 372		

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	HAL045126	A. BUILDING: _____ B. WING _____	C 06/16/2017

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D 372	Continued From page 12 Refer to interview with the Regional Operations Nurse on 6/15/17 at 2:45pm. Refer to interview with a Medication Aide (MA) on 6/15/17 at 3:15pm. Refer to interview with the Resident Care Services Director (RCSD) on 6/16/17 at 11:20am. B. Review of Resident #10's current FL2 dated 9/22/16 revealed: -Diagnoses included rheumatoid arthritis and chronic back pain. -A physician's order for Norco 5/325mg (used to treat moderate to severe pain) 1/2 tablet three times a day as needed for pain. Review of Resident #10's medication orders revealed: -An order dated 1/5/17 for Norco 5/325mg 1 tablet daily at 10pm and 4am, 60 tablets. -An order dated 2/9/17 to discontinue the current order for Norco 5/325 1 tablet daily at 10pm and 4am. -An order dated 2/9/17 for Norco 5/325mg 2 tablets daily at 10pm and 4am, 90 tablets. -An order dated 2/23/17 for Norco 5/325mg 2 tablets daily at 10pm and 4am, 90 tablets. -An order dated 2/24/17 to discontinue the current order for Norco 5/325 and start morphine ER (used to treat severe pain) 15 mg 1 tablet daily at 10am. -An order dated 4/13/17 for Norco 5/325mg 1 tablet twice daily as needed for pain, 60 tablets. -An order dated 4/20/17 for morphine ER 15mg 1 tablet daily at bedtime and Norco 5/325mg 1 tablet twice daily as needed for pain, 30 tablets. -A signed physician order sheet dated 5/17/17 for morphine ER 15mg 1 tablet daily at bedtime and Norco 5/325mg 1 tablet twice daily as needed for	D 372		

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D 372	Continued From page 13 pain. Telephone interview with the facility pharmacy provider on 6/15/17 at 4:45pm revealed: -Resident #10's current Norco 5/325mg order was dated 4/13/17 for Norco 5/325mg 1 tablet twice daily as needed. -Norco 5/325mg for Resident #10 prescription #2066636 was last dispensed to the facility on 4/13/17, 60 tablets. -They had received another prescription for Resident #10 for Norco 5/325mg dated 4/20/17 which had not been dispensed. Review of Resident #10's narcotic count sheet for Norco 5/325mg tablets for RX# 2066636 revealed: -The first dose was signed out on 4/26/17 at 5pm. -Thirty eight tablets were documented as administered out of the 60 tablets dispensed 4/13/17. -Seven tablets were documented as "borrowed." -The seven "borrowed" tablets were signed out on 6/4/17 at 12pm, 6/4/17 at 6pm, 6/5/17 at 12am, 6/5/17 at 6am, 6/6/17 at 12am, 6/6/17 at 6pm, and 6/7/17 at 12am. -Four tablets were signed out on 6/4/17 though the Norco 5/325mg was only ordered twice daily as needed. -Three tablets were signed out on 6/6/17 though the Norco 5/325mg was only ordered twice daily as needed. Review of Resident #10's April 2017 eMAR from 4/26/17 to 4/30/17 revealed: -An entry for Norco 5/325mg 1 tablet two times a day as needed for pain. -The Norco 5/325mg was documented as administered 3 times from 4/26/17 to 4/30/16.	D 372		

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D 372	Continued From page 14 Review of Resident #10's May 2017 eMAR revealed: -An entry for Norco 5/325mg 1 tablet two times a day as needed for pain. -The Norco 5/325mg was documented as administered 20 times from 5/2/17 to 5/31/17. Review of Resident #10's June 2017 eMAR revealed: -An entry for Norco 5/325mg 1 tablet two times a day as needed for pain. -The Norco 5/325mg was documented as administered 8 times from 6/3/17 to 6/12/17. Observation of Resident #10's medications available on the medication cart on 6/15/17 at 4:27pm revealed there were 22 tablets of Norco 5/325mg tablets from prescription #2066636 dispensed on 4/13/17 available for resident use. Review of the facility's "Borrow Sheet" located in the front of the narcotic count sheet notebook revealed: -Seven consecutive doses of Norco 5/325mg were documented as borrowed for Resident #9, from Resident #10. -Five doses had a date beside the borrowed entry (6/4/17, 2 doses on 6/6/17, 2 doses on 6/7/17). -There was no documentation Resident #10 was paid back for the 7 borrowed doses. Interview with the facility's registered nurse, the Resident Care Services Director (RCSD) on 6/15/17 at 11:55am revealed residents were paid back for medications borrowed from them. Interview with Resident #10 on 6/15/17 at 4:00pm revealed: -"Anytime I ask for pain medication they give it to me."	D 372		

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D 372	Continued From page 15 -"They are very good to me." -The staff brought her pain medication "quickly" when she requested it. Refer to interview with the Regional Operations Nurse on 6/15/17 at 2:45pm. Refer to interview with a MA on 6/15/17 at 3:15pm revealed: Refer to interview with the RCSD on 6/16/17 at 11:20am. C. Review of Resident #9's FL2 dated 2/2/17 revealed: -Diagnoses of idiopathic peripheral neuropathy, history of prostate cancer, insomnia, hypertension, degenerative joint disease, and degenerative disk disease. -A physician order for Norco 5/325mg (used to treat pain) 1 tablet every six hours. Interview with a pharmacist at the provider pharmacy on 6/15/17 at 4:25pm revealed they had dispensed 120 tablets of Norco 5/325mg on 5/3/17 and 6/6/17. Telephone interview with a nurse at the prescribing physician's office on 6/16/17 at 9:55am revealed that prescriptions for the Norco 5/325mg were written on 5/2/17 and 6/5/17. Review of Resident #9's electronic Medication Administration Record (eMAR) for May and June 2017 revealed: -An entry for Norco 5/325mg, take 1 tablet by mouth every 6 hours with scheduled administration times of 6:00am, 12:00pm, 6:00pm, and 12:00am	D 372		

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D 372	Continued From page 16 -The Norco 5/325mg had been documented as administered 148 times from 5/1/17 at 6:00am to 6/7/17 at 6:00am. -No documentation was recorded for 5/3/17 at 6:00pm and 5/4/17 at 12:00am. Review of the facility's "Borrow Sheet" located in front of the narcotic count sheet notebook revealed: -6 consecutive doses of Norco 5/325mg borrowed from Resident #10 for Resident #9. One dose on 6/4/17, two doses on 6/6/17, and two doses on 6/7/17. Two doses borrowed had no date beside the entry. -There was no documentation that Resident #10 was paid back for the borrowed doses. -4 consecutive doses of Norco 5/325mg borrowed from Resident #9 for Resident #11. One entry had a date of "6/6." -There was no documentation that Resident #9 was paid back for the borrowed doses. Interview with the Resident Care Services Director (RCSD) 6/16/17 at 11:22am revealed: -Resident #9's prescription for the Norco 5/325mg was "written the same day staff told me it was out." -A family member was told the resident was out of the medication and had gone to Resident #9's physician's office to pick up the prescription and had dropped it off at the facility's backup pharmacy to be filled the same day. Telephone interview with Resident #9's family member on 6/16/17 at 10:22am revealed her dad was getting his pain medications on a regular basis as far as she knew. Telephone interview with Resident #9 on 6/16/17 at 10:25am revealed he didn't have any issues	D 372		

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D 372	Continued From page 17 with his pain medications. "I don't think they ever ran out". Refer to interview with the Regional Operations Nurse on 6/15/17 at 2:45pm. Refer to interview with a MA on 6/15/17 at 3:15pm revealed: Refer to interview with the RCSD on 6/16/17 at 11:20am. D. Review of Resident #6's current FL2 dated 2/22/17 revealed: -Diagnoses included gastroesophageal reflux disease, diverticulitis, anxiety, right hip fracture, stomatitis, recurrent interstitial cystitis, irritable bowel syndrome, and hernia repair. -A physician's order for oxycodone 5mg, ½ tablet every 4 hours. -A physican's order allowing the resident to self-medicate. Interview with Resident #6 on 6/15/17 at 10:00am revealed "Someone once came in to my room and tried to give me an opioid and I refused, I told them I self-administer my own medications." Review of Resident #6's February and March 2017 eMAR revealed: -An entry for oxycodone 5mg ½ tablet every 4 hours. -Entry for self administer was documented on eMAR beginning 2/23/2017. Review of the facility's "Borrow Sheet" located in the front of the narcotic count sheet notebook revealed one dose of oxycodone 5mg was documented as borrowed on 3/17/17 for Resident #6, from Resident #12.	D 372		

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D 372	Continued From page 18 Refer to interview with the Regional Operations Nurse on 6/15/17 at 2:45pm. Refer to interview with a MA on 6/15/17 at 3:15pm revealed: Refer to interview with the RCSD on 6/16/17 at 11:20am. _____ Interview with the Regional Operations Nurse on 6/15/17 at 2:45pm revealed: -"We do not have a written policy on borrowing." -"We follow the rule." -"Routine medications should have been obtained from the backup pharmacy." -"The narcotics borrowed may have been due to waiting on hard scripts from the physician." Interview with a MA on 6/15/17 at 3:15pm revealed: -They documented on the facility's "borrow sheet" which residents they borrowed medications for and who they borrowed medications from. -They paid back residents that were borrowed from by using the bubble pack from the residents borrowed for when their medications came in from the pharmacy. -The MAs tried to order narcotic medications a week or two in advance to keep residents from running out of their medications. -It was difficult to obtain a hard (written) script for narcotics from some resident's physicians. -The MA did not document when residents are "paid back" from borrowed medications. -If a resident were in pain, and we could not get the medication, that would be an emergency.	D 372		

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D 372	Continued From page 19 -"We try not to run out." Interview with the RCSD on 6/16/17 at 11:20am revealed: -The Medication Aides "are not supposed to be borrowing at all." -"I was unaware they were doing it until yesterday" (6/15/17). -When the Medication Aides had borrowed medications they should have documented on the control sheet who they had borrowed from and to whom received the medication. -"None" of the management staff were aware the Medication Aides were borrowing medications.	D 372		