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
	FCL079033	A. BUILDING: ______ B. WING ______	11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY RUCKER'S FAMILY CARE HOME #2	**503 NE MARKET STREET REIDSVILLE, NC 27320**

(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 survey on 11/20/18-11/21/18.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 3 sampled residents related to medication refusals of a nasal spray (#1 and #2) and an inhaler (#2) for 2 of 3 sampled residents. The findings are: 1. Review of Resident #2's current FL-2 dated 01/26/18 revealed diagnoses included hypertension, hyperlipidemia, iron deficiency anemia, diabetes mellitus, hearing loss, schizophrenia, and chronic bronchitis. Review of Resident #2's Care Plan dated 04/24/18 revealed Resident #2 was deaf and mute. a. Review of Resident #2's current FL-2 dated 01/26/18 revealed an order for Fluticasone (a steroid medication used to treat allergies) 50 mcg Nasal Spray; 2 sprays into each nostril once a day. Review of Resident #2's October 2018 Medication Administration Record (MAR) revealed:	C 246		

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-There was an entry for Fluticasone 50 mcg nasal spray; 2 sprays into each nostril once a day at 8:00 am.
-The Fluticasone was documented as refused from 10/01/18 through 10/31/18.

Review of Resident #2's November 2018 MAR from 11/01/18 through 11/20/18 revealed:
-There was an entry for Fluticasone 50 mcg nasal spray; 2 sprays into each nostril once a day at 8:00 am.
-The Fluticasone was documented as refused from 11/01/18 through 11/09/18 and 11/12/18 through 11/20/18.

Observation of medications on hand on 11/20/18 at 5:33 pm revealed:
-There were 3 Fluticasone containers on hand.
-Two of the three containers were expired (03/15/18 and 04/10/18).
-The Fluticasone 50 mcg was last dispensed on 05/21/18 for a 30 day supply.

Interview with a representative from the contracted pharmacy on 11/20/18 at 2:50 pm revealed:
-The Fluticasone 50 mcg was last dispensed on 05/21/18 for a 30 day supply.
-The Fluticasone 50 mcg was not set up for autofill.
-The facility had not requested the Fluticasone to be refilled.

Interview with a Supervisor-in-Charge (SIC) on 11/20/18 at 5:45 pm revealed:
-Resident #2 refused Fluticasone in October and November 2018.
-Resident #2 was deaf and mute and would use gestures to refuse medications.
-She notified the Administrator regarding refusals

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of the Fluticasone but did not document the communication in Resident #2's record.
-She was unable to remember the dates she notified the Administrator.

Interview with the Administrator on 11/21/18 at 10:21 am revealed:
-She knew Resident #2 refused Fluticasone in October and November 2018.
-She was responsible for notifying the physician for medication refusals.
-After Resident #2 refused Fluticasone 3-4 times staff notified her and she notified the physician.
-She was not able to remember the dates she notified the physician.
-She did not document the physician notification in Resident #2's record.

Interview with Resident #2 on 11/21/18 at 12:00 pm revealed:
-She did not remember refusing Fluticasone in October and November 2018.
-She could not remember the last time she received Fluticasone.
-She was able to communicate with some staff through sign language and writing in her notebook.

Review of Resident #2's records revealed there was no documentation that Resident #2's ordering provider or Primary Care Provider (PCP) had been notified of the refusal to take medications.

Attempted telephone interview with Resident #2's PCP on 11/20/18 4:50 pm and 11/21/18 at 11:12 am was unsuccessful.

b. Review of Resident #2's current FL-2 dated 01/26/18 revealed an order for Symbicort (a

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C 246	Continued From page 3 medication used to treat asthma and chronic obstructive pulmonary disease) 160/4.5 mcg; inhale 2 puffs twice a day. Review of Resident #2's October 2018 Medication Administration Record (MAR) from revealed: -There was an entry for Symbicort 160/4.5 mcg; inhale 2 puffs twice a day at 8:00 am and 8:00 pm. -The Symbicort was documented as refused from 10/01/18 through 10/31/18. Review of Resident #2's November 2018 MAR from 11/01/18 through 11/20/18 revealed: -There was an entry for Symbicort 160/4.5 mcg; inhale 2 puffs twice a day at 8:00 am and 8:00 pm. -The Symbicort was documented as refused from 11/01/18 through 11/09/18 and 11/12/18 through 11/20/18. Observation of medications on hand on 11/20/18 at 5:33 pm revealed: -There were 2 Symbicort inhalers on hand. -One of the two containers expired on 03/29/18. -The Symbicort 160/4.5 mcg was last dispensed on 10/04/18 for a 30 day supply. Interview with a representative from the contracted pharmacy on 11/20/18 at 2:50 pm revealed: -The Symbicort 160/4.5 mcg was last dispensed on 10/04/18 for a 30 day supply. -The Symbicort was not set up for autofill. -The facility has not requested Symbicort to be refilled. Interview with a Supervisor-in-Charge (SIC) on 11/20/18 at 5:45 pm revealed:	C 246		

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-Resident #2 refused the Symbicort in October and November 2018.
-She notified the Administrator regarding refusals of the Symbicort but did not document the communication in the Resident #2's record.
-She could not remember the dates she notified the Administrator.

Interview with the Administrator on 11/21/18 at 10:21 am revealed:
-She knew Resident #2 refused Symbicort in October and November 2018.
-She was responsible for notifying the physician for medication refusals.
-After Resident #2 refused the Symbicort 3-4 times staff notified her and she notified the physician.
-She could not remember that dates she notified the physician.
-She did not document the physician notification in Resident #2's record.

Interview with Resident #2 on 11/21/18 at 12:00 pm revealed:
-She did not remember refusing the Symbicort in October and November 2018.
-No shortness of breath reported.

Review of Resident #2's records revealed there was no documentation that Resident #2's ordering provider or Primary Care Provider (PCP) had been notified of the refusal to take medications.

Attempted telephone interview with Resident #2's PCP on 11/20/18 4:50 pm and 11/21/18 at 11:12 am was unsuccessful.

2. Review of Resident #1's current FL-2 dated 09/12/18 revealed:

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C 246	Continued From page 5 -Diagnoses included Hyperlipidemia, Diabetes, and Schizophrenia. -Resident #1 was constantly disoriented. -There was a medication order for Fluticasone (a steroid medication used to treat allergies) 50 mcg Nasal Inhale two sprays in each nostril each day. Review of Resident #1's September 2018 Medication Administration Record (MAR) revealed: -There was an entry for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril once a day, scheduled at 8:00 am. -Fluticasone was documented as administered from 09/01/18-09/30/18. Review of Resident #1's October 2018 MAR revealed: -There was an entry for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril once a day, scheduled at 8:00 am. -Fluticasone was documented as refused 31 out of 31 days. Review of Resident #1's November 2018 MAR revealed: -There was an entry for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril once a day, scheduled at 8:00 am. -Fluticasone was documented as administered from 11/01/18-11/20/18. Observation of Resident #1's medications on hand on 11/21/18 at 5:15 pm revealed: -A 30 day supply of Fluticasone was available for administration. -The dispense date on the Fluticasone was 11/07/17. -The expiration date on the Fluticasone was 11/07/18.	C 246		

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Review of Resident #1's progress notes revealed there was no documentation the Resident #1's Primary Care Provider (PCP) had been notified of Resident #1's refusal to take Fluticasone.

Interview with Resident #1 on 11/20/18 at 12:45 pm revealed:
-Staff administered all medications.
-She did not remember refusing any medication.
-She did not remember staff administering Fluticasone for the past month.
-She thought the reason she did not receive the Fluticasone was because she thought the facility staff did not have nasal spray available to administer.

Telephone interview with a representative from the contracted pharmacy on 11/20/18 at 2:45 pm revealed:
-The Fluticasone was not on autofill; the facility staff was required to contact the pharmacy for refills for Fluticasone
-Once the facility staff called the pharmacy for a refill, the pharmacy filled the order the same day.
-The facility staff had not called the pharmacy for a refill since November 2017.
-The Fluticasone was last dispensed on 11/07/17.
-The medication was dispensed for a 30 day supply.

Interview with the Supervisor in Charge (SIC) on 11/20/18 at 5:00 pm revealed:
-She documented on the MAR as administering Fluticasone when Resident #1 refused the Fluticasone.
-She documented an "R" on the MAR when the resident refused medications.
-She had not administered Resident #1's Fluticasone because "she refused it all the time

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anyway".
-She initialed the MAR even when she did not offer the Fluticasone to Resident #1.
-She did not notify the PCP of medication refusal, the Administrator was notified any time a resident refused medication
-She notified the Administrator that Resident #1 refused the Fluticasone but could not remember when she notified the Administrator.
-She could not remember when Resident #1 stopped taking Fluticasone because she did not document the refusal.

Telephone interview with Resident #1's PCP on 11/21/18 at 9:45 am revealed:
-Resident #1 was last seen on 09/12/18.
-She was not notified Resident #1 had been refusing to take Fluticasone.
-She expected staff to administer Fluticasone as ordered.
-If Resident #1 was not having symptoms, she did not need to take Fluticasone and could refuse it.
-She would have discontinued the Fluticasone if the facility staff had notified her Resident #1 was no longer taking the Fluticasone.

Interview with Administrator on 11/21/18 at 10:30 am revealed:
-She did not know staff had not administered Resident #1's Fluticasone.
-She did not know Resident #1 continued to refuse the Fluticasone.
-Resident #1 had told the Administrator she would start taking her medication after the first refusal, (could not remember date SIC had informed her of refusal).
-The staff were expected to inform the Administrator when residents refused to take medication.
-The staff were expected to document an "R" on

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C 246	Continued From page 8 the MAR for refusal of medication. - Resident #1's PCP was not notified of the refusal for Fluticasone. -She did not know staff documented the Fluticasone as administered on the MAR.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician notification for clarification of medication orders for 1 of 3 sampled residents (Resident #2) with no orders for sliding scale insulin (SSI) or parameters. The findings are: Review of Resident #2's current FL-2 dated 01/26/18 revealed: -Diagnoses included hypertension, hyperlipidemia, iron deficiency anemia, diabetes	C 315		

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mellitus, hearing loss, schizophrenia, and chronic bronchitis.
-There was no physician's order for SSI with parameters.
-There was no order for fingerstick blood sugar (FSBS).

Review of a previous order for Resident #2 dated 11/21/16 by the Specialist Provider revealed:
-Humalog (a rapid acting insulin used to treat and manage elevated blood sugars) SSI before meals as followed,
less than 70 = 0 units
70-150 = 3 units
151-200 = 6 units
201-250 = 9 units
251-300 = 12 units
greater than 300 = 15 units

Review of Resident #2's Care Plan dated 04/24/18 revealed Resident #2 was deaf and mute.

Review of Resident #2's Resident Register revealed an admission date of 10/14/15.

Review of Resident #2's September, October, and November 2018 Medication Administration Record (MAR) revealed there was no entry for sliding scale insulin on the MAR.

Review of Resident #2's blood sugars on the September 2018 handwritten blood sugar flowsheet revealed a range from 101 to 366.

Review of Resident #2's blood sugars on the October 2018 handwritten blood sugar flowsheet revealed a range from 63 to 569.

Review of Resident #2's blood sugars on the

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November 2018 handwritten blood sugar flowsheet revealed a range from 90 to 440.

Review of Resident #2's record revealed:
-There was no documentation the physician was notified regarding clarification of the SSI.
-There was no clarification orders for the SSI in the resident's record.

Telephone interview with a representative from the contracted pharmacy on 11/21/18 at 9:03 am revealed:
-The facility did not always fax over the FL2's.
-The pharmacy did not have a current order for SSI for the resident.
-The last time the SSI order was active was in 2016.
-The pharmacist informed the staff on 05/31/18 the SSI was not an active order.

Interview with the Supervisor-in-Charge (SIC) on 11/21/18 at 9:50 am revealed:
-She administered Humalog SSI per the 11/21/16 order.
-She was using the flex pen from a scheduled order for Humalog at meals to administer the SSI as needed.
-She knew the SSI was not on the MAR.
-She did not notify the pharmacy the SSI was not on the MAR.
-She documented all blood sugars and SSI administered on a handwritten flowsheet.
-The staff did not notify the pharmacy or physician.
-The Administrator knew the SSI was not on the MAR.
-The Administrator was responsible for notifying the pharmacy and physician with issues or concerns.
-The physician required the facility staff to bring

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the handwritten flowsheet with the resident's blood sugar readings and the SSI amount administered to each visit.

Interview with the Administrator on 11/21/18 at 10:20 am revealed:
-She was responsible for completing FL2's and faxing FL2's to the pharmacy.
-She knew the staff was administering the SSI from an order written in 2016.
-She knew the SSI was not on the MARs in the recent months, but did not know it was because the SSI order was left off of the current FL2.
-Facility staff accompanied the resident to all appointments and the prescribing physician expected the resident to be on SSI.
-She knew the staff checked the resident's blood sugar four times a day and administered SSI three times a day as needed depending on the resident's blood sugar reading.
-She was responsible for notifying the pharmacy and physician of issues or concerns.

Telephone interview with Resident #2's Specialist Provider on 11/21/18 at 11:15 am revealed:
-Resident #2 was last seen in the office in March 2018.
-The physician expected the resident to receive SSI as previously ordered and would send over a clarification order immediately.
-The physician knew the resident was receiving SSI.
-The staff brought in FSBS readings at each visit.
-The facility had not called to request clarification regarding the SSI order.

Interview with Resident #2 on 11/21/18 at 12:00 pm revealed:
-The staff checked her blood sugar four times a day and administered insulin as needed.

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-She did not know the parameters for the SSI.
-She received insulin the morning of 11/21/18.

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10A NCAC 13G .1004(j) Medication Administration

10A NCAC 13G .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:
Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Record (MAR) was accurate and complete for 1 of 3 sampled residents (#1).

The findings are:

Review of Resident #1's current FL-2 dated

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BEVERLY RUCKER'S FAMILY CARE HOME #2	503 NE MARKET STREET REIDSVILLE, NC 27320

(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
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09/12/18 revealed:
-Diagnoses included Hyperlipidemia, Diabetes, and Schizophrenia.
-Resident #1 was constantly disoriented.
-There was a medication order for Fluticasone (a steroid medication used to treat allergies) 50 mcg Nasal Inhale two sprays in each nostril each day.

Review of the six month physician order dated 09/12/18 for Resident #1 revealed a medication order for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril each day.

Review of Resident #1's September 2018 Medication Administration Record (MAR) revealed:
-There was an entry for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril once a day, scheduled at 8:00 am.
-Fluticasone was documented as administered from 09/01/18-09/30/18.

Review of Resident #1's October 2018 MAR revealed:
-There was an entry for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril once a day, scheduled at 8:00 am.
-Fluticasone was documented as refused 31 out of 31 days.

Review of Resident #1's November 2018 MAR for revealed:
-There was an entry for Fluticasone 50 mcg Nasal Inhale two sprays in each nostril once a day, scheduled at 8:00 am.
-Fluticasone was documented as administered from 11/01/18-11/20/18.

Observation of Resident #1's medications on hand on 11/21/18 at 5:15 pm revealed:

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-A 30 day supply of Fluticasone was available for administration.
-The dispense date on the Fluticasone was 11/07/17.
-The expiration date on the Fluticasone was 11/07/18.

Interview with Resident #1 on 11/20/18 at 12:45 pm revealed:
-Staff administered all medications.
-She did not remember refusing any medication.
-She did not remember staff administering nasal spray for the past month.
-She thought the reason she did not receive the Fluticasone was because she thought the facility staff did not have nasal spray available to administer.

Telephone interview with a representative from the contracted pharmacy on 11/20/18 at 2:45 pm revealed:
-The Fluticasone was not on autofill; the facility staff was required to contact the pharmacy for refills for Fluticasone.
-Once the facility staff called the pharmacy for a refill, the pharmacy filled the order the same day.
-The facility staff had not called the pharmacy for a refill since November 2017.
-The Fluticasone was last dispensed on 11/07/17.
-The medication was dispensed for a 30 day supply.

Interview with the Supervisor in Charge (SIC) on 11/20/18 at 5:00 pm revealed:
-She documented on the MAR as administering Fluticasone when Resident #1 refused the Fluticasone.
-She documented an "R" on the MAR when the resident refused medications.
-She had not administered Resident #1's

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C 342	Continued From page 15 Fluticasone because "she refused it all the time anyway". -She initialed the MAR even when she did not offer the Fluticasone to Resident #1. Telephone interview with Resident #1's PCP on 11/21/18 at 9:45 am revealed: -Resident #1 was last seen on 09/12/18. -She expected staff to administer Fluticasone as ordered. -If Resident #1 was not having symptoms, she did not need to take Fluticasone and could refuse it. Interview with Administrator on 11/21/18 at 10:30 am revealed: -She did not know staff had not administered Resident #1's Fluticasone. -She did not know Resident #1 continued to refuse the Fluticasone. -The staff were expected to document an "R" on the MAR for refusal of medication. -Resident #1's PCP was not notified of the refusal for Fluticasone. -She did not know staff documented the Fluticasone as administered on the MAR. Telephone Interview with Supervisor in Charge (SIC) on 11/21/18 at 11:15 am revealed: -She worked on 11/10/18 and 11/11/18. -She administered medication to the residents on 11/10/18 and 11/11/18. -She forgot to document medication administration on the MAR on 11/10/18 and 11/11/18. -She used the MAR to administer medication but failed to document for two days.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances	C 367		

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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:
Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record in order to accurately reconcile controlled substances for 1 of 2 residents (#2) sampled who had orders for a controlled substance used to treat pain.

The findings are:

Review of Resident #3's current FL-2 dated 02/20/18 revealed:
-Diagnoses included gastrointestinal bleed, type II diabetes mellitus, chronic renal disease, congestive heart failure, and hypothyroid.
-There was an order for Norco (medication used to treat moderate pain) 10/325 mg, take 1-2 tablets every 4 hours as needed for pain.

Review of Resident #3's Resident Register revealed an admission date of 02/22/18.

Review of subsequent physician's orders dated 08/07/18 revealed Norco 10/325 mg, take 1 tablet every 4-6 hours as needed for pain.

Review of subsequent physician's orders dated 11/09/18 revealed Norco 10/325 mg, take 2 tablets every 4-6 hours as needed for pain.

Review of Resident #3's November 2018

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Medication Administration Record (MAR) revealed:
-There was an entry for Norco 10/325 mg, take 1 tablet every 4-6 hours as needed for pain.
-No Norco was documented as administered from 11/01/18 to 11/19/18.

Review of Resident #3's controlled substance count sheet (CSCS) logs revealed:
-There was a handwritten CSCS log started on 11/19/18 for Norco 10/325 mg, take 2 tablets every 4-6 hours as needed for pain with a count of 29.
-According to review of the MAR, medications on hand, dispensed dated and amount dispensed, the beginning count for Norco should have been 35 tablets.
-The previous CSCS log for Norco 10/325 mg, take 2 tablets every 4-6 hours as needed for pain was completed on 11/18/18 at 9:30 am.
-There was no Norco documented as administered from 11/18/18 at 9:30 am to 11/19/18 at 11:30 am.
-Some of the CSCS logs were pharmacy provided and some of the CSCS logs were handwritten by the facility.
-On 11/19/18 at 11:30 am, staff documented 2 tablets were administered to the resident.
-The CSCS log reflected the current count was 27.
-On 11/19/18 at 8:45 pm, staff documented 2 tablets were administered to the resident.
-The CSCS log reflected the current count was 25.
-On 11/20/18 at 1:00 am, staff documented 2 tablets were administered to the resident.
-The CSCS log reflected the current count was 23.
-On 11/20/18 at 11:30 am, staff documented 2 tablets were administered to the resident.

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-The CSCS log reflected the current count was 21.

Observation of Resident #3's medications on hand on 11/20/18 at 5:40 pm revealed:
-There was one bubble pack of Norco 10/325 mg dispensed by the contracted pharmacy on 10/01/18.
-The instructions were to take 1 tablet every 4-6 hours as needed for pain.
-There were 35 tablets dispensed on 10/01/18.
-There were 21 tablets remaining in the bubble pack.
-According to review of the MAR, medications on hand, dispensed dated and amount dispensed, the beginning count for Norco should have been 35 tablets.
-There were 6 Norco tablets unaccounted for.

Interview with a representative from the contracted pharmacy on 11/21/18 at 8:55 am revealed:
-The Norco 5/325 mg, take 1 tablets every 4-6 hours as needed for pain was dispensed on 10/01/18 for 180 tablets.
-The Norco order was changed to 2 tablets every 4-6 hours as needed for pain on 11/09/18.
-There was 5 bubble packs of 35 tablets and 1 bubble pack of 10 tablets.
-The staff did not attempt to refill prescription before the designated time frame.

Interview with the Supervisor-in-Charge (SIC) on 11/21/18 at 9:50 am revealed:
-She administered Norco to Resident #3 3-4 times each day as needed for pain control.
-The Norco should be documented on the MAR and CSCS when administered to the resident.
-She had not documented the Norco was administered on the MAR because the order on

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the MAR was not correct.
-She had not notified the pharmacy the Norco entry was incorrect on the MAR.
-The facility policy was for the staff to notify the Administrator and then the Administrator notified the pharmacy of issues or concerns.
-She notified the Administrator on the evening of 11/20/18 of the incorrect entry on the MAR.

Interview with a second SIC on 11/21/18 at 11:25 am revealed:
-Resident #3 requested Norco 10/325 mg 3-4 times each day for pain.
-When she started work on 11/19/18 the bubble pack for Norco 10/325 mg had 29 tablets in the packet.
-The Administrator provided a handwritten CSCS log sheet and she wrote 29 at the top of the CSCS log to indicate how many tablets were in the bubble pack.
-If the staff noticed an error on the MAR they were to notify the Administrator and the Administrator would notify the pharmacy.
-She was not sure why there were 6 tablets unaccounted for.

Interview with Resident #3 on 11/21/18 at 11:00 am revealed:
-She knew she was ordered Norco 10/325 mg as needed for pain.
-She requested the Norco 10/325 mg 4 times a day to manage her pain.
-She could not remember how often she requested pain medication on 11/18/18 and 11/19/18.

Interview with the Administrator on 11/21/18 at 10:20 am revealed:
-Resident #3 had chronic pain and requested the Norco 10/325 several times each day for pain

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C 367	Continued From page 20 management. -The pharmacy did not always provide a CSCS log and she would handwrite a CSCS log for staff to use. -She did not know why the CSCS log had 29 tablets written at the top instead of 35 tablets. -She did not know why there was missing documentation for 6 tablets. -She did not know why 6 Norco tablets were unaccounted for.	C 367		