Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 A follow-up survey was conducted by the Adult Care Licensure Section and the Brunswick County Department of Social Services on June 14, 2017 and June 15, 2017.	{D 000}		
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: Based on observations, interviews and record reviews, the facility failed to accurately document the receipt, administration and disposition of a controlled substance (oxycodone) for 1 of 5 sampled residents (Resident # 4). The findings are: Review of Resident #4's Resident Register revealed an admission date of 10/18/16. Review of Resident #4's current FL-2 dated 01/11/17 revealed diagnoses that included anxiety, depression, personality disorder and hypothyroidism. Interview with Resident #4 on 06/18/17 at 12:15pm revealed: -The resident woke up on the morning of 06/10/17 around 6:00am in pain. -She was given Tylenol (an over the counter analgesic) for her pain which helped some. -The resident was taken to a local Emergency	D 392	It is the policy of Shallotte Assisted Living that The facility will have a record of all controlled Substances by documenting the receipt, Administration and disposition of controlled Substances. These records shall be maintained With the residents medical file and will be accurate. The ARCD will monitor the MAR and the control Sheets daily to make sure all meds are signed for And documented on the back of the Mar along With making sure the Narc count and sheet are Correct. The RCD will follow up weekly to make sure all Areas above are in compliance When the medication is "zeroed" out, the RCD Will put the control Sheet in the residents medical file and will be Available for review. The ARCD will monitor the control counts daily To make sure that each med aide is counting the Narcotics after/before each shift. The RCD will follow up weekly to make sure All is in compliance. Administrator has scheduled a medication in-service 07/06/2017.	07/06/17 & On-Going

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tammie Bullard, Admin. — 07/06/2017

Reviewed & accepted
J. Bowen, RN
09/25/17

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D 392	Continued From page 1 Room (ER) where she was diagnosed with 3 fractured ribs, hip contusion and a urinary tract infection (UTI). -The resident was given prescriptions for oxycodone (an opoid pain medication) for pain while in the ER. -The resident had been given an "orange tablet" for pain. -She could not remember how often she was given the pain medicine. -The resident's pain was not being relieved by the pain medication. Review of Resident #4's ER discharge instructions dated 06/12/17 revealed: -The resident was diagnosed with "multiple fractures" of ribs left side, contusion of left hip and UTI. -The resident was prescribed an antibiotic and Oxycodone 5mg, 1 to 2 tablets every 4 to 6 hours as needed for pain.. -The resident was prescribed Oxycodone 5mg, 1 to 2 tablets every 4 to 6 hours as needed pain. Observations of medications on hand for Resident #4 on 06/15/17 at 1:20pm revealed: -A medication bottle from a local ER labeled with the resident's name and dated 06/11/17. -The medication bottle was labeled with "Oxycodone 5mg: 4 tabs". -The medication bottle labeled Oxycodone 5mg contained 2 uncoated, medium blue tablets. -The medication bottle from the ER was the only Oxycodone on the medication cart labeled for Resident #2. Review of Resident #4's Controlled Substance Log for Oxycodone 5 mg tablets on 06/15/17 revealed: -The sheet was started on 06/12/17.	D 392		

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D 392	Continued From page 2 -The beginning count for Oxycodone tablets was documented as 14. -One tablet was documented as administered on 06/12/17 at 12:00pm. -One tablet was documented as administered on 06/12/17 at 5:00pm. -One tablet was documented as administered on 06/12/17 at an undocumented time. -One tablet was documented as administered on 06/13/17 at 12:30am. -One tablet was documented as administered on 06/13/17 at 6:00am. -One tablet was documented as administered on 06/13/17 at 12:00pm. -One tablet was documented as administered on 06/13/17 at 4:00pm. -One tablet was documented as administered on 06/14/17 at 12:00pm. -One tablet was documented as administered on 06/14/17 at 7:30am. -One tablet was documented as administered on 06/14/17 at 12:30pm. -One tablet was documented as administered on 06/14/17 at 4:30pm. -One tablet was documented as administered on 06/15/17 at 5:30am. -The last entry on the Controlled Substance Log left a count of 2 tablets. Review of Resident #4's June 2017 Medication Administration Record (MAR) revealed: -There was a handwritten entry dated 06/12/17 for Oxycodone 5mg, 1 tablet every 4 hours as needed for pain. -Nine Oxycodone tablets were documented as administered from 06/12/17 through 06/15/17. -There was documentation of 8 Oxycodone tablets administered on the Exception page for the June 2017 MAR.	D 392		

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D 392	Continued From page 3 Interview with a Medication Aide (MA) aide on 06/15/17 at 4:20pm revealed: -She was on duty when the resident returned from the ER on 06/11/17. -The resident returned from the ER with a medication bottle with 4 Oxycodone 5mg tablets. -She called the ER to clarify the orders for the Oxycodone. -The MA documented the order, Oxycodone 5mg 1 tablet every 4 hours as needed for pain, on the June 2017 MAR. -The MA started a Control Substance Log for the 4 tablets. -The MA faxed the prescription to the prescribing pharmacy. -The MA did not recognize the initials on the first entry, 06/12 at 12:00pm, on the control substance count sheet for 14 tablets. -The MA could not locate the Controlled Substance Log that she started on 06/11/17. -The MA could not locate the fax transmittal verification sheet for the prescription that she faxed to the prescribing pharmacy on 06/11/17. Interview with a second MA on 06/15/17 at 6:00pm revealed: -She did not recognize the initials on the 06/11/17 12:00pm entry on Resident #4's Controlled Substance Log. -She had given the resident pain medication from the ER medication bottle. -The MA thought she had only given the resident "blue" tablets. -She did not know how many tablets were in the medication bottle. Telephone interview with a nurse in the local ER on 06/15/17 at 5:25pm revealed: -Resident #4 was seen in the ER on 06/11/17. -The ER medical provider gave Resident #4 a	D 392		

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D 392	Continued From page 4 prescription for an antibiotic and Oxycodone. -The ER was only allowed to dispense 4 tablets of Oxycodone. - Resident #4 was given a prescription for Oxycodone 5mg, 1 to 2 tablets every 4 to 6 hours as needed for pain, dispense 20 tablets. Telephone interview with the backup pharmacy on 06/15/17 at 06:11pm revealed they did not have a prescription for Oxycodone for the resident. Interview with the dispensing pharmacy on 06/15/17 at 2:45pm revealed: -The pharmacy received a prescription for Oxycodone 5mg tablets, 1 tablet every 4 hours as needed for pain, dispense 180 tablets on 06/12/17 for Resident #4. -The facility's medical provider wrote the 06/12/17 prescription for Oxycodone. -This was the first prescription filled for Oxycodone for the resident. -The dispensing pharmacy did not receive the ER prescription for Oxycodone. -The pharmacist was not familiar with "orange" Oxycodone tablets. Telephone interview with the facility's medical provider on 06/15/17 at 4:36pm revealed: -He received a telephone call from the facility's Resident Care Coordinator (RCC) on 06/12/17. -The RCC told him that Resident #4 had fractured ribs and was not given enough pain medication by the ER. -The facility's medical provider provided an order for Oxycodone 5mg, 1 tablet every 4 hours as need for pain, dispense 180 tablets. -He did not know the resident had been given a prescription for 20 Oxycodone tablets in the ER.	D 392		

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D 392	Continued From page 5 Interview with the RCC on 06/15/17 at 2:30pm revealed: -He was not aware of the ER prescription for Oxycodone 5mg, 20 count. -The 180 tablets of Oxycodone from the 06/12/17 prescription had not been put on the medication cart. -He could not explain the discrepancy on the Controlled Substance Log. Observation on 06/15/17 at 2:35pm in the RCC's office revealed: -There were 2 bubble cards labeled with the resident's name and dated 06/12/17. -The bubble cards were labeled Oxycodone 5mg, 1 tablet every 4 hours as needed for pain -The bubble cards were labeled with the dispensing pharmacy's name. -Each bubble card contained 90 white tablets. Interview with the Administrator on 06/15/17 at 6:20pm revealed: -She could not explain the discrepancy on the Controlled Substance Count Sheet. -She did not recognize the initials on the first entry on the Controlled Substance Log. -The Controlled Substance Log started on 06/11/17 with 4 tablets of Oxycodone could not be found. -The Administrator would arrange for an In-service on documentation for all MA as soon as possible.	D 392		