STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARILLON ASSISTED LIVING OF NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Liscensure Section conducted an annual and follow-up survey on 09/25/19 through 09/30/19.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 7 sampled staff (Staff C) was tested upon hire for Tuberculosis (TB) disease. The findings are: Review of Staff C's, supervisor, personnel record revealed: -She was hired on 12/14/16. -There was documentation of a TB skin test administered on 12/14/16 and read on 12/17/16 with no documented results. -There was documentation of a chest-x-ray completed on 12/19/16 for Staff C to rule out TB -There was no evidence of old or new TB. Telephone interview with Staff C on 09/30/19 at 12:05pm revealed:	D 131		

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D 131	Continued From page 1 -She had a TB skin test, and the results were positive. -She needed to get a chest-x-ray to rule out evidence of TB. Telephone interview on 09/27/19 at 4:06pm with the nurse who administered the TB skin test revealed: -She administered one TB skin test for Staff C, but she did not write down the results. -The area on the left arm was "large". -A chest-x-ray had been completed for Staff C to rule out TB. Interview with Business Office Manager (BOM) on 09/30/19 at 9:45am revealed: -The Resident Care Director (RCD) was responsible for making sure staff had one TB skin test prior to hire. -The RCD was responsible for making sure staff had a 2nd step TB skin test within 2 weeks of hire. -Once the 2-step TB skin test was completed by the RCD, the BOM would get a copy of it and file the information in the personnel record. Interview with the RCD on 09/30/19 at 10:30am revealed: -She thought Staff C's TB skin test was documented as positive. -The RCD/designee was responsible for making sure staff had one TB skin test the 1st day of hire. -The RCD/designee was responsible for making sure staff had a 2nd step TB skin test within 10-14 days of hire. -The RCD/BOM/Regional Nurse audited the personnel records weekly. Interview with the Executive Director (ED) on 09/30/19 at 4:00pm revealed:	D 131		

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D 131	Continued From page 2 -The personnel record for Staff C had been audited. -It was an oversight because the auditors did not see the result of the TB skin test was not documented. -It was documented Staff C needed a chest-x-ray because the TB skin test was established to be positive. -The RCD/Regional Nurse was responsible for making sure staff had one TB skin test prior to hire. -The RCD/Regional Nurse was responsible for making sure staff had a 2nd step TB skin test within 14 days of hire. -Staff qualifications were audited weekly by assigned staff.	D 131		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to the floors, ice machine, reach in refrigerator, the deep fryer, the stove top, the convection oven, the hot food holding table, can opener; staff did not wear hairnets while in the food preparation area; undated and unlabeled stored food; and the improper freezer temperature.	D 282		

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D 282	Continued From page 3 The findings are: 1. Review of the kitchen cleaning schedule posted in the kitchen on 09/26/19 revealed: -The posted cleaning schedule was dated for the week of 09/07/19; there were blank spaces where the initials indicating completion of any task for the week would have been documented. -The schedule was divided into tasks by shift; am (morning) and pm (evening) cleaning tasks. -The schedule was divided into weekly cleaning tasks and daily cleaning tasks. -The kitchen floor was scheduled to be swept twice daily. -The utility room was scheduled to be swept and mopped on Monday evenings. -The hot food holding table was scheduled to be cleaned and polished twice daily. -The floor under the dish washer was scheduled to be swept and mopped on Tuesday mornings. -The reach-in refrigerator was scheduled to be cleaned and disinfected on Friday mornings. -The area behind the deep fryer was scheduled to be cleaned with degreaser on Friday evenings. -The deep fryer, the stove top, the convection oven, the steamer and the can opener were not listed on the kitchen cleaning schedule. Review of a second kitchen cleaning schedule provided by the Kitchen Manager on 09/26/19 at 10:28am revealed the daily cleaning schedule for the morning shift had been initialed for 09/27/19 and 09/28/19 as completed. Observation of the kitchen on 09/26/19 at 9:15am revealed: -There was dirt on top of the dishwasher. -There were three cups, one fork, and two dessert bowls and debris scattered on the floor	D 282		

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behind the dishwasher.
-There was debris next to and behind the ice machine.
-The can opener blade and bracket had a sticky black debris caked on them.
-The shelf in the deep fryer had large amounts of food residue on it.
-There was a yellow liquid, sticky residue and food debris on the outside of the deep fryer, the floor beside the deep fryer and the sides of the stove.
-There was dried food residue on the stove grates.
-There was a dried splash residue on the side of the warming box.
-There was food debris and grease on the stove griddle.
-There was a sticky residue on the oven door handles.
-There were black crumbs and burnt food on the inside of the convection ovens and on the racks; the doors had a brown coating on the inside and the glass.

Observation of the hot food holding table on 09/27/19 at 7:47am revealed:
-There was food and debris in the water in the hot holding pan and the water was a brownish color.
-The pans that held the water had a dark brown buildup on the inside.

Observation of the walk-in freezer on 09/26/19 at 9:30am revealed:
-The thermometer on the outside of the door read 8 degrees Fahrenheit.
-There were no thermometers inside the freezer.
-There were three opened, undated containers of ice cream.
-There was raw hamburger patties and raw pork patties stored on top of ready to eat loaves of

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bread.
-There was a dried reddish-brown liquid on the floor inside the freezer next to the freezer.

Observation of the walk-in cooler on 09/26/19 at 9:37am revealed:
-There was a box of discolored, shriveled, red and green bell peppers with sunken areas and black spots on them.
-There was a dated, unlabeled container of cooked ravioli.
-There was a dated, unlabeled container of sliced oranges.
-There was a dated, unlabeled container of desserts.
-There was an undated, unlabeled tray with six small bowls of pudding.
-There were four dated, unlabeled containers of salad dressing.
-There was a dated, unlabeled container of beets.
-There was a package of dated, unlabeled food that looked like mashed potatoes.
-There was an undated, unlabeled container of prepared soup.
-There were two open, undated pies.
-There were three pans of turkey divan that were not dated or labeled.

Observation of the reach-in cooler on 09/26/19 10:34am revealed:
-There was debris on the shelves.
-There was a container of unlabeled lunch meat.
-There was a container of unlabeled, undated tuna salad.
-There was a black spotted film buildup on the gasket and on the area where the gasket made contact with the reach-in refrigerator.

Observation of the dry goods storage area on 09/26/19 revealed:

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D 282	Continued From page 6 -There was a large, undated container of flour. -There was a brown and black sticky build up on the lip, top and handles to the bulk flour and sugar bins. -There were corn flakes stored in a rice krispies plastic container. -There was a container of balsamic vinegar with dried contents around the lid. -There was a container of mustard with dried contents around the lid. -There was an opened, undated container of barbecue sauce. -There was an opened, undated container of hot cereal mix. -There was an opened, undated container of fried onions. -There was an opened, undated container of cookie icing. -There was an unlabeled container of tortilla strips. -There was an unlabeled container of peanuts. -There was one dented can each of jellied cranberries, mandarin oranges, and baked beans. Observation of the utility closet in the kitchen on 09/26/19 revealed: -There was debris on the floor. -There were dirty rags on the storage shelves. Interview with the chef on 09/26/19 at 9:59am revealed: -The grates to the stove were cleaned daily after lunch by running them through the dish washer; he "walked into the dirty grates this morning". -Someone failed to clean the grates the day before. -The ovens under the stove were used to store items so they do not get wiped down every day. -He cleaned the reach-in refrigerator everyday by	D 282		

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wiping it down.
-The convection oven was cleaned once a month but wiped down every day after use; the last time the convection oven was cleaned was about a month ago and the racks were removed and cleaned as well.
-The oil in the deep fryer was changed once a month by one the cooks and was done about a month ago; the food particles in the deep fryer should be removed after every use and the outside should be wiped down.

Interview with the chef on 09/27/19 at 7:47am revealed:
-The hot food holding table was cleaned at the end of the day by one the cooks; he did not know the last time the water was changed, or the pans cleaned.
-He understood the hot food holding table needed to be kept clean because food was served from the table.

Interview with the Kitchen Manager on 09/27/19 at 1:56pm revealed:
-She was currently certified in food safety and had taken a food service orientation test.
-The floors in the kitchen, including the floor under the dish washer, the floor beside the deep fryer and the floor in the utility room were to be swept and mopped daily.
-The floors under equipment and behind doors were also supposed to be swept and mopped daily.
-The deep fryer was supposed to be cleaned when the oil turned "dark" and the crumbs in the oil are supposed to be cleaned out after every use; the deep fry oil was removed, and the fryer was cleaned with soapy water about two weeks ago.
-The sides and front of the deep fryer were only

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D 282	Continued From page 8 supposed to be cleaned "as needed". -The grates to the stove top were cleaned a week ago; one cook was very messy and did not clean after he used the stove. -The grates to the stove top were removed and soaked in the pot and pan sink "as needed". -She could see the gaskets on the reach-in refrigerator had not been cleaned in a while; the gaskets needed to be removed to properly clean them and she did not want to risk tearing them when they were removed. -The gaskets and the reach-in refrigerator were on the daily cleaning schedule; the kitchen staff should be wiping them down. -The convection oven was deep cleaned once a month "as needed"; the racks were removed, and the inside was cleaned about three weeks ago. -She explained "as needed" meant something was not up to standards and she made the determination when something was not clean enough or not up to standards. -She did not require the staff to wipe down the inside of the oven, but she did expect them to wipe off the outside daily. -All the kitchen equipment should be wiped off daily. -The water in the hot food holding table should have been emptied every night and the pans cleaned with vinegar once a week; she explained vinegar had to be used because degrease was not allowed to be used in the kitchen. -She understood there were hazards to dirty equipment in the kitchen. -She was not sure what the parameters for the temperatures for the walk-in freezer were or what the current documented temperatures for the walk-in freezer were. -The first kitchen staff to report in for work in the morning came in at 6:00am and documented on the freezer log.	D 282		

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D 282	Continued From page 9 -Kitchen staff did not have to label food items as they placed them in the walk-in refrigerator because "anyone can see a green bean is a green bean". -Everything that goes into the walk-in refrigerator had to have a date. -The reusable containers for the dressing were emptied and cleaned once a week. -The can opener was cleaned at the pot sink "as needed" about once a week; it was last cleaned about a week ago. Interview with the Executive Director on 09/27/19 at 2:50pm revealed: -He toured the kitchen every Monday; he looked to see if the kitchen was organized, cleaned and if the cleaning schedules were completed from the prior week. -He looked at the temperature logs for the equipment and the food. -He expected the floors to the kitchen and the walk-in freezer to be swept after each meal and mopped at the end of the day. -He expected the deep fryer, oven grates, the convection oven, the reach in refrigerator and the hot food holding table to be wiped clean every day or after each use and deep cleaned once a week by the kitchen staff. -The can opener was to be cleaned once a week. -All food had to be dated and labeled when stored in the walk-in refrigerator or walk-in freezer. -He purchased cleaning products for the kitchen staff to use on all the kitchen equipment and the floors. 2. Observation of the kitchen on 09/26/19 at 9:15am revealed there were three kitchen staff, the kitchen manager and the Executive Director who were not wearing hairnets while in the kitchen.	D 282		

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D 282	Continued From page 10 Interview with the Kitchen Manager (KM) on 09/26/19 at 9:50am revealed: -She did not wear a hairnet when she was working at her desk in the kitchen. -The staff who washed the dishes needed to wear a hairnet. Interview with the Executive Director (ED) on 09/26/19 at 9:50am revealed: -Hairnets were required only when preparing food. -Department heads did not need to wear a hairnet while in the kitchen. -Personal Care Aides (PCA) did not wear hairnets when getting meal trays from the kitchen. 3. Review of the kitchen cleaning schedule posted in the kitchen on 09/26/19 revealed: -There were weekly cleaning tasks scheduled for maintenance staff to perform; the ice bin was to be emptied and disinfected on Wednesdays by maintenance staff. -The ice machine was scheduled to be cleaned by the kitchen staff on Thursday mornings. Review of a second kitchen cleaning schedule provided by the Kitchen Manager on 09/26/19 at 10:28am revealed: -The daily cleaning schedule for the morning shift had been initialed for 09/27/19 and 09/28/19 as completed. -The weekly cleaning schedule for the ice machine assigned to the kitchen staff had been initialed for that day, 09/26/19 as completed. -The weekly cleaning schedule for the maintenance staff was initialed as completed for the ice machine on 09/25/19. Observation of the ice machine in the kitchen on	D 282		

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D 282	Continued From page 11 09/26/19 at 9.22am revealed: -There was a black build up on the inside lip of the ice machine where the ice dropped after freezing. -The inside walls of the bin had black specks and a pink film where the ice made contact. Interview with a dietary aide on 09/26/19 at 10:44am revealed she wiped down the outside of the ice machine every day, but she had never cleaned the inside of the machine. Interview with a dietary aide on 09/26/19 at 10:44am revealed she wiped down the outside of the ice machine every day, but she had never cleaned the inside of the machine. Interview with the Kitchen Manager on 09/26/19 at 10:44am revealed the inside of the ice machine was deep cleaned once a month but she did not know the date it was last cleaned. Interview with the Executive Director on 09/27/19 at 2:57pm revealed: -He did not know the ice machine needed to be cleaned until it had been brought to his attention on 09/26/19. -Maintenance cleaned the inside and the bin of the ice machine on 09/26/19.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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	D 358		

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D 358	Continued From page 12 (2) rules in this Section and the facility's policies and procedures.	D 358		

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 prescribing practitioner for 4 of 6 sampled residents (#2, #4, #5, and #6) related to a pain medication (#2), eye drops (#4), a corticosteroid cream (#5) and anti-anxiety medication (#6).

The findings are:

1. Review of Resident #4's current FL-2 dated 07/03/19 revealed diagnoses included cerebral vascular disease, dysphagia oropharyngeal phase, vascular dementia, hypothyroidism, dysphagia oral-phase, gastro esophageal reflux, osteoarthritis, hypertension.

Review of Resident #4's physician's orders dated 07/15/19 revealed an order for latanoprost solution 0.005% one drop in both eyes at bedtime (latanoprost solution is used to treat glaucoma).

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for latanoprost solution

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0.005% one drop in each eye at bedtime with a scheduled administration time of 9:00pm.
-There was documention Resident #4 received 24 doses of latanoprost everynight from 07/04/19 to 07/31/19.

Review of Resident #4's August 2019 eMAR revealed:
-There was an entry for latanoprost solution 0.005% one drop in each eye at bedtime with a scheduled administration time of 9:00pm.
-There was documention Resident #4 received 30 doses of latanoprost everynight from 08/01/19 to 08/31/19.

Review of Resident #4's September 2019 eMAR revealed:
-There was an entry for latanoprost solution 0.005% one drop in each eye at bedtime with a scheduled administration time of 9:00pm.
-There was documention Resident #4 received 24 doses of latanoprost everynight from 09/01/19 to 09/31/19.

Observation of Resident #4's medications on hand on 09/26/19 at 3:57pm revealed:
-There were two bottles of latanoprost eye drops; one bottle was opened, and one was unopened.
-The opened bottle of latanoprost had a dispense date of 09/17/19 and was half full.
-The unopened bottle of latanoprost had a dispense date of 08/21/19 and the word "new" written by hand on the top of the box.

Telephone interview with a representative from the contracted pharmacy on 09/27/19 at 10:17am revealed:
-There was an active order for latanoprost solution 0.005% administer one drop in each eye at bedtime.

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-Latanoprost was used to treat glaucoma and pressure in the eyes for Resident #4.
-Resident #4's latanoprost had been dispensed one bottle at a time on 07/03/19, 08/21/19 and 09/17/19.
-Each bottle contained enough drops for twenty-five to thirty days.
-The bottle dispensed on 08/21/19 should have been used before the bottle on 09/17/19.
-If Resident #4 was not administered the latanoprost as ordered over a period of time the resident could experience increased pressure and increased discomfort in the eyes and possible issues with vision.

Interview with Resident #4 on 09/27/19 at 3:30pm revealed:
-She did not get her eye drops every night; she did not get them the night before and she did not remember the last time she got them.
-She did not know what the eye drops were for.
-She did not have pain in her eyes or problems with her vision; she did use glasses to see with.

Interview with a medication aide (MA) on 09/27/19 at 3:43pm revealed:
-Resident #4 never resisted getting her eye drops and she never refused her eye drops.
-He administered Resident #4's latanoprost as ordered, every night he worked.
-He did not know why Resident #4 had an unused bottle of latanoprost dated 08/21/19; he did not know how long the bottle of latanoprost should have lasted with the current order.
-Resident #4 did not complain of discomfort in her eyes or difficulty with her vision.

Interview with the Resident Care Director (RCD) on 09/30/19 at 3:53pm revealed:
-The MAs were expected to administer Resident

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#4's medication as ordered.
-She did not have an explanation for the extra bottle of latanoprost; the MAs should have used the bottle of latanoprost that was dispensed on 08/21/19 before opening the bottle dispensed on 09/15/19.
-She was not aware the latanoprost contained enough drops for twenty-five to thirty days worth of administration.
-If Resident #4 had been administered her medication as ordered, there would not have been a full bottle of latanoprost available.

Interview with the Executive Director (ED) on 09/30/19 at 4:42pm revealed:
-He expected Resident #4's latanoprost to be administered as ordered.
-He was not aware of the unused bottle of latanoprost; the latanoprost dispensed on 08/21/19 should have been used first.
-He knew Resident #4 was admitted with some of her medications, but it did not explain why Resident #4 had an unused bottle of latanoprost dispensed on 08/21/19 and a half of a bottle of latanoprost dispensed on 09/15/19.
-He thought Resident #4 was not administered the latanoprost as ordered; he was concerned the latanoprost was not being administered as ordered for Resident #4.

2. Review of Resident #5's current FL-2 dated 08/14/19 revealed diagnoses included anxiety, depression, hypertension, right side hemiplegia, and hemiparesis cerebrovascular accident.

Review of Resident #5's physician's orders dated 08/29/19 revealed on order for triamcinolone cream 0.1% apply to legs and abdomen twice daily (triamcinolone cream is a corticosteroid used to treat skin conditions).

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D 358	Continued From page 16 Review of Resident #5's July 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for triamcinolone cream 0.1% apply to legs and abdomen twice a day with scheduled administration times of 8:00am and 8:00pm. -Triamcinolone cream was documented as administered twice a day from 07/01/19 to 07/31/19. Review of Resident #5's August 2019 eMAR revealed: -There was an entry for triamcinolone cream 0.1% apply to legs and abdomen twice a day with scheduled administration times of 8:00am and 8:00pm. -Triamcinolone cream was documented as administered twice a day from 08/01/19 to 08/31/19 . Review of Resident #5's September 2019 eMAR revealed: -There was an entry for triamcinolone cream 0.1% apply to legs and abdomen twice a day with scheduled administration times of 8:00am and 8:00pm. -Triamcinolone cream was documented as administered twice a day from 09/01/19 to 09/25/19. Observation of Resident #5's medication on hand on 09/26/19 at 4:17pm revealed: -There was an unopened, full tube of triamcinolone cream with a dispensed date of 07/15/19. -There were no other tubes of triamcinolone cream available.	D 358		

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D 358	Continued From page 17 Telephone interview with a representative from the contracted pharmacy on 09/30/19 at 1:44pm revealed: -There was an active order for triamcinolone cream 0.1% administered twice a day to legs and abdomen for Resident #5. -Triamcinolone cream was dispensed on 03/19/19, 4/19/19 and 07/15/19; one tube was dispensed on each date. -One tube of triamcinolone cream would last a few days to one week depending on the amount used when administered. -Triamcinolone cream would be used to treat skin rashes. -If triamcinolone cream was not administered as ordered for a period of time, the skin rash could get worse and cause discomfort and possible irritation. Interview with Resident #5 on 09/27/19 at 3:43pm revealed she did not remember any cream being applied to her legs or abdomen in the last three months and she had no complaints of a skin rash. Observation of Resident #5's abdomen on 09/27/19 at 3:43pm revealed she did not have a rash on her abdomen. Interviews with a medication aide (MA) on 09/27/19 at 3:43pm and 4:41pm revealed: -He applied the triamcinolone cream to Resident #5's legs and abdomen every evening; he used a gauge that came with the tube of triamcinolone to determine how much cream to use for Resident #5. -He could not locate the gauge he used to measure the triamcinolone cream. -He applied a small amount of the triamcinolone cream to Resident #5's legs from the knees down; "a little bit went a long way".	D 358		

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D 358	Continued From page 18 -Resident #5's rash was so bad he could feel the "heat" in the rash when he applied the cream. -The tube of triamcinolone would last 2-3 weeks; he could not explain why the tube of cream was still full after he had been administering it for the last three months. -Resident #5 had other creams and lotions she was administered; she never refused her medications and would remind him if he missed applying a cream. -Sometimes one tube would be opened and used while there was still an unused portion of a tube available. Interview with a second MA on 09/30/19 at 10:38am revealed: -She administered Resident #5's triamcinolone cream every morning by applying the cream to Resident #5's legs and abdomen. -She did not use a gauge; she put a small amount on her hand. -It seemed like the cream did not last a long time; the tube of triamcinolone cream dispensed on 07/15/19 should not have lasted that long. Telephone interview with a representative from Resident #5's Dermatologist office on 09/30/19 at 1:44pm revealed Resident #5 had been ordered the triamcinolone cream in February 2019 for a skin rash on her legs and abdomen; the original order was for triamcinolone cream 0.1% apply to legs and abdomen twice daily. Interview with the Resident Care Director (RCD) on 09/30/19 at 3:53pm revealed: -She could not explain why Resident #5 had a full, unused tube of triamcinolone cream with a dispense date of 07/15/19. -She expected Resident #5 to receive her triamcinolone cream as ordered by her physician.	D 358		

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D 358	Continued From page 19 Interview with the Executive Director (ED) on 09/30/19 at 4:42pm revealed: -He was not aware Resident #5 was not administered the triamcinolone cream as ordered by the physician. -He trusted the MAs to administer Resident #5 all medication as ordered; he was disappointed the MAs were not applying Resident #5's triamcinolone cream. 3. Review of Resident #2's current FL-2 dated 08/14/19 revealed: -Diagnoses included mitral valve insufficiency, shortness of breath, chronic kidney disease, diabetes mellitus, dyslipidemia, first degree atrioventricular block, osteoarthritis, and hypertension. -There was an order for Norco 5/325mg every 8 hours as needed for pain, not to exceed 3 tablets per day. (Norco is a narcotic used to treat moderate to severe pain.) -There was an order for Tylenol 500mg 2 tablets every 4 hours as needed for headache and/or minor pain, not to exceed 3 doses every 24 hours. Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Norco 5-325mg take 1 tablet every 8 hours as needed for pain, not to exceed 3 tablets per day. -On 08/23/19, there was documentation of administration of Norco at 7:26am and 11:36am. -The 11:36am administration of Norco was 3 hours 50 minutes earlier than ordered. -There was an entry for Tylenol 500mg 2 tablets every 4 hours as needed for headache and/or minor pain, not to exceed 3 doses every 24	D 358		

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D 358	Continued From page 20 hours. -There was no documentation Tylenol was administered in August 2019. Review of Resident #2's September 2019 eMAR revealed: -There was an entry for Norco 5-325mg take 1 tablet every 8 hours as needed for pain, not to exceed 3 tablets per day. -On 09/05/19, there was documentation of administration of Norco at 7:30am and 3:12pm. -The 3:12pm administration of Norco was 18 minutes earlier than ordered. -On 09/06/19, there was documentation of administration of Norco at 9:07am and 3:26pm. -The 3:26pm administration of Norco was 1 hour 41 minutes earlier than ordered. -On 09/07/19, there was documentation of administration of Norco at 7:55am and 3:04pm. -The 3:04pm administration of Norco was 51 minutes earlier than ordered. -On 09/16/19, there was documentation of administration of Norco at 1:06pm and 3:45pm. -The 3:45pm administration of Norco was 5 hours 21 minutes earlier than ordered. -On 09/17/19, there was documentation of administration of Norco at 7:30am and 3:10pm. -The 3:10pm administration of Norco was 20 minutes earlier than ordered. -On 09/19/19, there was documentation of administration of Norco at 8:05am and 3:11pm. -The 3:11pm administration of Norco was 54 minutes earlier than ordered. -On 09/26/19, there was documentation of administration of Norco at 12:37pm, 6:17pm, and 11:05pm. -The 6:17pm administration of Norco was 2 hours 20 minutes earlier than ordered. -The 11:05pm administration of Norco was 4 hours 48 minutes earlier than ordered.	D 358		

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D 358	Continued From page 21 -There was an entry for Tylenol 500mg 2 tablets every 4 hours as needed for headache and/or minor pain, not to exceed 3 doses every 24 hours. -There was no documentation Tylenol was administered in September 2019. Review of Resident #2's record revealed there was no documentation of contact with the physician regarding the early administration of as needed Norco. Interview with a medication aide (MA) on 09/26/19 at 2:25pm and 09/27/19 at 2:40pm revealed: -When medications were given early or late, an explanation was documented in the eMAR. -As needed medications could not be administered early. -The medication administration software did not permit further as needed medication to be administered if the effectiveness of the previous dose was not documented. -She told Resident #2 she would have to wait when she asked for an as needed medication earlier than ordered. -She did not call the physician for an order to administer the medication sooner. -She administered as needed Tylenol between Norco doses. -The new [as of mid-August 2019] software program had a different process for administering as needed medication. -She had to "back out" of the new system to give an as needed medication. -Administering as needed medications interrupted the flow of administering scheduled medications. -There were glitches with the old software system, such as the time would not be correct. -She had not called the computer software	D 358		

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D 358	Continued From page 22 customer service center this year. Interview with a second MA on 09/27/19 at 1:55pm revealed: -Resident #2 knew her medications. -Sometimes Resident #2 followed her around when Resident #2 wanted medication. -She checked the previous administration time before giving an as needed medication to make sure she was not giving it early. -The computer program showed the previous administration time and asked if the as needed medication was effective. -The program prompted a user to wait if it was not time to administer another dose. -She could not override the program. -She always gave her medications on time. -The previous computer program permitted administration of as needed medication before the ordered time if she recorded the effectiveness of the as needed medication. Interview with a third MA on 09/27/19 at 4:15pm revealed: -As needed medications were given at the ordered time. -The computer software indicated if it was too soon to give a dose. -There was no way to give an as needed medication early. -She waited the amount of time shown on the order before giving another dose. -She never noticed the computer program time being different from the actual time. -Three months ago, the computer was offline and did not record the medication administration time. -She called the software company directly and was advised to move the computer to another location in the facility. -The computer was offline earlier on 09/26/19,	D 358		

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and the Resident Care Director (RCD) instructed her to move the computer to another location.

Interview with a fourth MA on 09/27/19 at 4:44pm revealed:
-An as needed order meant that a resident could have the medication whenever it was needed.
-She waited to administer the medication according to the order time.
-She gave an alternative medication between as needed doses.
-She checked the time frame when the resident asked for an as needed medication.
-She clicked on the medication in the software program, confirmed she was giving the right medication, signed the Controlled Substance Count Sheet (CSCS), and then gave the pill.

Interview with a fifth MA on 09/27/19 at 5:15pm revealed:
-He waited the ordered amount of time between administering as needed medication.
-He checked the last administration time on the computer.
-He checked the effectiveness of the as needed medication 30 minutes to 1 hour after administration.
-There was no way to override the computer program.
-On 09/16/19, the MA on the previous shift documented late and it made his administration of Norco look like it had been given too early.
-He did not know why his entries on Resident #2's eMARs were showing up as medication being administered sooner than ordered.

Telephone interview with a representative from the computer software company on 09/27/19 at 4:00pm revealed:
-The computer screen showed the last time the

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medication was given.
-A subsequent as needed medication could not be administered unless the results of the previous dose had been documented in the eMAR.
-The responsibility was on the MA to administer the medication at the right time.

Interview with the RCD on 09/26/19 at 3:30pm revealed:
-As needed medication administration times were firm.
-The medication administration software provided an alert if someone tried to administer an as needed medication sooner than ordered.
-She did not know if the software could be overridden so an as needed medication could be administered earlier than ordered.
-She would give another medication until it was time for the as needed medication to be administered.
-An order from the physician was needed to give an as needed medication earlier than ordered.
-Documentation of phone calls to the physician was kept in the resident's record.

Interview with the Nurse Consultant on 09/26/19 at 3:30pm revealed an as needed medication order was strict as far as the administration time of the medication.

Interview with Resident #2 on 09/26/19 at 3:45pm revealed:
-Norco lessened her pain.
-Norco was available to her three times a day.
-She took Norco twice a day, every 8 hours.
-She took Tylenol between doses.
-She never received Norco less than 8 hours between doses.
-She received Norco at 8:00am on 09/26/19.

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Second interview with Resident #2 on 09/27/19 at 9:15am revealed:
-She received Norco at 8:00am and 3:00pm on 09/26/19.
-She regularly took Norco at 8:00am, 3:00pm, and 10:00pm.

Interview with the Executive Director (ED) on 9/27/19 at 5:55pm revealed:
-He came in and worked on the floor as needed.
-He did not give medications.
-The eMARs were reviewed each morning by the RCD.
-Medication errors were reported to him or the RCD by the MAs.
-He relied on the RCD and Resident Care Coordinator (RCC) to handle medication errors.
-He did not know if eMAR audits were being done.
-The MAs had been working at the facility "too long to not know what to do."
-There were times the medication administration software operated slowly.
-The pharmacist reviewed the medication cart, the eMAR, and the CSCS.

Second interview with the RCD on 09/30/19 at 3:12pm revealed:
-The last eMAR audit she conducted was in August 2019.
-The audits coincided with the six-month physician order review for each resident.
-The eMAR audit consisted of verifying the physician orders were on the eMAR.
-The CSCS were reviewed between shifts by the MAs.
-There was no way to go back and correct the documentation time on the eMAR in both the old and new computer systems.
-Resident #2's as needed Norco should have

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been given every 8 hours.
-On 09/30/19, an MA told her as needed medications could be administered early after documenting the effectiveness of the previous dose in the computer system.

Second interview with the ED on 09/30/19 at 4:03pm revealed:
-The pharmacist reviewed the eMARs with the RCD.
-The CSCS was a balance sheet.
-Resident #2's CSCS was audited by the MAs during change of shift.
-The MA audit consisted of verifying the number of available doses on the CSCS matched the number of doses on hand.
-There was a two-hour window for administering as needed medications.
-Medication administration audits were done in real time by the MAs as they administered the medication.
-The MAs were not documenting correctly or there was a software problem.
-This situation provided a coaching opportunity.

4. Review of Resident #6's current FL-2 dated 01/31/19 revealed diagnoses included Alzheimer's dementia, depression, history of colon cancer, memory loss and hypertension.

Review of a physician's order for Resident #6 dated 05/30/19 revealed an order for Alprazolam 0.25 mg take one tablet every 12 hours as needed for agitated and resistive behaviors. (Alprazolam is used to treat anxiety disorders caused by depression).

Review of a physician order for Resident #6 dated 08/19/19 revealed:
-An order to discontinue Alprazolam 0.25 mg one

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tablet every 12 hours as needed.
-Start Alprazolam 0.50 mg one tablet every 12 hours as needed for agitation.

Review of Resident #6's physician's note dated 08/19/19 revealed:
-Staff reported that patient was combative with staff and verbally aggressive,
-Staff reported on 08/19/19 the resident was punching her and cursing at her.

Review of Resident #6's August 2019 electronic medication administration records (e-MARs) revealed:
-There was entry for Alprazolam 0.25 mg every 12 hours as needed for agitation and resistive behaviors from 08/01/19-08/18/19.
-There was documentation Alprazolam 0.25 mg was administered on 08/01/19-08/12/19 six times.
-There was a record entry for Alprazolam 0.50mg every 12 hours as needed for agitation from 08/19/19 -08/31/19.
-There was documentation Alprazolam 0.50mg was administered on 08/22/19-08/30/19 four times.

Review of Resident #6's controlled substance count sheet (CSCS) for Alprazolam 0.25mg from 08/01/19-08/18/19 revealed the MAs documented administering Alprazolam 0.25mg.

Review of Resident #6's CSCS for Alprazolam 0.25mg from 08/19/19-08/31/19 revealed the MAs documented administering Alprazolam 0.25mg instead Alprazolam of 0.50mg.

Review of Resident #6's CSCS for Alprazolam 0.5mg from 08/19/19-08/31/19 revealed the MAs had not administered any of the Alprazolam of 0.50mg.

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D 358	Continued From page 28 Review of Resident #6's September 2019 e-MARs revealed: -There was entry for Alprazolam 0.50mg every 12 hours as needed for agitation. -There was documentation Alprazolam 0.50mg was administered from 09/01/19 - 09/27/19 nine times. Review of Resident #6's CSCS for Alprazolam 0.25mg from 09/01/19-09/27/19 revealed the MAs documented administering Alprazolam 0.25mg instead of Alprazolam 0.50mg. Review of Resident #6's CSCS for Alprazolam 0.50mg from 09/01/19-09/27/19 revealed the MAs had not administered any of the Alprazolam of 0.50mg. Observation of medication on hand for Resident #6 on 09/27/19 at 10:15am revealed: -There was a bubble pack of 60 tablets of Alprazolam 0.25mg dispensed on 05/30/19. -On 09/27/19, there were 10 tablets of Alprazolam 0.25mg remaining. -There was a bubble pack of 60 tablets of Alprazolam 0.50 mg dispensed on 08/19/19. -On 09/27/19, there were 60 tablets of Alprazolam 0.50 mg tablets remaining. Interview with a medication aide (MA) on 09/30/19 at 9:44am revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50 mg on the e-MAR. -Resident #6 could be combative at times. -It was usually during personal care and waking him up in the morning.	D 358		

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D 358	Continued From page 29 -He made gestures with his fist, but he did not make physical contact with staff. Telephone interview with a second MA on 09/30/19 at 11:45am revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR. -It took 2 staff to perform personal care for Resident #6. -It was not easy to handle Resident #6 because he had a lot of anxiety. -When he got Alprazolam 30 minutes prior to personal care, he was more cooperative. Telephone interview with a third MA on 09/30/19 at 11:58am revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR. -Resident #6 could be combative during personal care Telephone interview with a fourth MA on 09/30/19 at 12:05pm revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR -Resident #6 was combative during personal care if he did not know the staff. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/30/19 at 1:08pm revealed:	D 358		

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D 358	Continued From page 30 -The order for Resident #6's Alprazolam 0.25mg was increased to 0.50mg on 08/19/19. -If Resident #6 received Alprazolam 0.25mg instead of Alprazolam 0.50mg the medication may not take care of Resident #6's agitation. -There would not be no negative reaction. Interview with the Resident Care Director (RCD) on 09/30/19 at 3:10pm revealed: -She did not know the MAs were administering Alprazolam 0.25mg to Resident #6 instead of Alprazolam 0.50 mg. -The MAs should read the e-MAR and administer the correct dosage of Alprazolam. -Alprazolam 0.25mg would not be as effective as the Alprazolam 0.50mg to prevent Resident #6's behavior. Interview with the Executive Director (ED) on 09/30/19 at 4:00pm revealed: -He did not know the MAs were administering Alprazolam 0.25mg to Resident #6 instead of Alprazolam 0.50mg. -Alprazolam 0.25 mg should have been removed from the medication cart in a day or 2 after Alprazolam 0.50mg was on hand. -The MAs should have read the e-MARs and given the correct dosage of Alprazolam. -He could not say if Alprazolam 0.50mg would have changed Resident #6's behavior. -The auditor should have caught the error on the audit. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Attempted interview with Resident #6's physician on 09/30/19 at 3:16pm was unsuccessful.	D 358		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of 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 electronic medication administration records (eMARs) were accurate and complete for 2 of 6 sampled residents (#2, and #6) including inaccurate	D 367		

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documentation of a narcotic used to treat moderate to severe pain (#2), and an anti-anxiety medication (#6).

The findings are:

1. Review of Resident #2's current FL-2 dated 08/14/19 revealed:
-Diagnoses included mitral valve insufficiency, shortness of breath, chronic kidney disease, diabetes mellitus, dyslipidemia, first degree atrioventricular block, osteoarthritis, and hypertension.
-There was an order for Norco 5/325mg every 8 hours as needed for pain, not to exceed 3 tablets per day. (Norco is a narcotic used to treat moderate to severe pain.)

Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Norco 5-325mg take 1 tablet every 8 hours as needed for pain, not to exceed 3 tablets per day.
-On 08/16/19, there was documentation of administration of Norco at 3:03pm.
-On 08/18/19, there was documentation of administration of Norco at 9:50am.
-On 08/23/19, there was documentation of administration of Norco at 7:26am and 11:36am.

Review of Resident #2's Controlled Substance Count Sheet (CSCS) for 08/14/19-08/21/19 revealed:
-On 08/14/19, there was documentation Norco was signed out at 8:00am and 8:00pm.
-On 08/15/19, there was documentation Norco was signed out at 8:00am and 8:00pm.
-On 08/16/19, there was documentation Norco was signed out at 8:00pm.

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D 367	Continued From page 33 -On 08/17/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/18/19, there was documentation Norco was signed out at 8:00pm. -On 08/19/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/20/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/21/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -There was documentation no further doses remained. Review of Resident #2's CSCS for 08/22/19-08/31/19 revealed: -On 08/22/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/23/19, there was documentation Norco was signed out at 8:00pm. -On 08/24/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/25/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/26/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/27/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/28/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/29/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 08/30/19, there was documentation Norco was signed out at 8:00am, 3:00pm, and 8:00pm. -On 08/31/19, there was documentation Norco was signed out at 8:00am, 3:00pm, and 11:00pm. -There was documentation 37 doses remained. Based on review of the August 2019 eMAR and CSCS for Resident #2, there were 35 times Norco was signed out on the CSCS and not	D 367		

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D 367	Continued From page 34 documented as administered on the eMAR. Review of Resident #2's September 2019 eMAR revealed: -There was an entry for Norco 5-325mg take 1 tablet every 8 hours as needed for pain, not to exceed 3 tablets per day. -On 09/04/19, there was documentation of administration of Norco at 3:21pm. -On 09/05/19, there was documentation of administration of Norco at 7:30am and 3:12pm. -On 09/06/19, there was documentation of administration of Norco at 9:07am and 3:26pm. -On 09/07/19, there was documentation of administration of Norco at 7:55am and 3:04pm. -On 09/08/19, there was documentation of administration of Norco at 3:17pm. -On 09/10/19, there was documentation of administration of Norco at 3:30pm. -On 09/12/19, there was documentation of administration of Norco at 2:59pm. -On 09/13/19, there was documentation of administration of Norco at 3:31pm. -On 09/16/19, there was documentation of administration of Norco at 1:06pm and 3:45pm. -On 09/17/19, there was documentation of administration of Norco at 7:30am and 3:10pm. -On 09/19/19, there was documentation of administration of Norco at 8:05am and 3:11pm. -On 09/20/19, there was documentation of administration of Norco at 3:14pm. -On 09/21/19, there was documentation of administration of Norco at 9:05am. -On 09/25/19, there was documentation of administration of Norco at 8:40am. -On 09/26/19, there was documentation of administration of Norco at 12:37am., 6:17pm, and 11:05pm. -On 09/27/19, there was documentation of administration of Norco at 7:35am.	D 367		

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D 367	Continued From page 35 Review of Resident #2's CSCS for 09/01/19-09/13/19 revealed: -On 09/01/19, there was documentation Norco was signed out at 8:00am, 3:00pm, and 8:00pm. -On 09/02/19, there was documentation Norco was signed out at an illegible time, 3:00pm, and 8:00pm. -On 09/03/19, there was documentation Norco was signed out at 8:00am, 3:00pm and 8:00pm. -On 09/04/19, there was documentation Norco was signed out at 7:00am and 8:00pm. -On 09/05/19, there was documentation Norco was signed out at 8:00pm. -On 09/06/19, there was documentation Norco was signed out at 11:00pm. -On 09/07/19, there was documentation Norco was signed out at 8:00pm. -On 09/08/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 09/09/19, there was documentation Norco was signed out at 8:00am, 3:00pm, and 11:00pm. -On 09/10/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 09/10/19 [incorrect date entered on record] there was documentation Norco was signed out at 8:00am and 3:00pm. -On 09/11/19, there was documentation Norco was signed out at 8:00pm. -On 09/12/19, there was documentation Norco was signed out at 8:00am and 8:00pm. -On 09/13/19, there was documentation Norco was signed out at 8:00am. -There was documentation no further doses remained. Review of Resident #2's CSCS for 09/13/19-09/23/19 revealed: -On 09/13/19, there was documentation Norco was signed out at 11:00pm.	D 367		

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-On 09/14/19, there was documentation Norco was signed out at 8:00am, 3:00pm, and 11:00pm.
-On 09/15/19, there was documentation Norco was signed out at 8:00am, 8:00pm, and 11:00pm.
-On 09/16/19, there was documentation Norco was signed out at 10:00pm.
-On 09/17/19, there was documentation Norco was signed out at 8:00pm.
-On 09/18/19, there was documentation Norco was signed out at 8:00am, 3:00pm, and 8:00pm.
-On 09/19/19, there was documentation Norco was signed out at 8:00pm.
-On 09/20/19, there was documentation Norco was signed out at 8:00am and 8:00pm.
-On 09/21/19, there was documentation Norco was signed out at 8:00pm.
-On 09/22/19, there was documentation Norco was signed out at 8:00am and 8:00pm.
-On 09/23/19, there was documentation Norco was signed out at 8:00am and 7:00pm.
-There was documentation no further doses remained.

Review of Resident #2's CSCS for 09/23/19-09/27/19 revealed:
-On 09/23/19, there was documentation Norco was signed out at 11:00pm.
-On 09/24/19, there was documentation Norco was signed out at 7:00am, 3:00pm, and 8:00pm.
-On 09/25/19, there was documentation Norco was signed out at 8:00pm.
-There was documentation 35 doses remained.

Based on review of the September 2019 eMAR and CSCS for Resident #2, there were 52 times Norco was signed out on the CSCS and not documented as administered on the eMAR.

Review of pharmacy dispensing records for Resident #2 revealed:

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D 367	Continued From page 37 -On 08/16/19 and 09/17/19 each, there were 90 Norco tablets dispensed. Observation of Resident #2's medication on hand on 09/26/19 at 4:40pm revealed: -There were 83 Norco tablets available. -There was a punch card containing 38 of 45 tablets. -The label was dated 09/17/19 and indicated 1 of 2 punch cards. -There was a second punch card containing 45 tablets. -The label was dated 09/17/19 and indicated 2 of 2 punch cards. Interview with a medication aide (MA) on 09/27/19 at 1:55pm revealed: -She was consistent with her documentation. -She never signed the CSCS without administering the medication. -She signed the CSCS before administering the medication. -She entered the administration in the eMAR before giving the medication. -She administered Norco to Resident #2 on 09/23/19. -She did not know why the administration was not documented on the eMAR. Interview with a second MA on 09/27/19 at 3:55pm revealed: -She signed the CSCS whenever she administered Norco to Resident #2. -She did not know why the entries were not on the eMARs. -Sometimes she forgot to click on the eMAR when she gave a medication. -On an unknown date, she forgot to click on the computer when she gave Resident #2 Norco because she was taking care of another resident.	D 367		

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CARILLON ASSISTED LIVING OF NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

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D 367	Continued From page 38 Interview with a third MA on 09/27/19 at 4:44pm revealed: -When she gave Norco, she clicked on the medication in the software program, confirmed she was giving the right medication, signed the CSCS, and then gave the medication. -On 09/23/19, she gave Norco to Resident #2 but may have been busy counting medications or doing something else and did not document the administration in the eMAR. -She did not know how many times she had not documented Resident #2's Norco administration on the eMAR. Interview with a fourth MA on 09/27/19 at 5:15pm revealed: -He documented the administration of Norco on the CSCS after administering it. -Sometimes the computer was offline; he would click on the screen, and it did not register. -The medication administration times were not showing up in the eMAR. Interview with the Executive Director (ED) on 9/27/19 at 5:55pm revealed: -The eMARs were reviewed each morning by the Resident Care Director (RCD). -The pharmacist reviewed the medication cart, the eMARs, and the CSCS. -The pharmacist reviewed the eMARs with the RCD. -He did not know if medication administration times were included in the eMAR review. -The MAs had been working at the facility "too long to not know what to do." Interview with the RCD on 09/30/19 at 3:12pm revealed: -The last eMAR audit she conducted was in	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092187	A. BUILDING: _____ B. WING _____	R 09/30/2019

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D 367	Continued From page 39 August 2019. -The audits coincided with the six-month physician order review for each resident. -The eMAR audit consisted of verifying the physician orders were entered on the eMAR. -The MAs audited the CSCS at the change of shift by verifying the amount of available doses documented on the CSCS matched the amount of available medication on hand. Interview with the ED on 09/30/19 at 4:03 revealed: -The pharmacist reviewed the eMARs with the RCD. -The CSCS was a balance sheet for narcotics. -The CSCS was audited by the MAs during change of shift. -The MA audit consisted of verifying the number of available doses on the CSCS matched the available doses of medication on hand. -Medication administration audits were done in real time by the MAs as they administered the medication. -The MAs were not documenting correctly or there was a software problem related to the missing documentation on the eMAR. 2. Review of Resident #6's current FL-2 dated 01/31/19 revealed diagnoses included Alzheimer's dementia, depression, history of colon cancer, memory loss and hypertension. Review of a physician's order for Resident #6 dated 05/30/19 revealed an order for Alprazolam 0.25mg one tablet every 12 hours as needed for agitated and resistive behaviors. Review of a physician's order for Resident #6 dated 08/19/19 revealed:	D 367		

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D 367	Continued From page 40	D 367		

- An order to discontinue Alprazolam 0.25mg one tablet every 12 hours as needed.
-Start Alprazolam 0.50mg one tablet every 12 hours as needed for agitation.

Review of Resident #6's August 2019 electronic medication administration records (e-MARs) revealed:
-There was entry for Alprazolam 0.25 mg every 12 hours as needed for agitation and resistive behaviors from 08/01/19-08/18/19.
-There was documentation Alprazolam 0.25 mg was administered on 08/01/19-08/12/19 six times.
-There was a record entry for Alprazolam 0.50mg every 12 hours as needed for agitation from 08/19/19 -08/31/19.
-There was documentation Alprazolam 0.50mg was administered on 08/22/19-08/30/19 four times.

Review of Resident #6's controlled substance count sheet (CSCS) for Alprazolam 0.25mg from 08/01/19-08/18/19 revealed the MAs documented administering Alprazolam 0.25mg.

Review of Resident #6's CSCS for Alprazolam 0.25mg from 08/19/19-08/31/19 revealed the MAs documented administering Alprazolam 0.25mg instead Alprazolam of 0.50mg.

Review of Resident #6's CSCS for Alprazolam 0.5mg from 08/19/19-08/31/19 revealed the MAs had not administered any of the Alprazolam of 0.50mg.

Review of Resident #6's September 2019 e-MARs revealed:
-There was entry for Alprazolam 0.50mg every 12 hours as needed for agitation.
-There was documentation Alprazolam 0.50mg

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D 367	Continued From page 41 was administered from 09/01/19-09/27/19 nine times. Review of Resident #6's CSCS for Alprazolam 0.25mg from 09/01/19-09/27/19 revealed the MAs documented administering Alprazolam 0.25mg instead of Alprazolam 0.50mg. Review of Resident #6's CSCS for Alprazolam 0.50mg from 09/01/19- 09/27/19 revealed the MAs had not administered any of the Alprazolam of 0.50mg. Observation of medication on hand for Resident #6 on 09/27/19 at 10:15am revealed: -There was a bubble pack of 60 tablets of Alprazolam 0.25mg dispensed on 05/30/19. -On 09/27/19, there were 10 tablets of Alprazolam 0.25mg remaining. -There was a bubble pack of 60 tablets of Alprazolam 0.50 mg dispensed on 08/19/19. -On 09/27/19, there were 60 tablets of Alprazolam 0.50 mg tablets remaining. Interview with a medication aide (MA) on 09/30/19 at 9:44am revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR. Telephone interview with a second MA on 09/30/19 at 11:45am revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR.	D 367		

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D 367	Continued From page 42 Telephone interview with a third MA on 09/30/19 at 11:58am revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR. Telephone interview with a fourth MA on 09/30/19 at 12:05pm revealed: -She was still administering Alprazolam 0.25mg to Resident #6. -She had not noticed Alprazolam for Resident #6 had increased from 0.25mg to 0.50mg on the e-MAR. Interview with the Resident Care Director (RCD) on 09/30/19 at 3:10pm revealed: -She did not know the MAs were administering Alprazolam 0.25mg to Resident #6 instead of Alprazolam 0.50 mg. -The MAs should have read the e-MAR and given the correct dosage of Alprazolam to Resident #6. Interview with the Executive Director (ED) on 09/30/19 at 4:00pm revealed: -Alprazolam 0.25mg for Resident #6 should have been removed from the medication cart in a day or 2 after Alprazolam 0.50 mg was on hand. -The MAs should have read the e-MAR for Resident #6 and administered the correct dosage of Alprazolam.	D 367		