STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001144	A. BUILDING: _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B AND N FAMILY CARE HOME	301 HOMEWOOD AVENUE BURLINGTON, NC 27217

(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 a complaint investigation on September 17-19, 2019 with an exit conference via telephone on September 23, 2019.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 medications were administered as ordered by a licensed practitioner for 1 of 3 residents sampled (Resident #1) including a depression medication, and 2 inhalers. The findings are: Review of Resident #1's current hospital FL-2 dated 03/27/19 revealed diagnoses included acute hyperkalemia, chronic obstructive pulmonary disease (COPD), and end stage renal disease (on dialysis). 1. Review of Resident #1's current hospital FL-2 dated 03/27/19 revealed there was an order for Spiriva 18 mcg (used to treat COPD) capsule one capsule into inhaler and inhale daily.	C 330		

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C 330	Continued From page 1 Observation during the initial tour on 09/17/19 at 10:33am revealed: -Resident #1 had 2 inhalers on top of a table at the entrance door of his room. -Each of the inhalers had the name of the medication printed by the manufacturer on the container. -One of the inhalers was labeled Spiriva. Observation of Resident #1 on 09/17/19 at 11:30am revealed: -The resident returned from dialysis and walked to his room. -Resident #1 administered Spiriva inhaler 2 puffs orally. Review of Resident #1's September 2019 medication administration record (MAR) revealed there was staff initials documenting administration of Spiriva 18 mcg at 8:00am on 09/17/19. Interview with Resident #1 on 09/17/19 at 11:45am revealed: -The medications he took, that were on the table in his room, were his morning medications. -On dialysis days (Tuesday, Thursday, and Saturday), his medications were prepared in the plastic container and inhalers were placed in his room. Sometimes the medications were prepared the same morning and sometimes the night before. -He routinely took the medications when he returned from dialysis. -On days he did not go to dialysis, he received his medications around 8:00am when other residents received their medications. -He took the medications prepared by the medication aide/Supervisor-in-Charge (MA/SIC). -He had oxygen to use as needed for breathing problems.	C 330		

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C 330	Continued From page 2 -His inhalers helped his breathing. 2. Review of Resident #1's previous FL-2 dated 02/04/19 revealed there was an order for Proair HFA 90 mcg per actuation (used to treat wheezing and shortness of breath in COPD and asthma) one puff every 4 hours as needed. Review of Resident #1's current FL-2 dated 03/27/19 revealed there was no order for Proair HFA inhaler listed on the current FL-2 dated 03/27/19. Telephone interview with a nurse at Resident #1's physician's office on 09/23/19 at 10:20am revealed Proair 90 mcg inhaler one puff every 4 hours as needed was listed on the resident's current medications. Observation during the initial tour on 09/17/19 at 10:33am revealed: -Resident #1 had 2 inhalers on top of a table at the entrance door of his room. -Each of the inhalers had the name of the medication printed by the manufacturer on the container. -One of the inhalers was labeled Proair HFA. Observation of Resident #1 on 09/17/19 at 11:30am revealed: -The resident returned from dialysis and walked to his room. -The resident shook the Proair HFA inhaler and administered 2 puffs orally. Review of Resident #1's September 2019 MAR revealed Proair 90 mcg per actuation was not listed on the MAR and no documentation available for the administration of Proair 90 mcg.	C 330		

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C 330	Continued From page 3 Interview with Resident #1 on 09/17/19 at 11:45am revealed: -The medications he took, that were on the table in his room, were his morning medications. -On dialysis days (Tuesday, Thursday, and Saturday), his medications were prepared in the plastic container and inhalers were placed in his room. Sometimes the medications were prepared the same morning and sometimes the night before. -He routinely took the medications when he returned from dialysis. -On days he did not go to dialysis, he received his medications around 8:00am when other residents received their medications. -He took the medications prepared by the medication aide/Supervisor-in-Charge (MA/SIC). -He had oxygen to use as needed for breathing problems. -His inhalers helped his breathing. Interview with the MA/SIC on 09/17/19 at 2:30pm revealed: -Resident #1 received his medicines sometimes before he went to dialysis and sometime when he comes back. -Resident #1 "gets Spiriva and Symbicort inhalers. They are usually in his room when he gets back from dialysis." -Resident #1 had an extra Proair HFA inhaler in his overstock medication. -She did not realize she had placed Proair inhaler instead of Symbicort inhaler in the room for Resident #1 on the morning of 09/17/19. Interview with the Manager/Nurse (M/N) on 09/19/19 at 3:00pm revealed the MA/SIC must have mistaken the Proair for the Symbicort canister when she prepared medications.	C 330		

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C 330	Continued From page 4 3. Review of Resident #1's current hospital FL-2 dated 03/27/19 and subsequent hospital discharge summary dated 09/04/19 revealed there was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs 2 times a day. Observation during the initial tour on 09/17/19 at 10:33am revealed: -Resident #1 had 2 inhalers on top of a table at the entrance door of his room. -Each of the inhalers had the name of the medication printed by the manufacturer on the container. -One of the inhalers was labeled Spiriva. -The other inhaler was labeled Proair HFA. -There was no Symbicort 160-4.5 mcg inhaler on the tablet top. Observation of Resident #1 on 09/17/19 at 11:30am revealed: -The resident returned from dialysis and walked to his room. -Resident #1 administered Spiriva inhaler 2 puffs orally. -The resident shook the Proair HFA inhaler and administered 2 puffs orally. -The medication canisters for Proair 90 mcg per inhalation and Symbicort 160-4.5 mcg were both red and similar in appearance. Observation of medications on hand for administration for Resident #1 on 09/17/19 revealed the resident had an unopened Symbicort 160-4.5 mcg inhaler dispensed on 03/20/19 in overstock. Review of Resident #1's September 2019 MAR revealed there was an entry for Symbicort 160-4.5 mcg scheduled for administration at 8:00am and 8:00pm and documented as	C 330		

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C 330	Continued From page 5 administered on 09/17/19 at 8:00am. Interview with Resident #1 on 09/17/19 at 11:45am revealed: -The medications he took, that were on the table in his room, were his morning medications. -On dialysis days (Tuesday, Thursday, and Saturday), his medications were prepared and inhalers were placed in his room. Sometimes the medications were prepared the same morning and sometimes the night before. -He routinely took the medications when he returned from dialysis. -On days he did not go to dialysis, he received his medications around 8:00am when other residents received their medications. -He took the medications prepared by the medication aide/Supervisor-in-Charge (MA/SIC). -He had oxygen to use as needed for breathing problems. -His inhalers helped his breathing. Interview with the MA/SIC on 09/17/19 at 2:30pm revealed: -Resident #1 received his medicines sometimes before he went to dialysis and sometimes when he comes back. -Resident #1 "gets Spiriva and Symbicort inhalers. They are usually in his room when he gets back from dialysis." -She did not realize she had placed Proair inhaler instead of Symbicort inhaler in the room for Resident #1 on the morning of 09/17/19. Telephone interview with a nurse at Resident #1's primary care physician's office on 09/18/19 at 10:18am revealed Resident #1's list of current medications included Symbicort 160-4.5 mcg. Interview with the Manager/Registered Nurse	C 330		

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C 330	Continued From page 6 (M/RN) on 09/19/19 at 3:00pm revealed the MA/SIC should administer medications as ordered. 4. Review of Resident #1's current hospital FL-2 dated 03/27/19 and subsequent hospital discharge summary dated 09/04/19 revealed there was an order for citalopram 20mg (used to treat depression) take one tablet daily. Observation of Resident #1's medications on hand for administration on 09/17/19 revealed: -The resident's medications were dispensed by the contracted pharmacy in multi-dose packages rolled up in a box with the morning medications packaged together in the same package. -Citalopram 20mg was not included in the box of medications dispensed by the pharmacy . Observation of medication administration on 09/18/19 at 8:00am revealed: -The kitchen table was set with plates and tableware for breakfast. -Residents' medications were placed on the table in front of their assigned seats, including a small plastic container with Resident #1's name and 5 medications (7 pills). -Citalopram 20 mg was not included in the medications. Review of Resident #1's September 2019 medication administration record (MAR) revealed thee was an entry for citalopram 20 mg one tablet daily and documented as administered daily from 09/01/19 to 09/18/19. Review of Resident #1's September 2019 medication administration record (MAR) on 09/18/19 at 8:35am revealed: -There were staff initials documenting	C 330		

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administration of cetirizine 10 mg at 8:00am on 09/18/19.
-There were staff initials documenting administration of folic acid 1 mg at 8:00am on 09/18/19.
-There were staff initials documenting administration of metoprolol succinate 50 mg at 8:00am on 09/18/19.
-There were staff initials documenting administration of vitamin D 5000 international units at 8:00am on 09/18/19.
-There were staff initials documenting administration of Spiriva 18 mcg at 8:00am on 09/18/19.
-There were staff initials documenting administration of Symbicort 160-4.5 mcg at 8:00am on 09/18/19.
-There was no entry for Auryxia tablets and no documentation for administration.

Interview with Resident #1 on 09/17/19 at 11:45am revealed:
-The medications he took that were sitting on the table in room were his morning medications.
-On dialysis days (Tuesday, Thursday, and Saturday), his medications were prepared in the plastic container and inhalers were placed in his room. Sometimes the medications were prepared the same morning and sometimes the night before.
-He routinely took the medications when he returned from dialysis.
-On days he did not go to dialysis, he received his medications around 8:00am when other residents received their medications.

Telephone interview with a pharmacist at the contracted pharmacy on 09/17/19 at 3:30pm revealed:
-The pharmacy dispensed medications packaged

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C 330	Continued From page 8 together by morning, noon, evening, and bedtime in plastic sleeves. -The pharmacy last dispensed citalopram 20 mg for Resident #1 on 07/15/19 for a 30 day supply. -The pharmacy needed a new order for the medication, but the physician had not responded to the pharmacy's faxed refill request. -The facility staff should routinely be notified by the pharmacy if the resident did not have refills and the physician had not responded but he did not have a way to verify if the facility was notified. -The facility staff was responsible to verify medications sent in multi-dose packages for residents' current orders. -The facility staff did not routinely send discharge summaries or FL-2s for residents. Interview with a nurse at Resident #1's primary care physician's office on 09/18/19 at 10:18am revealed: -Resident #1 had an appointment scheduled today (09/17/19) for medication review and renewals. -Resident #1's list of current medications included citalopram 20mg. -The office nurse was not aware Resident #1 was out of citalopram 20mg until the facility called this week to schedule a visit for medication renewal. Interview with the Manager/Registered Nurse (M/RN) on 09/19/19 at 3:00pm revealed: -The pharmacy routinely requested refills for medications that needed new orders. -She was not aware Resident #1 had ran out of citalopram 20 mg.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration	C 335		

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C 335	Continued From page 9 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept	C 335		

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in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration and protected from contamination and spillage for 1 of 6 residents (Resident #1) residing in the facility.

The findings are:

Review of Resident #1's current FL-2 dated 03/27/19 revealed:
-Diagnoses included acute hyperkalemia, chronic obstructive pulmonary disease (COPD), end stage renal disease (on dialysis).
-There was an order for cetirizine 10 mg (used to treat allergies) one tablet daily.
-There was an order for folic acid 1 mg (supplement used to prevent folic acid deficiency in dialysis patients) one daily.
-There was an order for metoprolol succinate 50 mg (used to treat high blood pressure) one tablet daily.
-There was an order for Vitamin D 5000 international units (used to supplement vitamin D and promote healthy bones) one capsule daily.
-There was an order for Spiriva 18 mcg (used to treat COPD) inhaled daily.
-There was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs into lungs 2 times a day.
-There was no order for Proair HFAinhaler ((used to treat wheezing and shortness of breath in COPD and asthma) listed on the current FL-2 dated 03/27/19.

Review of Resident #1's previous FL-2 dated 02/04/19 revealed there was an order for Proair HFA 90 mcg per actuation one puff every 4 hours as needed.

Telephone interview with a nurse at Resident #1's

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physician's office on 09/23/19 at 10:20am revealed Proair 90 mcg inhaler one puff every 4 hours as needed was listed on the resident's current medications.

Review of Resident #1's hospital discharge summary dated 09/04/19 revealed:
-There was an order for cetirizine 10 mg (used to treat allergies) one tablet daily.
-There was an order for folic acid 1 mg (supplement used to prevent folic acid deficiency in dialysis patients) one daily.
-There was an order for metoprolol succinate 50 mg (used to treat high blood pressure) one tablet daily.
-There was an order for Vitamin D 5000 international units (used to supplement vitamin D and promote healthy bones) one capsule daily.
-There was an order for Spiriva 18 mcg (used to treat COPD) inhaled daily.
-There was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs into lungs 2 times a day.
-There was no order for Proair HFA inhaler listed on the hospital discharge summary dated 09/04/19.

Observation during the initial tour on 09/17/19 at 10:33 am revealed:
-Resident #1 had a plastic container with 4 medications inside, and 2 inhalers on top of a table at the entrance door of his room.
-The plastic container was labeled with Resident #1's last name and 8:00 am.
-There was no label identifying the medications inside the plastic container.
-Each of the inhalers had the name of the medication printed by the manufacturer on the container.
-One of the inhalers was labeled Spiriva but did

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not have the resident's name on the container.
-The other inhaler was labeled Proair HFA but did not have the resident's name on the container.

Observation of Resident #1 on 09/17/19 at 11:30 am revealed:
-The resident returned from dialysis and walked to his room.
-Resident #1 opened the plastic container containing 4 medications and took the medications.
-The plastic container did not have the name of the medications on the container.
-Resident #1 administered the Spiriva inhaler 2 puffs orally and Proair HFA inhaler and administered 2 puffs orally.
-The medication aide/Supervisor-in-Charge (MA/SIC) was in the kitchen area preparing lunch.
-The MA/SIC did not watch Resident #1 take his medications.

Interview with Resident #1 on 09/17/19 at 11:45am revealed:
-The medications he took, that were sitting on the table in his room, were his morning medications.
-On dialysis days (Tuesday, Thursday, and Saturday), his medications were prepared in the plastic container and inhalers were placed in his room. Sometimes the medications were prepared the same morning and sometimes the night before.
-He routinely took the medications when he returned from dialysis.
-On days he did not go to dialysis, he received his medications around 8:00am when other residents received their medications.

Interview with the MA/SIC on 09/17/19 at 2:30pm revealed:
-Resident #1 received his medicines sometimes

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C 335	Continued From page 13 before he went to dialysis and sometimes when he returned from dialysis. -Resident #1 did not take his inhalers with him to dialysis. Interview with the Manager/Registered Nurse (M/RN) on 09/19/19 at 3:00pm revealed: -She was not aware the MA/SIC was pre-pouring Resident #1's medications on dialysis days. -She was trying to spend more time in the facility, but had a lot of appointments for residents and several facilities to manage. -The MA/SIC had been trained to prepare and administer medications to one resident at a time and watch the resident take the medication before administering medications to another resident. Telephone interview with the Administrator on 09/23/19 at 10:30am revealed: -He was not aware the MA/SIC was pre-pouring medications. -The MA/SIC had pre-poured medications when he was on a visit to the facility several month ago. -He discussed not to pre-pour medications with the MA/SIC at that visit and left the MA/SIC information for properly preparing medications which included preparing and administering medications to one resident.	C 335		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	C 341		

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C 341	Continued From page 14	C 341		

medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident taking the medications and failed to maintain a safe system to assure medications were documented at the time of administration for 4 of 4 sampled residents (#1, #2, #3, and #4).

The findings are:

Observation on 09/18/19 at from 7:30am to 8:20am revealed:
-The medications for the four residents were on the dining room table at the resident's respective seats.
-No residents were seated at the dining room table.
-The medication aide/Supervisor-in-Charge (MA/SIC) was in the kitchen preparing breakfast.
-The MA/SIC left the kitchen and walked to the back room leaving the medications unattended.

Observation of medication administration on 09/18/19 at 8:00am revealed medications were prepared for 4 residents and placed on the dining room table for administration (one resident did not have morning medications and one resident refused medications).

Review of the medication administration records

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C 341	Continued From page 15 (MARs) for the 4 residents on 09/18/19 at 8:15am revealed the administration of medications was documented in the MARs for 4 residents prior to observing the residents take the medications. 1. Review of Resident #1's current FL-2 dated 03/27/19 revealed: -Diagnoses included acute hyperkalemia, chronic obstructive pulmonary disease (COPD), end stage renal disease (on dialysis). -There was an order for cetirizine 10 mg (used to treat allergies) one tablet daily. -There was an order for folic acid 1 mg (supplement used to prevent folic acid deficiency in dialysis patients) one daily. -There was an order for metoprolol succinate 50 mg (used to treat high blood pressure) one tablet daily. -There was an order for Vitamin D 5000 international units (used to supplement vitamin D and promote healthy bones) one capsule daily. -There was an order for Spiriva 18 mcg (used to treat COPD) inhaled daily. -There was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs into lungs 2 times a day. Review of Resident #1's hospital discharge summary dated 09/04/19 revealed: -There was an order for cetirizine 10 mg (used to treat allergies) one tablet daily. -There was an order for folic acid 1 mg (supplement used to prevent folic acid deficiency in dialysis patients) one daily. -There was an order for metoprolol succinate 50 mg (used to treat high blood pressure) one tablet daily. -There was an order for Vitamin D 5000 international units (used to supplement vitamin D and promote healthy bones) one capsule daily.	C 341		

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C 341	Continued From page 16 -There was an order for Spiriva 18 mcg (used to treat COPD) inhaled daily. -There was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs into lungs 2 times a day. Telephone interview with a nurse at the local dialysis center on 09/17/19 at 3:15pm revealed: -Resident #1 was sent from dialysis today (09/17/18) with a sample bottle of Auryxia (used to bind phosphates in dialysis patients) because his insurance was not paying for one of his other binders. -Resident #1 was supposed to take 3 tablets with each meal. -A physician's order was not sent with the medication, but the nurse would send an order for Auryxia from the renal physician. Observation on 09/18/19 at 7:45am revealed: -Resident #1 had a plastic container, labeled with Resident #1's name, with 7 medications inside, and 2 inhalers on top of the dining table. -The medications in the plastic container were cetirizine 10 mg, folic acid 1mg, metoprolol succinate 50 mg, vitamin D 5000 international units, and Auryxia. -Each of the inhalers had the name of the medication printed by the manufacturer on the container. -One of the inhalers was labeled Spiriva. -The other inhaler was labeled Symbicort 160-4.5mg. -Resident #1 self-administered the medications at 8:00am. -The MA/SIC did not observe Resident #1 take his medications. Observation of the medication aide/Supervisor-in -Charge (MA/SIC) on 09/18/19 from 7:45am to	C 341		

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C 341	Continued From page 17 8:30am revealed: -The MA/SIC prepared breakfast, served breakfast, and cleaned up the kitchen area and dining table. -The MA/SIC did not have the residents' medication administration records (MARs) in the kitchen area during breakfast. Review of Resident #1's September 2019 medication administration record (MAR) on 09/18/19 at 8:35am revealed: -There were staff initials documenting administration of cetirizine 10 mg, folic acid 1 mg at 8:00am, metoprolol succinate 50 mg , vitamin D 5000 international units, Spiriva 18 mcg and Symbicort 160-4.5 mcg at 8:00am on 09/18/19. -There was no entry for Auryxia tablets and no documentation for administration. -The MA/SIC documented administration of Resdent #1's medications prior to observing the medications administered. Interview with Resident #1 on 09/18/19 at 10:00am revealed: -He went to dialysis 3 times a week (Tuesday, Thursday, and Saturday). -The MA/SIC had been placing his medications on the dining table on non-dialysis mornings for several weeks. -He took his medications and used his inhalers while he sat at the table. -The MA/SIC was usually cleaning up the kitchen and diod not observe him take his medications. Refer to confidential interview with a resident on 09/18/19 at 7:40am. Refer to the interview with the MA/SIC on 09/18/19 at 7:53am.	C 341		

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C 341	Continued From page 18 Refer to the interview with the Owner on 09/19/19 at 11:37am. Refer to the interview with the MA/SIC on 09/19/19 at 4:15pm. 2. Review of Resident #4's current FL-2 dated 08/30/19 revealed: -Diagnoses included noncompliance, dyslipidemia, high blood pressure, diabetes, and undifferentiated schizophrenia. -There was an order for amlodipine 5 mg (used to treat high blood pressure) one tablet daily. -There was an order for atorvastatin 40 mg (used to lower cholesterol) one daily. -There was an order for enalapril 20 mg (used to treat high blood pressure) one tablet daily. -There was an order for fenofibrate 145 mg (used to lower triglycerides) one tablet daily. -There was an order for glimepiride 2 mg one tablet daily. -There was an order for metformin 850 mg one tablet 2 times a day with a meal. Review of Resident #4's physician's orders dated 09/03/19 revealed: -There was an order for docusate sodium 100 mg (used to treat constipation) one capsule 3 times a day. -There was an order for metoprolol succinate 50 mg (used to treat high blood pressure and control heart rate) take one daily. -There was an order for estradiol 1 mg (used for hormone replacement) take on tablet daily. -There was an order for vitamin B12 1000 mcg (a vitamin supplement) daily. -There was an order for loratadine 10 mg (used to treat allergies) one daily. -There was an order for pantoprazole sodium 40 mg (used to treat gastric reflux) one daily.	C 341		

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C 341	Continued From page 19 Observation of medication administration on 09/18/19 at 7:55am revealed: -Resident #4 had four multi-dose plastic packets containing a total of 12 medications labeled with the resident's name and medications in each packet, and the time of day for administration on the dining room table placed in front of a chair. -Resident #4 took the medications from the table and left the kitchen area to self-administer the medications at 8:00am. Observation of the medication aide/Supervisor-in-Charge (MA/SIC) on 09/18/19 from 7:45am to 8:30am revealed: -The MA/SIC prepared breakfast, served breakfast, and cleaned up the kitchen area and dining table. -The MA/SIC did not have the residents' medication administration records (MARs) in the kitchen area during breakfast. Review of Resident #4's September 2019 medication administration record (MAR) on 09/18/19 at 8:27am revealed: -There were staff initials documenting administration of amlodipine 5 mg at 8:00am, atorvastatin 40 mg, enalapril 20 mg, fenofibrate 145 mg, glimepiride 2 mg, metformin 850 mg, docusate sodium 100 mg, metoprolol succinate 50 mg, estradiol 1 mg, vitamin B 12 1000mcg, loratadine 10 mg, and pantoprazole sodium 40 mg at 8:00am on 09/18/19. -The MA/SIC documented administration of Resdent #1's medications prior to observing the medications administered. Confidential interview with a resident on 09/18/19 at 7:40am revealed: -The staff routinely administered morning	C 341		

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medications by placing the resident's medications at the dining room table at "their places".
-The staff would give him all his medications in the morning in the packages from the pharmacy.
-He would take them when they were due that day at noon or in the evening.
-He was not sure when or how the staff documented the medications administrations.

Interview with Resident #4 on 09/18/19 at 8:01am revealed:
-The MA/SIC had not always placed the medications on the dining room table in the mornings.
-The MA/SIC had been placing the medications on the dining room tablet for residents for some time.
-She had never received another resident's medication packets.
-She did not know when the MA/SIC documented her medications administered.

Refer to confidential interview with a resident on 09/18/19 at 7:40am.

Refer to the interview with the MA/SIC on 09/18/19 at 7:53am.

Refer to the interview with the Owner on 09/19/19 at 11:37am.

Refer to the interview with the MA/SIC on 09/19/19 at 4:15pm.

3. Review of Resident #2's current FL-2 dated 01/14/19 revealed:
-Diagnoses included schizophrenia paranoid type, anti-social personality disorder, positive tuberculin skin test with negative chest x-ray, hyperlipidemia, gastro-esophageal reflux disease

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C 341	Continued From page 21 (GERDs), bowel hernia, nicotine dependence, history of migraines and history of intentional tremors. -There was an order for escitalopram 20 mg one daily (used to treat depression). -There was an order for bupropion HCL xl 150 mg one daily (used to treat depression and support smoking cessation). -There was an order for propranolol ER 80 mg one every evening (used to prevent migraine headaches). -There was an order for cetirizine HCL 10 mg one daily (used to treat allergies). -There was an order for docusate sodium 100 mg one daily (stool softener used to treat constipation). -There was an order for benztropine MES 1 mg one twice a day (used to treat tremors caused by antipsychotic medications). -There was an order for gemfibrozil 600 mg one twice a day (used to treat abnormal blood lipid levels). -There was an order for sucralfate 1 gm one three times a day before meals (used to treat GERDs). -There was an order for pravastatin sodium 20 mg one every evening (used to prevent heart disease and abnormal lipids). -There was an order for Depakote ER 500 mg one in the morning and 2 in the evening (used to treat bipolar disorder and treat migraine headaches). -There was an order for Seroquel XR 400 mg 2 at bedtime (used to treat schizophrenia). -There was an order for Creon DR 36,000 units one with snacks and 2 with each meal (used to help digest food). -There was an order for Pantoprazole SOD DR 40 mg one twice a day 30 minutes before breakfast and 30 minutes before supper (used to	C 341		

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treat GERDs).
-There was an order for Miralax 17 gm in 8 oz of water nightly (used to treat constipation).
-There was an order for Invega Trinza injection 819 IM every 90 days (used to treat schizophrenia).
-There was an order for sumatriptan succinate 100 mg one at the onset of headache and may repeat after 2 hours with a maximum of 2 tablets/day (used to treat migraine headaches).

Review of Resident #2's physician's order revealed a subsequent order dated 09/11/19 for Levaquin 750 mg (used to treat infections) one daily for 10 days.

Observation of medication administration on 09/18/19 at 7:30am revealed:
-The medication aide/Supervisor-in-Charge (MA/SIC) was in the kitchen preparing breakfast.
-Resident #2 was provided with 11 oral medications and 1 inhaler for morning, 1 oral medication for noon, and 6 oral medications for evening prepared and located on the tablet in front of a plate.
-Resident #2 took 11 oral medications and 2 puffs of his inhaler at 7:45am.
-The MA/SIC retrieved the one noon medication and the 6 evening medications from the resident.

Observation of the medication aide/Supervisor-in-Charge (MA/SIC) on 09/18/19 from 7:45am to 8:30am revealed:
-The MA/SIC prepared breakfast, served breakfast, and cleaned up the kitchen area and dining table.
-The MA/SIC did not have the residents' medication administration records (MARs) in the kitchen area during breakfast.

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C 341	Continued From page 23 Review of Resident #2's September 2019 medication administration record (MAR) on 09/18/19 at 8:27am revealed: -There were staff initials documenting administration of escitalopram 20 mg, pantoprazole sodium DR 40 mg, Creon DR 36,000 units 2, Depakote ER 500 mg, sucralfate 1 gm, gemfibrozil 600 mg, benztropine mes. 1 mg, cetirizine HCL 10 mg, bupropion HCL xl 150 mg, Levaquin 750 mg, and docusate sodium 100 mg at 8:00am on 09/18/19. -The medications were documented as administered before the MA/SIC observed the resident take the medications. Interview with primary care provider (PCP) on 09/23/19 at 4:24pm revealed: -She was not aware the staff allowed Resident #2 to take his medications out of the packaging. -His diagnosis of paranoid type schizophrenia would concern her for taking his medications without the MA witnessing it. -He may or may not be compliant depending on his mood for that day. -Missing doses of his medications, especially his psychotropic medications, could cause behavioral changes. Refer to confidential interview with a resident on 09/18/19 at 7:40am. Refer to interview with the MA/SIC on 09/18/19 at 7:53am. Refer to interview with the Owner on 09/19/19 at 11:37am. Refer to interview with the MA/SIC on 09/19/19 at 4:15pm.	C 341		

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C 341	Continued From page 24 4. Review of Resident #3's current FL-2 dated 08/19/19 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), cerebrovascular accident (CVA) with left sided hemiplegia (paralysis), and dementia. -There was an order for aspirin enteric coated 81 mg one daily (to prevent further CVAs). -There was an order for vitamin D2 50,000 units one every week (vitamin supplement that helps the body absorb calcium). -There was an order for meloxicam 15 mg one daily (used to treat pain and inflammation). -There was an order for ezetimibe 10 mg one daily (used to treat high blood cholesterol). -There was an order for Stiolto Respimat inhaler 2 puffs daily (used to prevent airflow obstruction and reduce flare ups in adults with COPD). Observation of the 8:00am medication pass on 09/18/19 at 7:30am revealed: -The MA/SIC was in the kitchen preparing breakfast. -Resident #3 took 3 oral medications and 1 inhaler at 7:50am. Review of Resident #3's September 2019 MAR on 09/18/19 at 8:27am revealed: -There were staff initials documenting administration of aspirin enteric coated 81 mg, ezetimibe 10 mg, Stiolto Respimat inhaler 2 puffs, and meloxicam 15 mg at 8:00am on 09/18/19. -The medications were documented as administered before the MA observed the resident take the medications. Refer to confidential interview with a resident on 09/18/19 at 7:40am. Refer to interview with the MA/SIC on 09/18/19 at	C 341		

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C 341	Continued From page 25 7:53am. Refer to interview with the Owner on 09/19/19 at 11:37am. Refer to interview with the MA/SIC on 09/19/19 at 4:15pm. _____ Confidential interview with a resident on 09/18/19 at 7:40am revealed: -The staff routinely administered morning medications by placing the resident's medications at the dining room table at "their places". -The staff would give him all his medications in the morning in the packages from the pharmacy. -He would take them when they were due that day at noon or in the evening. -He was not sure when or how the staff documented the medications administrations. Interview with the MA/SIC on 09/18/19 at 7:53am revealed: -She routinely placed residents' medication on the dining room table each morning to administer just before breakfast. -She administered medications to the residents at the dining room table. -She used the residents' MARs to prepare the residents medications. -She documented administration on the residents' MARs as she prepared the medications. -She did not watch them take their medications. -She knew the residents and that they would take their medications she had prepared. Interview with the Owner on 09/19/19 at 11:37am revealed: -She was not aware the staff pre-poured and pre-charted the medications for administration. -She did periodic checks on the staff to observe	C 341		

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C 341	Continued From page 26 her giving medications. -"She knows she's not supposed to pre-pour or pre-chart". -The staff did not do that when she came to observe. -She had reviews on medication administration at least annually for documentation and order accuracy. -She was not sure the last time a review was done. Interview with the MA/SIC on 09/19/19 at 4:15pm revealed she knew she should not document in the MAR before observing the resident take the medication.	C 341		
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to	C 350		

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C 350	Continued From page 27 self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (#1) had a self-administration order signed by a physician. The findings are: Review of Resident #1's current FL-2 dated 03/27/19 revealed: -Diagnoses included acute hyperkalemia, chronic obstructive pulmonary disease (COPD), end stage renal disease (on dialysis). -There was an order for cetirizine 10 mg (used to treat allergies) one tablet daily. -There was an order for folic acid 1 mg (supplement used to prevent folic acid deficiency in dialysis patients) one daily. -There was an order for metoprolol succinate 50 mg (used to treat high blood pressure) one tablet daily. -There was an order for Vitamin D 5000 international units (used to supplement vitamin D and promote healthy bones) one capsule daily. -There was an order for Spiriva 18 mcg (used to treat COPD) inhaled daily. -There was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs into lungs 2 times a day. Review of Resident #1's previous FL-2 dated 02/04/19 revealed Proair HFA 90 mcg (used to treat wheezing and shortness of breath in COPD and asthma) per actuation one puff every 4 hours	C 350		

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C 350	Continued From page 28 as needed was ordered. Review of Resident #1's hospital discharge summary dated 09/04/19 revealed: -There was an order for cetirizine 10 mg (used to treat allergies) one tablet daily. -There was an order for folic acid 1 mg (supplement used to prevent folic acid deficiency in dialysis patients) one daily. -There was an order for metoprolol succinate 50 mg (used to treat high blood pressure) one tablet daily. -There was an order for Vitamin D 5000 international units (used to supplement vitamin D and promote healthy bones) one capsule daily. -There was an order for Spiriva 18 mcg (used to treat COPD) inhaled daily. -There was an order for Symbicort 160-4.5 mcg (used to treat COPD) 2 puffs into lungs 2 times a day. Telephone interview with a nurse at the local dialysis center on 09/17/19 at 3:15pm revealed: -Resident #1 was sent from dialysis today (09/17/18) with a sample bottle of Auryxia (used to bind phosphates in dialysis patients) because his insurance was not paying for one of his other binders. -Resident #1 was supposed to take 3 tablets with each meal. -A physician's order was not sent with the medication, but the nurse would send an order for Auryxia from the renal physician. Telephone interview with a nurse at Resident #1's physician's office on 09/23/19 at 10:20am revealed Proair 90 mcg inhaler one puff every 4 hours as needed was listed on the resident's current medications	C 350		

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C 350	Continued From page 29 Review of Resident #1's FL-2 dated 02/04/19, FL-2 dated 03/27/19, hospital discharge dated 09/04/19, physician's orders and resident's noted revealed there was no order for the resident to self administer medications available for review. 1. Observation during the initial tour on 09/17/19 at 10:33 am revealed: -Resident #1 had a plastic container with 4 medications inside, and 2 inhalers on top of a table at the entrance door of his room. -The plastic container was labeled with Resident #1's last name and 8:00 am. -Each of the inhalers had the name of the medication printed by the manufacturer on the container. -One of the inhalers was labeled Spiriva. -The other inhaler was labeled Proair HFA. Observation of Resident #1 on 09/17/19 at 11:30 am revealed: -The resident returned from dialysis and walked to his room. -Resident #1 opened the plastic container containing 4 medications and took the medications. -Resident #1 administered the Spiriva inhaler 2 puffs orally. -The resident administered Proair HFA inhaler 2 puffs orally. Observation of the medication aide/Supervisor-in-Charge (MA/SIC) on 09/17/19 at 11:30am revealed: -The medication aide was in the kitchen area preparing lunch. -The MA/SIC did not observe Resident #1 take his medications. Interview with Resident #1 on 09/17/19 at	C 350		

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C 350	Continued From page 30 11:45am revealed: -The medications he took, that were sitting on the table in his room, were his morning medications. -On dialysis days (Tuesday, Thursday, and Saturday), his medications were prepared in the plastic container and inhalers were placed in his room. Sometimes the medications were prepared the same morning and sometimes the night before. -He routinely took the medications on the table in his room when he returned from dialysis. -On days he did not go to dialysis, he received his medications around 8:00am when other residents received their medications. Interview with the MA/SIC on 09/17/19 at 2:30pm revealed: -Resident #1 received his medicines sometimes before he went to dialysis and sometimes when he returned. -She removed his medications from the multi-dose pharmacy package, placed the medications in the container labeled with his name, and left the medications in his room because he left at 5:30am on dialysis days. -She left 2 inhalers in his room also for the resident to administer. -She knew she was supposed to watche residents take their medication unless the resident had an order to self administer medications. Interview with the Manager/Registered Nurse (M/RN) on 09/19/19 at 3:00pm revealed: -She did not know the MA/SIC was leaving Resident #1's morning medications for him to take him to take on his own on dialysis days. -The MA/SIC had been trained to administer medications to one resident at a time and watch the resident take the medication before	C 350		

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C 350	Continued From page 31 administering medications to another resident unless the resident had an order to self administer medications Telephone interview with the Administrator on 09/23/19 at 10:30am revealed he did not know the MA/SIC was allowing residents' to self administer medications without an order to self administer. 2. Telephone interview with a nurse at the local dialysis center on 09/17/19 at 3:15pm revealed: -Resident #1 was sent from dialysis today (09/17/18) with a sample bottle of Auryxia (used to bind phosphates in dialysis patients) because his insurance was not paying for one of his other binders. -Resident #1 was supposed to take 3 tablets with each meal. -A physician's order was not sent with the medication but the nurse would send an order for Auryxia from the renal physician. Observation on 09/18/19 at 7:45am revealed: -Resident #1 had a plastic container, labeled with Resident #1's name, with 7 medications inside, and 2 inhalers on top of the dining table along with tableware. -The medications in the plastic container were cetirizine 10 mg, folic acid 1mg, metoprolol succinate 50 mg, vitamin D 5000 international units, and three Auryxia tablets. -Each of the inhalers had the name of the medication printed by the manufacturer on the container but not the resident's name. -One of the inhalers was labeled Spiriva. -The other inhaler was labeled Symbicort 160-4.5mg. -Resident #1 self-administered the medications at 8:00am.	C 350		

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C 350	Continued From page 32 Observation of the medication aide/Supervisor-in-Charge (MA/SIC) on 09/18/19 at 8:00am revealed: -The medication aide was in the kitchen area preparing breakfast. -The MA/SIC did not watch Resident #1 take his medications. Interview with the MA/SIC on 09/18/19 at 8:13am revealed: -She knew was supposed to prepare each resident's medication at time of administration. -She knew she was supposed to administer each resident's medication, document on the medication administration record MAR) and move to the next resident. -Resident #1 had taken his medications from the plastic container at breakfast for a while (she did not say how long). Interview with Resident #1 on 09/17/19 at 11:45am revealed: -The medications he took, that were sitting on the table in the dining room, were his morning medications. -He routinely administered his own medications at the breakfast table. Interview with the MA/SIC on 09/17/19 at 2:30pm revealed she removed Resident #1's medications from the multi-dose pharmacy package and placed the medications in the container labeled with his name. Interview with the Manager/RN on 09/19/19 at 3:00pm revealed: -The MA/SIC had been employed at the facility for a long time. -She did not realize the MA/SIC was leaving	C 350		

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C 350	Continued From page 33 Resident #1's medications on the dining table for the resident to administer himself. Telephone interview with the Administrator on 09/23/19 at 10:30am revealed he did not know the MA/SIC was allowing residents' to self administer medications. Telephone interview with the nurse at Resident #1's primary care provider's office on 09/23/19 at 4:20pm revealed: -Resident #1 did not have an order to self administer his medications. -The prescriber would be concerned the resident would not be compliant with his medications if he took them on his own.	C 350		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and reconciled for 1 of 2 residents sampled (#1) who was prescribed a controlled substance for moderate to severe pain.	C 367		

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C 367	Continued From page 34 The findings are: Review of Resident #1's current FL-2 dated 03/27/19 revealed diagnoses included acute hyperkalemia, chronic obstructive pulmonary disease (COPD), end stage renal disease (on dialysis). Review of Resident #1's previous FL-2 dated 02/07/18 revealed: -Diagnoses included COPD, congestive heart failure, multiple myeloma, hypertension, and kidney failure with dialysis on Tuesday, Thursday, and Saturday. -There was an order for oxycodone 10 mg (an opoid medication used to treat moderate to severe pain) one tablet every 6 hours as needed for pain. Telephone interview with a pharmacist at the contracted pharmacy on 09/18/19 at 8:55am revealed: -The pharmacy sent controlled substance count sheets (CSCS) for tracking the administration of controlled medications with each dispensing. -On 06/08/18, Resident #1 was dispensed 60 tablets of oxycodone 10 mg labeled one tablet every 6 hours as needed for pain. -On 06/22/18, Resident #1 was dispensed 60 tablets of oxycodone 10 mg labeled one tablet every 6 hours as needed for pain. -On 07/06/18, Resident #1 was dispensed 60 tablets of oxycodone 10 mg labeled one tablet every 6 hours as needed for pain. -On 07/27/18, Resident #1 was dispensed 60 tablets of oxycodone 10 mg labeled one tablet every 6 hours as needed for pain. Telephone interview with a pharmacist at the oncology treatment center pain management	C 367		

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clinic pharmacy on 09/19/19 at 8:55am revealed the pharmacy dispensed 120 oxycodone 10 mg tablets on 08/28/18 with directions to take one tablet every 6 hours as needed for pain.

Review of Resident #1's June 2018 medication administration record (MAR) revealed:
-Oxycodone 10 mg one tablet every 6 hours as needed for pain was preprinted on the MAR and scheduled as needed (PRN).
-Oxycodone 10 mg tablets were documented as administered 46 occasions from 06/10/18 at 6:00pm to 06/22/18 at 12:00pm (noon) on the MAR.
-There was one tablet not documented as administered on the MAR but signed out on the CSCS on 06/18/18 at 12:00am(midnight).
-Oxycodone 10 mg tablets were documented as administered on 34 occasions from 06/23/18 at 6:00pm to 06/30/18 at 12:00am(midnight) on the June 2018 MAR (from tablets dispensed on 06/22/18).

Review of Resident #1's controlled substance count sheet (CSCS) for 60 tablets dispensed on 06/08/18 compared to the June 2018 MAR from 06/08/18 to 06/22/18 revealed:
-Oxycodone 10 mg tablets were documented for administration for 60 doses on the CSCS.
-There were 2 doses documented as administered on the CSCS but not documented on the MAR (06/18/18 and 06/20/18 at 12:00am(midnight).
-On 06/17/18, Four duplicate doses were documented as administered at 6:00am, 12:00pm, 6:00pm and 12:00 (midnight) on the CSCS on separate columns; On 06/16/18, Twelve duplicate doses (3 different entries for four tablets) were incorrectly documented as administered at 6:00am, 12:00pm, 6:00pm and

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12:00 (midnight) on the CSCS.
-There were 16 doses of the tablets dispensed on 06/08/18 not accounted for due to incorrect CSCS documentation.

Review of Resident #1's July 2018 MAR revealed:
-Oxycodone 10 mg one tablet every 6 hours as needed for pain was preprinted on the MAR and scheduled as PRN.
-Oxycodone 10 mg tablets were documented as administered on 19 occasions from 07/01/18 to 07/07/18 on the July 2018 MAR.
-Oxycodone 10 mg tablets were documented as administered on 55 occasions from 07/08/19 at 6:00am to 07/24/18 8:00am on the MAR.
-Oxycodone 10 mg tablets were documented as administered on 17 occasions from 07/27/19 at 12:00pm to 07/31/18 12:00am(midnight) on the July 2018 MAR.

Review of Resident #1's CSCS for 60 tablets dispensed on 06/22/18 compared to the resident's June 2018 MAR and July 2018 MAR revealed:
-Oxycodone 10 mg tablets were documented as administered on 34 occasions from 06/23/18 at 6:00pm to 06/30/18 at 12:00am(midnight) on the CSCS. All doses were accounted for on the June 2018 MAR.
-Oxycodone 10 mg tablets were documented as administered 26 occasions on the CSCS from 07/01/18 to 07/07/18.
-There were 7 doses of oxycodone 10 mg not documented as administered on the MAR compared to CSCS as follows: On 07/03/18 one dose at 6:00am, 6:00pm and 12:00 midnight; on 07/04/18 one dose at 6:00am, 12:00pm, and 6:00pm; and on 07/07/18 one dose at 6:00pm.

Review of Resident #1's CSCS for 60 tablets

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dispensed on 07/06/18 compared to the resident's July 2018 MAR revealed:
-Oxycodone 10 mg tablets were documented as administered correctly on 55 occasions from 07/08/18 at 6:00am to 07/24/18 8:00am on the CSCS.
-There was one dose on 07/17/18 at 12:00am(midnight) not documented on the MAR compared to the CSCS.
-On 07/15/18, there were 4 duplicate entries for oxycodone 10 mg doses documented as administered at 6:00am, 12:00pm, 6:00pm, and 12:00am(midnight) on the CSCS.
-There were 4 doses of tablets dispensed on 07/06/18 not accurately accounted for due to incorrect CSCS documentation.

Review of Resident #1's August 2018 MAR revealed:
-Oxycodone 10 mg one tablet every 6 hours as needed for pain was preprinted on the MAR and scheduled as PRN.
-Oxycodone 10 mg tablets were documented as administered on 105 occasions from 08/01/18 at 6:00am to 08/27/18 at 12:00am(midnight) on the August 2018 MAR.
-Oxycodone 10 mg tablets were documented as administered 14 occasions on the August MAR from 08/28/18 at 11:00am and 08/31/18 at 11:00pm.
-On 08/28/18, one dose at 6:00am was documented on the MAR but not on the CSCS.
-On 08/30/18, one dose at 6:00am was documented on the MAR but not on the CSCS.
-On 08/31/18, one dose at 6:00am was documented on the MAR but not on the CSCS.

Review of Resident #1's CSCS for 120 tablets dispensed on 07/27/18 compared to the resident's July 2018 and August 2018 MARs

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revealed:
-Oxycodone 10 mg tablets were documented as administered on 17 occasions from 07/27/19 at 12:00pm to 07/31/18 12:00am (midnight) on the CSCS.
-Oxycodone 10 mg tablets were documented as administered on 103 occasions from 08/01/19 at 6:00am to 08/27/18 at 12:00am(midnight) on the August 2018 CSCS.
-On 08/22/18, one dose at 12:00pm (noon) was documented on the August 2018 MAR but not on the CSCS.
-On 08/24/18, one dose at 6:00pm was documented on the MAR but not on the CSCS.
-All 120 doses of tablets dispensed on 07/27/19 were accounted for.

Review of Resident #1's September 2018 MAR revealed:
-Oxycodone 10 mg one tablet every 6 hours as needed for pain was preprinted on the MAR and scheduled as PRN.
-Oxycodone 10 mg tablets were documented as administered 75 occasions on the September 2018 MAR and 73 occasions on the CSCS (leaving 36 tablets).
-On 09/05/18, one dose at 6:00am was documented on the MAR but not on the CSCS.
-On 09/10/18, one dose at 12:00am(midnight) was documented on the MAR but not on the CSCS.

Review of Resident #1's CSCS for 120 oxycodone 10 mg tablets dispensed from a local oncology clinic pharmacy on 08/28/18, beginning 08/28/18 and ending on 09/25/18, compared to the resident's August 2018 and September 2018 MARs revealed 84 tablets were accounted for as follows:
-Oxycodone 10 mg tablets were documented as

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administered 11 occasions from 08/28/18 at 11:00am and 08/31/18 at 11:00pm on the CSCS (leaving 109 tablets).
-Oxycodone 10 mg tablets were documented as administered 73 occasions on the CSCS (leaving 36 tablets).
-The ending balance on the CSCS sheet was 36 tablets remaining for the 120 tablets of oxycodone 10 mg dispensed on 08/27/18.
-There was no accounting for the administration or disposition (return to pharmacy or destroy) of the 36 tablets.

Based on review of Resident #1's dispensing records for oxycodone 10 mg from 06/08/18 to 08/28/18 compared to the resident's documentation for administration from 06/10/18 to 09/25/18 (CSCS and MARs) revealed there were 360 oxycodone 10 mg tablets dispensed for Resident #1 and a total of 56 oxycodone 10 mg tablets not accounted for.

Telephone interviews with a Detective for a local police department on 09/16/19 at 11:30am and 09/19/19 at 1:17pm revealed:
-The Detective contacted the Alamance Adult Care Specialist (AHS) on 09/13/18 regarding a referral to the police department for a resident at B and N Family Care Home.
-The resident was been seen at a local oncology clinic for pain related to multiple affected areas.
-The resident was tested for oxycodone in blood stream and had very low levels on 3 different tests at the clinic.
-The clinic staff did a law enforcement referral due to the low amount of oxycodone metabolites showing in the blood and the amount of oxycodone documented as being administered to the resident.
-The AHS and Detective conducted an

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investigation in September 2018.
-On 09/19/18 the total of oxycodone 10 mg tablets documented as remaining on the controlled substance count sheet (CSCS) did not match the number of tablets on hand (there were 5 tablets remaining in the bottle and more than 30 tablets documented as remaining in the CSCS).
-On a follow-up visit on 09/27/18, Resident #1's oxycodone 10 mg bottle was empty and the CSCS still documented tablets remaining.

Telephone interview with the Pharmacist at Resident #1's oncology clinic on 09/19/19 at 10:14am revealed:
-Resident #1 had been seen at the clinic for his pain management on 07/25/18, 08/28/18, and 09/25/18.
-The resident did not appear to be in any noticeable pain or exhibiting signs of not receiving oxycodone (sweating, cramping, agitation, nervousness, or signs of obvious pain).
-On 07/25/18 and 08/28/18, the Pharmacist tested Resident #1's blood for concentration of oxycodone or derivatives, with very low levels showing on the test.
-On 09/25/18, Resident #1 was changed to acetaminophen (mild pain reliever) as needed.

Telephone interview with the Adult Home Specialist (AHS) on 09/17/19 at 10:00am revealed:
-He did an investigation regarding Resident #1's oxycodone 10 mg tablets starting on 09/19/18 which included interviews with the oncology Pharmacist.
-"On 09/19/18 at 10:08am, Resident #1 had 5 tablets remaining in a bottle of 120 tablets dispensed on 08/28/18". The CSCS documented there should be 44 tablets remaining.
-The AHS substantiated allegations of missing

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oxycodone 10 mg and initiated a Corrective Action Report (CAR) at a violation level.
-Resident #1 told the AHS during his investigation on 09/19/18 that he had not experienced any negative medication withdrawal signs nor was any longer in bad pain (Documented in the CAR and confirmed during interview).

Later interview with AHS on 09/19/19 at 1:25pm revealed:
-He had received a call from the detective on 09/16/18, which was a Friday.
-He went to the home (facility) on Monday 09/19/18.
-He and the detective had interviewed the medication aide/Supervisor in Charge (MA/SIC) at the facility and had an audio recording of the interview.

Telephone interview with a representative for the facility's contracted pharmacy on 09/19/19 at 3:23pm revealed:
-The pharmacy documented any controlled substances sent back to pharmacy by the facility.
-There was no documentation for return of oxycodone 10 mg for Resident #1 during the time frame from September 2018 to present.
-There was no documentation the facility had ever notified the pharmacy for missing oxycodone 10mg for Resident #1.

Review of information on the recording on 09/19/19 at 1:30pm revealed:
-The MA/SIC stated she went home on 09/05/18.
-A second MA/SIC covered at the facility for her leave.
-When she returned on 09/10/18 around 2:00pm, the second MA did not want to count the controlled substances.
-She stated the second MA said "Girl I don't got

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time to count them pills. I've worked here before and I know what I'm doing".
-She said the second MA was grabbing her personal items saying "I gotta catch this ride".
-She said she knew "the bottle of oxycodone did not look right" but did not count the pills at that time.
-She did not report to the owner (Administrator at the time) because she did not wan to get anyone in trouble.

Interview with the Manager/Owner on 09/19/19 at 11:45pm revealed:
-As best she could remember, Resident #1 never complained to her about having any pain or not getting medication when he was receiving oxycodone June 2018 to September 2018.
-The MA/SIC working now was the MA/SIC working one year ago.
-The facility's policy was when one MA/SIC went off duty, the oncoming MA/SIC and the leaving MA/SIC were responsible to count all controlled drugs for accuracy of the quantity on hand compared to the CSCS.
-She did not have a policy in place at the time of the incident to audit controlled substance.
-The MA/SIC was responsible to administer medications and assure all medications, including controlled medications, remained secured in the medication room/SIC bedroom.
-She did not know the facility had missing oxycodone 10 mg for Resident #1 until the AHS and detective told her she had a discrepancy.
-She talked to the 2 MA/SIC at the time but could not determine what happened to the missing medication.
-Resident #1 no longer had an order for oxycodone 10 mg.
-She did an investigation regarding the incident with the missing oxycodone 10 mg but was not

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C 367	Continued From page 43 sure where she had placed the paperwork since it was one year ago. Interview with Resident #1 on 09/19/19 at 3:00pm revealed: -He had back pain and myeloma in his lower back bones. -His back pain was a lot worse about a year ago, when he was taking a lot of pain medication. -At that time, he was on 2 different pain medications and was referred to hospice for his pain. -He did not think he needed hospice at the time and could not function on the hospice pain medication plus the oxycodone 10 mg. -He commented "the best thing that happened to me was "hospice ending". I was too sedated to even get out of bed. -Now I go to dialysis 3 times a week and can get around well. -He received his pain medication and would have know if he was not getting the medications. -The only time he remembered wondering about any of his medication was when there was a fill-in person here a long time ago. Telephone interview with the current Administrator on 09/23/19 at 10:30am revealed: -He had been employed by the facility since April 2019. -He was familiar with the incident regarding missing oxycodone for Resident #1 because he had read the Plan of Correction from the facility. -He visited the facility to do controlled drug audits when he became Administrator. -Staff were supposed to do control medication counts whenever they left the building for time off. -He did think there had been any controlled medication missing since he became Administrator.	C 367		

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C 367	Continued From page 44 Telephone interview with the second MA/SIC (that worked at the facility during 09/05/18 to 09/10/18) on 09/23/19 at 1:07pm revealed: -She had been working as a medication aide for a long time. -She did not work at the facility except to fill in one time about one year ago. -She remembered Resident #1 went to dialysis, and that he was on a pain medication, the tablets were small, and they were in a prescription bottle. -She remembered she had to pour them out and count the little tablets for her controlled sheet. -She routinely would have done a count of the medication at least every other day since she was working 24 hour shifts with no relief person. -She remembered he received 2 or 3 oxycodone 10 mg tablets every day. -She did a count of Resident #1's oxycodone 10 mg before she left. -So far as she knew, the oxycodone 10 mg count matched the CSCS when she left the facility. -"This (today 09/23/19) was the first time it came up to her about pills being missing. She did not talk to a detective (or the AHS). -She was always careful to keep the medication room locked when she was not in the room and the medication cabinet inside the medication room locked also. -As best she remembered, no visitors came to the facility during the days she was there. The facility failed to assure an accurate accounting for controlled medications, related to the administration and disposition of Resident #1's oxycodone 10 mg, which placed the residents at risk for drug diversion or loss and was detrimental to the health and safety of the residents. This failure constitutes a Type B violation.	C 367		

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C 367	Continued From page 45 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/19/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 7, 2019.	C 367		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report an allegation of drug diversion from resident (#1) by one staff (Staff B) to the Health Care Personnel Registry (HCPR) within 24 hours and provide documentation the alleged act was investigated and reported to the HCPR within 5 days. The findings are: Attempted record review on 09/17/19 revealed there was no personnel record for Staff B, Medication Aide (MA) available for review at the	C 428		

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C 428	Continued From page 46 facility. Owner/Prior Administrator came to the facility on 09/19/19 at 11:45am and brought Staff B's personnel record. Review of Staff B's, Medication Aide/Supervisor-in-Charge (MA/SIC), personnel record revealed: -She was hired on 03/14/18. -There was documentation of a HCPR check for Staff B dated 03/14/18 with no substantiated findings. Interview with the Owner/Prior Administrator on 09/19/19 at 11:47am revealed: -She was the owner of the facility. -She was the Administrator of the facility when the alleged drug diversion occurred in 2018. -Staff B had worked with her for the past 18-20 years. -She had never had a problem with Staff B and narcotics or the counts being off. -She had not contacted law enforcement. -She first became aware of the alleged drug diversion when the adult home specialist (AHS) and a Detective for the local police department came to the facility. -She did not recall the date that the AHS and the Detective first came to the facility. -She faxed the 24-hour report to the HCPR naming Staff B in the report. -She faxed the five-day report for investigating the allegations. -She did not have a fax machine that provided confirmation of the fax being sent. -She did not recall the date that she faxed the 24-hour report to the HCPR naming Staff B in the report. -She did not recall the date that she faxed the	C 428		

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C 428	Continued From page 47 five-day report to the HCPR naming Staff B in the report. -The 24-hour and 5-day reports were at her office in another county. -She did not have a key for the office. -Her family member had the office key and was currently out of town. -Once her family member returned, she would obtain the office key and retrieve the reports and fax them to the surveyors. Telephone interview with Health Care Personnel Registry Representative on 09/19/19 at 1:45pm revealed: -There was not a 24-hour report nor a 5-day received from the facility. -They had not received any reports from the facility regarding the drug diversion in 2018. Second telephone interview with Health Care Personnel Registry representative on 09/23/19 at 10:06am revealed: -There was not a 24 hour report nor 5-day report received from the facility via facsimile or mail. -The facility should have a fax confoirmation available to review. -The HCPR would have responded to the report had they received the report. Telephone interview with the Administrator on 09/23/19 at 10:30am revealed: -He was aware the facility had missing controlled medications about one year ago. -He was not the Administrator at the time, so did not know if the Health Care Personnel Registry. -He had done controlled medication audits when he became Administrator in April 2019. _____ The facility failed to assure the Health Care Personnel Registry was notified with a 24-hour	C 428		

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C 428	Continued From page 48 and a 5-day report related to missing controlled medications for a resident. The facility's failure to meet this requirement was detrimental to the health, welfare and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/19/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 7, 2019.	C 428		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related accounting for controlled substances and reporting resident drug loss to the Health Care Personnel Registry. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and	C 912		

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C 912	Continued From page 49 reconciled for 1 of 2 residents sampled (#1) who was prescribed a schedule II controlled substance for moderate to severe pain. [Refer to Tag C367, 10A NCAC 13G .1008(a) Controlled Substances (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to report an allegation of drug diversion from resident (#1) by one staff (Staff B) to the Health Care Personnel Registry (HCPR) within 24 hours and provide documentation the alleged act was investigated and reported to the HCPR within 5 days.[Refer to Tag C428, 10A NCAC 13G .1206 Health Care Personnel Registry (Type B Violation)].	C 912		