STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL061008	A. BUILDING: _____ B. WING _____	R 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & L FAMILY CARE HOME	842 CANE CREEK ROAD BAKERSVILLE, NC 28705

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 12, 2018, with an exit conference via telephone on September 13, 2018.	C 000		
C 327	10A NCAC 13G .1003 (e) Medication Lable 10A NCAC 13G .1003 Medication Labels (e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for administration to a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep dispensed medications in original packaging for 1 of 3 sampled residents (Resident #1) related to transferring 11 different medications from their original dispensed packaging to previously used prescription bottles. Review of Resident #1's current FL2 dated 08/22/18 revealed diagnoses included traumatic brain injury, dysphagia, opioid dependence, hemiplegia, and hemiparesis. Review of Resident #1's Resident Registar revealed an admission date of 08/24/18. Review of Resident #1's medication list included on an electronically signed doctor's note dated 08/28/18 revealed: -There was an order for omeprazole 40mg take 1 capsule by mouth twice daily (used to treat acid reflux).	C 327		

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C 327	Continued From page 1	C 327		

-There was an order for hydromorphone 2mg take 1 tablet by mouth every 8 hours as needed (used to treat pain).
-There was an order for metoprolol 25mg take half tablet by mouth once daily (used to treat blood pressure).
-There was an order for potassium chloride 20mEq take 1 tablet by mouth 4 times daily (used as a supplement).
-There was an order for venlafaxine ER 75mg take 1 capsule by mouth once daily (used to treat depression).
-There was an order for venlafaxine ER 150mg take 1 capsule by mouth once daily (used to treat depression).
-There was an order for Vimpat 100mg take 1 tablet by mouth twice daily (used to treat seizures).
-There was an order for gabapentin 400mg take 2 capsules by mouth every 6 hours (used to treat nerve pain).
-There was an order for levothyroxine 25mcg take 1 tablet by mouth once daily in the morning (used to treat thyroid disease).
-There was an order for lorazepam 1mg take 1 tablet by mouth 3 times daily (used to treat anxiety).
-There was an order for furosemide 40mg take 1 tablet by mouth twice daily (used to treat fluid).

Review of Resident #1's August 2018 Medication Administration Record (MAR) revealed medications had been documented as administered from 08/24/18 to 08/31/18.

Review of Resident #1's September 2018 MAR revealed medications had been documented as administered from 09/01/18 to 09/12/18.

Observation of Resident #1's medication on hand

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C 327	Continued From page 2 on 09/12/18 revealed: -There were 11 medications that had been transferred from their original packaging. -The following medications were available to be admnistered to Resident #1, omeprazole 40mg, hydromorphone 2mg, metoprolol 25mg, potassium chloride 20mEq, venlafazine ER 75mg, venlafaxine ER 150mg, Vimpat 100mg, gabapentine 400mg, levothyroxine 25mcg, lorazepam 1mg, and furosemide 40mg. -Each prescription label showed a dispense date that was prior to Resident #1's admission to facility. -Prescription bottles did not match. -Bottles were orange or brown with white, orange or blue lids. -Prescription labels were taped to each bottle. -Medications were correctly labeled. -The remaining medications were in their original container from the dispensing pharmacy. Interview with Resident #1 on 09/12/18 at 4:45pm revealed she had received all her medications since she had moved into the facility. Interview with the Administrator on 09/12/18 at 9:50am revealed: -Resident #1 had brought a lot of medications to the facility on admission. -Each medication was originally packed individually in a medication card. -She did not have enough room in the medication cabinet to lock up all the medications. -She had popped out all the tablets from each medication card and put them in "old prescription bottles" that she had at the facility. -She had removed the label from the medication card and relabeled the prescription bottle for each medication. -She thought it would be okay to transfer the	C 327		

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C 327	Continued From page 3 medications to the previously used prescription bottles to allow the medications to be locked for storage. -She did not think the facility's contracted pharmacy would repackage the medication. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/12/18 at 2:52pm revealed: -It was not recommended to repackage medications. -The repackaged medication could be harmful to the resident because the medications could be repackaged with the wrong label and directions. -The pharmacy could repackage the medication if the facility needed. Telephone interview with a nurse from Resident #1's Primary Care Physician's (PCP) office on 09/12/18 at 4:03pm revealed: -There was a risk of putting the wrong medication in a bottle with the wrong label if medications were repackaged from their original packaging. -It was best practice to obtain new prescriptions from the pharmacy and to not use the medications that had been repackaged.	C 327		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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:	C 367		

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C 367	Continued From page 4 Based on observations, interviews, and record reviews, the facility failed to assure a record of controlled substances was available for 2 of 2 sampled residents (Resident #1 and #4) related to hydromorphone (schedule II medicatoin used to treat pain), lorazepam (schedule IV medication used to treat anxiety), Vimpat (schedule V medication used to treat seizures), and clonazepam (schedule IV medication used to treat seizure disorder). 1. Review of Resident #1's current FL2 dated 08/22/18 revealed diagnoses included traumatic brain injury, dysphagia, opioid dependence, hemiplegia, and hemiparesis. Review of Resident #1's Resident Register revealed an admission date of 08/24/18. a. Review of Resident #1's medication list on an electronically signed doctor's note dated 08/28/18 revealed an order for hydromorphone 2mg take 1 tablet every 8 hours as needed. Review of Resident #1's August 2018 Medication Administration Record (MAR) revealed: -There was a computer generated entry for hydromorphone 2mg take 1 tablet every 8 hours to be administered at 8:00am, 1:00pm, and 8:00pm. -Hydromorphone 2mg had been documented as administered 22 times from 08/24/18 to 08/31/18. Review of Resident #1's September 2018 MAR revealed: -There was a computer generated entry for hydromorphone 2mg take 1 tablet every 8 hours to be administered at 8:00am, 1:00pm, and 8:00pm. -Hydromorphone 2mg had been documented as	C 367		

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C 367	Continued From page 5 administered 34 times from 09/01/18 to 09/12/18. Observation of Resident #1's medications on hand on 09/12/18 at 12:24pm revealed: -There was 11 tablets of hydromorphone 2mg available to be administered. -Label showed 90 tablets had been dispensed to Resident #1 prior to admission on 08/20/18. Review of Resident #1's controlled substance count shee revealed no count sheet was available for hydromorphone 2mg. Interview with Resident #1 on 09/12/18 at 4:45pm revealed: -She had received all her medications since she had moved into the facility. -She had not ran out of medication or missed a dose of medication. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/12/18 at 2:52pm revealed that the pharmacy had not dispensed any hydromorphone 2mg to Resident #1. Interview with the Administrator on 09/12/18 at 3:44pm revealed: -She did not know how many hydromorphone 2mg tablets Resident #1 had brought to the facility on admission. -Resident #1 had asked for a dose of hydromorphone 2mg 3 times daily since admission. -She did not consider the hydromorphone 2mg as an as needed medication for Resident #1. -She had forgotten that she needed to keep an inventory record for each controlled substances. -She had not had a resident on a controlled substance in a "long time."	C 367		

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C 367	Continued From page 6 b. Review of Resident #1's medication list on an electronically signed doctor's note dated 08/28/18 revealed an order for lorazepam 1mg take 1 tablet by mouth every 8 hours. Review of Resident #1's August 2018 MAR revealed: -There was a computer generated entry for lorazepam 1mg take 1 tablet every 8 hours to be administered at 8:00am, 1:00pm, and 8:00pm. -Lorazepam 1mg had been documented as administered 22 times from 08/24/18 to 08/31/18. Review of Resident #1's September 2018 MAR revealed: -There was a computer generated entry for lorazepam 1mg take 1 tablet every 8 hours to be administered at 8:00am, 1:00pm, and 8:00pm. -Lorazepam 1mg had been documented as administered 34 times from 09/01/18 to 09/12/18. Observation of Resident #1's medication on 09/12/18 at 12:24pm revealed: -There was 12 whole tablets and 3 partial tablets of lorazepam 1mg available to be administered. -Label showed 90 tablets had been dispensed to Resident #1 prior to admission on 08/20/18. Review of Resident #1's controlled substance count sheet revealed no count sheet was available for lorazepam 1mg. Interview with Resident #1 on 09/12/18 at 4:45pm revealed: -She had received all her medications since she had moved into the facility. -She had not ran out of medication or missed a dose of medication.	C 367		

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C 367	Continued From page 7 Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/12/18 at 2:52pm revealed that the pharmacy had not dispensed any lorazepam 1mg to Resident #1. Interview with the Administrator on 09/12/18 at 3:44pm revealed: -She did not know how many lorazepam 1mg tablets Resident #1 had brought to the facility on admission. -She had forgotten that she needed to keep an inventory record for each controlled substances. -She had not had a resident on a controlled substance in a "long time." c. Review of Resident #1's medication list on an electronically signed doctor's note dated 08/28/18 revealed an order for Vimpat 100mg take 1 tablet by mouth twice daily. Review of Resident #1's August 2018 MAR revealed: -There was a computer generated entry for Vimpat 100mg take 1 tablet by mouth twice daily to be administered at 8:00am and 8:00pm. -Vimpat 100mg had been documented as administered 15 times from 08/24/18 to 08/31/18. Review of Resident #1's September 2018 MAR revealed: -There was a computer generated entry for Vimpat 100mg take 1 tablet by mouth twice daily to be administered at 8:00am and 8:00pm. -Vimpat 100mg had been documented as administered 23 times from 09/01/18 to 09/12/18. Observation of Resident #1's medication on 09/12/18 at 12:24pm revealed: -There was 23 tablets of Vimpat 100mg available to be administered.	C 367		

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C 367	Continued From page 8 -Label showed 60 tablets had been dispensed to Resident #1 prior to admission on 08/13/18. Review of Resident #1's controlled substance count sheet revealed no count sheet was available for Vimpat 100mg. Interview with Resident #1 on 09/12/18 at 4:45pm revealed: -She had received all her medications since she had moved into the facility. -She had not ran out of medication or missed a dose of medication. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/12/18 at 2:52pm revealed that the pharmacy had not dispensed Vimpat 100mg to Resident #1. Interview with the Administrator on 09/12/18 at 3:44pm revealed: -She did not know how many Vimpat 100mg tablets Resident #1 had brought to the facility on admission. -She did not know Vimpat was considered a controlled substance. -She had forgotten that she needed to keep an inventory record for each controlled substances. -She had not had a resident on a controlled substance in a "long time." 2. Review of Resident #4's current FL2 dated 03/01/18 revealed: -Diagnoses included seizure disorder and memory loss. -There was an order for clonazepam 0.5mg 3 times daily (used to treat seizure disorder). Review of Resident #4's Resident Register revealed an admission date of 12/15/17.	C 367		

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C 367	Continued From page 9 Review of Resident #4's electronically signed doctor's notes dated 05/31/18 revealed an order for clonazepam 0.5mg, take 1 tablet in the morning, ½ tablet at lunch, and 1 tablet at bedtime for 2 weeks, then decrease to ½ tablet in the morning, ½ tablet at lunch, and 1 tablet at bedtime. Review of Resident #4's August 2018 MAR revealed: -There was an entry for clonazepam 0.5mg, take ½ tablet twice daily at 8am and 2pm, and 1 tablet at 8pm. -Clonazepam had been documented as administered 90 times from 08/01/18 to 08/31/18. Review of Resident #4's September 2018 MAR revealed: -There was an entry for clonazepam 0.5mg, take ½ tablet twice daily at 8am and 2pm, and 1 tablet at 8pm. -Clonazepam had been documented as administered 34 times from 09/01/18 to 09/12/18 at 8am. Observation of Resident #4's medication on hand on 09/12/18 at 4:00pm revealed: -There were 88 tablets of clonazepam 0.5mg available to be administered. -Label showed 90 tablets had been dispensed to Resident #4 on 09/08/18. Review of Resident #4's controlled substance count sheet revealed no count sheet was available for clonazepam 0.5mg. Telephone interview with the pharmacy on 09/13/18 at 3:55pm revealed clonazepam 0.5mg, quantity 90 had been dispensed on 09/8/18.	C 367		

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C 367	Continued From page 10 Interview with the Administrator on 09/12/18 at 4:00pm revealed: -Resident #4 was on clonazepam (a controlled substance). -She had forgotten that she needed to keep an inventory record for clonazepam. Attempted telephone interview with Resident #4's Power of Attorney was unsuccessful on 09/12/18.	C 367		