STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 Licensure Section and the Cabarrus County Department of Social Services competed an Annual, Follow-up and Complaint survey March 20, 2024 through March 22, 2024.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 7 sampled residents (#4 and #5) had completed tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services. The findings are: 1.Review of Resident #4's current FL2 dated 09/20/23 revealed diagnoses included end stage renal disease and acute pain. Review of Resident #4's Resident Register revealed an admission date of 08/15/20. Review of Resident #4's facility record on 03/20/24 revealed:	D 234		

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-There was no tuberculosis (TB) skin test documentation upon admission.
-There was one documented negative TB skin test read on 02/10/24.

2.Review of Resident #5's current FL2 dated 09/19/23 revealed diagnoses included diabetes type II, diabetic neuropathy, and hypertension.

Review of Resident #5's Resident Register revealed an admission date of 11/03/21.

Review of Resident #5's facility record on 03/21/24 revealed:
-There was one documented negative TB skin test read on 10/21/21.
-There was no documentation of a second step TB skin test.

Refer to interview with the Admissions Coordinator on 03/21/24 at 10:30am.

Refer to interview with the Administrator on 03/21/24 at 3:30pm.

_____

Interview with the Admissions Coordinator on 03/21/24 at 10:30am revealed:
-She did not know Resident #4 and Resident #5 had incomplete TB skin tests.
-She was responsible for ensuring all TB skin tests were completed upon admission to the facility.

Interview with the Administrator on 03/21/24 at 3:30pm revealed:
-He did not know Resident #4 and Resident #5 had incomplete TB skin tests.
-He was aware TB skin tests were an issue and the facility had been completing chart audits.
-He knew each resident was supposed to have

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D 234	Continued From page 2 the first TB skin testing completed prior to admission to the facility and the second TB skin testing completed within a year.	D 234		
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 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 1 of 7 sampled residents (Resident #7) related to a medication used to control elevated blood sugar. The findings are: Review of Resident #7's current FL2 dated 07/25/23 revealed diagnoses included Type 2 diabetes, and mental retardation. Review of Resident #7's signed Physician orders dated 07/25/23 revealed: -There was an order to check finger stick blood sugar (FSBS) three times daily before each meal. -There was an order for Novolog Flexpen 100 units, (a rapid acting insulin used to lower elevated blood sugar levels), inject per sliding scale: FSBS: 180-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units,	D 358		

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D 358	Continued From page 3 351-400 = 10 units, greater than 400 contact Primary Care Provider (PCP). Review of Resident #7's January 2024 Medication Administration Record (MAR) revealed: -There was an entry for Novolog Flexpen 100 units, inject per sliding scale before each meal at 6:30am, 11:30am and 4:30pm. -On 01/24/24 at 4:30pm, the resident's FSBS was 291 and he received 2 units when the order stated he should have received 6 units. -On 01/30/24 at 11:30am, the resident's FSBS was 278 and he received 4 units when the order stated he should have received 6 units. Review of Resident #7's March 2024 MAR revealed: -There was an entry for Novolog Flexpen 100 units, inject per sliding scale before each meal at 6:30am, 11:30am and 4:30pm. -On 03/05/2024 at 11:30am, the resident's FSBS was 211 and he received 2 units when the order stated he should have received 4 units. -On 03/16/24 at 4:30pm, the resident's FSBS was 233 and he received 2 units when the order stated he should have received 4 units. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/22/24 at 8:36am revealed: -Resident #7 had an order for Novolog Flexpen 100 units, inject per sliding scale: FSBS: 180-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, and greater than 400 contact PCP. -On 01/15/24, 2 pens of Novolog Flexpen 100 units, 6 ml's each was dispensed to Resident #7. -Low blood sugar levels could cause passing out, confusion, dizziness, and weakness.	D 358		

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-High blood sugar levels could cause dry mouth, thirst, and potential organ damage.
-Cart audits were completed by a pharmacy registered nurse quarterly.

Telephone interview with Resident #7's PCP on 03/22/24 at 11:05am revealed:
-She had been his PCP from 01/17/24-03/15/24.
-She was not made aware of any sliding scale insulin errors for Resident #7.
-She would have wanted to be made aware of the errors.
-High levels of blood sugar could lead to organ failure in the long term, but several doses periodically would not have caused any detriment.

Interview with the second floor medication aide (MA) Supervisor on 03/21/24 at 12:15pm revealed:
-She was not aware she gave the wrong sliding scale insulin on 01/24/24 at 4:30pm, 1/30/24 at 11:30am, 03/05/24 at 11:30am and 03/16/24 at 4:30pm.
-She did not think she gave the wrong dose but hit the wrong button on the computer.
-She would not have given the wrong dose of sliding scale insulin because she checked the order each time before she gave the dose.
-She did not audit the charts and did not know if anyone did audits to check if sliding scale insulin was given according to the order.

Interview with the MA Supervisor on 03/22/24 at 3:20pm revealed:
-She was not aware Resident #7 received the incorrect sliding scale insulin.
-She did not audit the charts on the second floor unless the MA Supervisor on that floor asked her to.
-She checked the MAR with medications on the

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D 358	Continued From page 5 charts about once a month or every other month but usually just on the first floor. Interview with the Resident Care Coordinator (RCC) on 03/22/24 at 3:51pm revealed: -She was not aware Resident #7 was given the incorrect sliding scale insulin dose according to what was ordered. -She did not receive a medication error report on Resident #7. -The MA Supervisor was to do medication audits weekly but she was not sure if they were completed. -She did not get any documentation from the audits completed. Interview with the Administrator on 03/22/24 at 4:45pm revealed: -He was not aware Resident #7 received incorrect sliding scale insulin. -He did not receive a medication error report which documented when the PCP was made aware. -Audits were not being done on a regular basis until the Department of Social Services made the facility aware of a complaint in March 2024. -The lead MA Supervisor should be doing the audits on the FSBS. -His expectation was for all medications to be given according to the PCP orders.	D 358		
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;	D 367		

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D 367	Continued From page 6 (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, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) was accurate for 3 of 7 sampled residents (Resident #1, #4 and #5) related to medications used to treat pain (Resident #1), high blood pressure, anxiety, and pain (Resident #4) and a diabetic sensor for monitoring blood sugar levels (Resident #5). The findings are: 1. Review of Resident #1's current FL2 dated 12/29/23 revealed: -Diagnoses included cerebrovascular accident (stroke) and frequent falls secondary to severe neuropathy (nerve pain). -There was an order for oxycodone 15mg (a medication to treat pain), one tablet every six hours as needed.	D 367		

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Review of Resident #1's Primary Care Provider's (PCP) orders dated 02/07/24 and 02/21/24 revealed orders for oxycodone 15mg, one tablet every six hours as needed for pain.

Review of Resident #1's January 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxycodone 15mg, one tablet every six hours as needed for pain.
-Oxycodone 15mg, one tablet was documented as administered 5 times; on 01/22/24 at 7:11am, on 01/23/24 at 2:27pm, on 01/24/24 at 12:09pm, on 01/28/24 at 2:10pm and on 01/30/24 at 2:11pm.

Review of Resident #1's January 2024 controlled substance count sheets (CSCS) revealed:
-Oxycodone 15mg, 30 tablets were dispensed for Resident #1 on 01/17/24.
-Oxycodone 15mg, 26 tablets were dispensed for Resident #1 on 01/27/24.
-Oxycodone 15mg, one tablet was signed out for administration 39 times between 01/18/24 and 01/31/24.

Review of Resident #1's February 2024 eMAR revealed:
-There was an entry for oxycodone 15mg, one tablet every six hours as needed for pain.
-Oxycodone 15mg, one tablet was documented as administered 30 times; on 02/04/24 at 6:25pm, on 02/07/24 at 2:58pm, on 02/08/24 at 9:01pm, on 02/09/24 at 9:11am, on 02/12/24 at 2:31pm, on 02/18/24 at 2:18pm, on 02/19/24 at 6:23pm, on 02/21/24 at 9:19am, on 02/22/24 at 12:59pm, on 02/23/24 at 6:43pm and 7:35pm, on 02/24/24 at 9:11am, 3:01pm and 9:17pm, on 02/25/24 at 7:25am, 1:31pm and 9:35pm, on 02/26/24 at 6:48am, 12:48pm and 7:50pm, on 02/27/24 at

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D 367	Continued From page 8 7:00am, 12:45pm and 6:47pm, on 02/28/24 at 7:38am, 1:12pm and 6:43pm and on 02/29/24 at 1:06am, 7:08am, 1:06pm and 6:47pm. Review of Resident #1's February 2024 CSCS revealed: -Oxycodone 15mg, 30 tablets were dispensed for Resident #1 on 02/07/24. -Oxycodone 15mg, 26 tablets were dispensed for Resident #1 on 02/16/24. -Oxycodone 15mg, 30 tablets were dispensed for Resident #1 on 02/21/24. -Oxycodone 15mg, one tablet was signed out for administration 85 times between 02/01/24 and 02/29/24. Interview with a medication aide (MA) on 03/22/24 at 3:15pm revealed: -Prior to the middle of February 2024, not all MAs documented on the resident eMARs when administering a PRN (as-needed) controlled substance because they thought signing the CSCS was sufficient. -All MAs were trained in February 2024 to sign both the CSCS and the eMAR when administering a PRN controlled substance to a resident. -Prior to the training, she was not aware the eMAR was to be signed in addition to the CSCS. Refer to interview with the RCC on 03/22/24 at 3:50pm. Refer to interview with the Administrator on 03/22/24 at 4:30pm. 2. Review of Resident #4's current FL2 dated 09/20/23 revealed diagnoses included end stage renal disease and acute pain.	D 367		

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D 367	Continued From page 9 a. Review of Resident #4's physician orders dated 09/20/23 revealed there was an order for amlodipine (used to treat high blood pressure) 5mg by mouth daily. Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed there was an entry for amlodipine 5mg daily with documentation of administration daily from 01/01/24- 01/31/24. Review of Resident #4's February 2024 eMAR revealed there was an entry for amlodipine 5mg daily with documentation of administration daily from 02/01/24- 02/29/24. Review of Resident #4's March 2024 eMAR revealed there was an entry for amlodipine 5mg by mouth daily with documentation of administration daily from 03/01/24- 03/20/24. Observation of Resident #4's medications on hand on 03/21/24 at 3:35pm revealed that there was not any amlodipine 5mg on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/22/24 at 9:20am revealed: -There was an order to discontinue Resident #4's amlodipine on 10/16/23. -The pharmacy and facility were able to add and/or discontinue orders on the eMAR system. -The pharmacy discontinued Resident #3's amlodipine on 10/16/23. -The facility must have added the order for amlodipine back on to the eMAR system. -Resident #4's amlodipine was last filled on 09/27/23. -The facility had not requested a refill of Resident	D 367		

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D 367	Continued From page 10 #4's amlodipine after 09/27/23. Interview with a medication aide (MA) on 03/22/24 at 10:44am revealed: -She did not know Resident #4's amlodipine had been discontinued on 10/16/23. -MAs should not be documenting on the eMAR that a medication had been administered if the medication was not available. -She admitted to documenting on the eMAR that she had administered Resident #4's amlodipine when the medication was not available. -The RCC, MA Supervisors, and MAs were responsible for notifying the pharmacy and Primary Care Provider (PCP) if there was a medication not available for administration. -MAs were able to add and/or discontinue orders on the eMAR system. -She did not know if any medication cart audits were being completed. Refer to interview with the RCC on 03/22/24 at 3:50pm. Refer to interview with the Administrator on 03/22/24 at 4:30pm. b. Review of Resident #4's physician orders dated 09/20/23 revealed there was an order for lorazepam (used to treat anxiety) 0.5mg by mouth daily as needed. Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed there was an entry for lorazepam 0.5mg by mouth daily as needed with no documentation of medication being administered. Review of Resident #4's controlled substance count sheet (CSCS) for January 2024 revealed 5	D 367		

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lorazepam 0.5mg tablets were documented as being administered on 01/17/24, 01/18/24, 01/22/24, 01/24/24 and 01/29/24.

Review of Resident #4's February 2024 eMAR revealed there was an entry for lorazepam 0.5mg daily as needed with no documentation of medication being administered.

Review of Resident #4's CSCS for February 2024 revealed 2 lorazepam 0.5mg tablets were documented as being administered on 02/01/24 and 02/02/24.

Refer to interview with a MA on 03/22/04 at 2:45pm:

Refer to interview with the RCC on 03/22/24 at 3:50pm.

Refer to interview with the Administrator on 03/22/24 at 4:30pm.

c. Review of Resident #4's physician order dated 01/31/24 revealed there was an order for hydrocodone (used to treat pain) 5mg-325mg every six hours as needed.

Review of Resident #4's February 2024 eMAR revealed there was an entry for hydrocodone 5mg-325mg every six hours as needed with documentation of the medication being administered on 02/08/24, 02/23/24 and on 02/25/24.

Review of Resident #4's CSCS for February 2024 revealed there was 8 hydrocodone 5mg-325mg tablets documented as being administered on 02/03/24, 02/04/24 at 6:00am, 02/04/24 at 6:00pm, 02/13/24, 02/23/24 and 02/24/24.

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D 367	Continued From page 12 Review of Resident #4's March 2024 eMAR revealed there was an entry for hydrocodone 5mg-325mg every six hours as needed with documentation of the medication being administered on 03/16/24 and 03/19/24. Review of Resident #4's CSCS for March 2024 revealed there was 3 hydrocodone 5mg-325mg tablets documented as being administered on 03/16/24, 03/19/24 and 03/20/24. Refer to the interview with the MA on 03/22/24 at 2:45pm. _____ Interview with a MA on 03/22/24 at 2:45pm revealed: -She did not realize Resident #4's eMAR and CSCS were not accurate. -She admitted that she had not documented correctly on the eMAR when she had given Resident #4 controlled substance medications. -The MAs should be documenting the accurate time and date a medication had been given on the eMAR and on the CSCS. -The facility recently started an end of shift CSCS audits. Interview with the RCC on 03/22/24 at 3:50pm revealed: -She did not know Resident #4's eMAR and CSCS were not accurate. -The MAs should be documenting the accurate time and date a medication had been given on the eMAR and on the CSCS. -She did not complete any eMAR or CSCS audits. -The MAs were to complete a CSCS audit at the end of each shift. Interview with the Administrator on 03/22/23 at	D 367		

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4:30pm revealed:
-He did not know documentation on Resident #4's eMAR and CSCS was inaccurate.
-He expected the MAs to accurately document when a controlled medication was given on the eMAR and the CSCS.
-The eMAR and CSCS should have the exact same date and time the medication was administered.
-eMAR and CSCS audits had recently been started after a visit from the County Department of Social Services where it was identified the facility were not completing eMAR and CSCS accurately.
-The eMAR and CSCS audits were completed by the RCC and MA Supervisors.
-He reviewed the eMAR and CSCS audits.

3. Review of Resident #5's current FL2 dated 09/19/23 revealed diagnoses included diabetes type II, diabetic neuropathy, and hypertension.

Review of Resident #5's physician order dated 09/19/23 revealed an order for freestyle Libra sensor, apply sensor every two weeks.

Review of Resident #5's January 2024 eMAR revealed:
-There was an entry for freestyle Libra sensor, apply sensor every two weeks.
-There was documentation on 01/07/24 that the freestyle Libra sensor was on hold.
- There was documentation of the freestyle Libra sensor being applied on 01/21/24.

Review of Resident #5's February 2024 eMAR revealed:
-There was an entry for freestyle Libra sensor, apply sensor every two weeks.
-There was documentation of the freestyle Libra

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sensor being applied on 02/04/24 and 02/18/24.

Review of Resident #5's March 2024 eMAR revealed:
-There was an entry for freestyle Libra sensor, apply sensor every two weeks.
-There was documentation on 03/03/24 that the freestyle Libra sensor was on hold.
-There was documentation of the freestyle Libra sensor being applied on 03/17/24.

Interview with a medication aide (MA) on 03/22/24 at 10:44am revealed:
-She was aware that Resident #5 never received the freestyle Libra sensor.
-She said the reason Resident #5 never received the freestyle Libra sensor was due to staff not being trained on the sensor.
-MAs should not be documenting on the eMAR the freestyle Libra sensor has been placed if the sensor was not available.
-She admitted to documenting Resident #5's freestyle Libra sensor has been placed.
-She did not notify anyone that Resident #5 had not received his freestyle Libra sensor.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/22/24 at 11:23am revealed:
-The pharmacy received Resident #5's order for the freestyle Libra sensor on 01/09/23.
-The freestyle Libra sensor was not covered by Resident #5's insurance and resident would have an out-of-pocket cost of $134.65.
-The pharmacy notified the facility of insurance noncoverage on 01/21/23 with no response from the facility.

Telephone interview with a Pharmacist at Resident #5's Primary Care Provider's (PCP)

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office on 03/22/24 at 1:20pm revealed:
-He was aware that Resident #5 had not received the freestyle Libra sensor due to Resident #5 having an out-of-pocket cost for the freestyle Libra sensor.
-He did not feel Resident #5 needed or would benefit from having the freestyle Libra senor due to Resident #5's diabetes being well controlled.

Attempted telephone interview with Resident #5's PCP on 03/22/24 at 12:16pm was unsuccessful.

Interview with the RCC on 03/22/24 at 3:50pm revealed:
-She did not know Resident #5 has an order for the freestyle Libra sensor.
-She did not know MAs were signing the eMAR that Resident #5's freestyle Libra sensor had been placed when it had not.
-The MAs should be comparing the eMAR to the medications available on the medication cart.
-The MAs should not document on eMAR that Resident #5's freestyle Libra sensor had been placed when the sensor was not available.
-The MAs should have notified Resident #5's PCP or pharmacy that the freestyle Libra sensor had not been provided.
-She did not complete any chart, eMAR or cart audits.
-The facility did not run any missed medication report.
-She, the MA Supervisors and MAs were responsible for notifying residents PCPs and/or pharmacy of any missing medications or devices.

Interview with the Administrator on 03/22/24 at 4:30pm revealed:
-He did not know Resident #5's freestyle Libra sensor had not been provided.
-The RCC should have been made aware that

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D 367	Continued From page 16 Resident #5's freestyle Libra sensor had not been provided. -He expected the MAs to accurately document on the eMAR. -He expected the RCC, MA Supervisors or MAs to notify the PCP and/or pharmacy of any missing medications or devices. -The RCC and Supervisor were responsible for auditing the eMARs. -eMAR and med cart audits were to be completed by the MA Supervisors however the MA Supervisors had been working as MAs due to the facility still having staffing issues. -No eMAR or med cart audit forms were available.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able 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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 7	D 375		

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sampled residents (#5) had a physician's order to self-administer medications to treat allergy symptoms, skin irritation/rash, dandruff, and mild pain.

The findings are:

Review of Resident #5's current FL2 dated 09/19/23 revealed diagnoses included diabetes type II, diabetic neuropathy, and hypertension.

Review of Resident #5's physician orders dated 09/19/23 revealed:
-There was an order for fluticasone (used to treat allergy symptoms) 50mcg, two sprays in each nostril every morning.
-There was an order for hydrocortisone (used to treat skin irritation/rash) 2.5% lotion, apply one application topically to face twice daily as needed.
-There was an order for ketoconazole (used to treat dandruff) 2% shampoo, apply one application to scalp every other day, rinse out after five minutes.

Observation of the top of Resident #5's bedside table on 03/20/24 at 10:02 am revealed:
-There was a bottle of fluticasone 50mcg with pharmacy label but pharmacy label but no documentation of an order for self-administration.
-There was a bottle of hydrocortisone 2.5% lotion with pharmacy label but pharmacy label but no documentation of an order for self-administration.
-There was a bottle of ketoconazole 2% shampoo with pharmacy label but pharmacy label but no documentation of an order for self-administration.
-There was a bottle of over-the-counter ibuprofen (used to treat mild pain) 200 mg with no pharmacy label.

Review of Resident #5's record revealed:

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-There was not a physician's order for ibuprofen.
-There was not an order for Resident #5 to self-administer any medications.
-There was not an assessment completed for Resident #5 to self-administer any medications.

Interview with a medication aide (MA) on 03/21/24 at 5:30pm and on 03/22/24 at 10:44am revealed:
-She was aware that Resident #5 had fluticasone 50mcg, hydrocortisone 2.5% lotion and ketoconazole 2% shampoo in his room.
-She did not know Resident #5 had ibuprofen and said resident's family must have provided ibuprofen.
-She did not know Resident #5 did not have self-administration orders.
-She did know residents needed to have a self-administration order and a self-administration assessment for a resident to self-administrator any medications.
-She removed medications from Resident #5's room and stated she was going to notify the Primary Care Provider (PCP) to obtain a self-administration order if the PCP was agreeable.

Interview with the Resident Care Coordinator (RCC) on 03/22/24 at 3:50pm revealed:
-She did not know Resident #5 had medications in his room.
-She did know residents needed to have a self-administration order and a self-administration assessment for a resident to self-administrator any medications.
-She expected the MAs to know when residents had self-administration orders.
-She expected MAs to notify the PCP if medications were found in resident's room without a self-administration order and/or

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D 375	Continued From page 19 assessment. Interview with the Administrator on 03/22/24 at 4:30pm revealed: -He did not know Resident #5 had medications in his room. -Resident #5 should have had physician orders for self-administration and a self-administration assessment completed before the resident was allowed to self-medicate or be allowed keep any medications in the resident room. -He expected the MAs to know which residents had self-administration orders. -If medications were found in resident's rooms, he expected the MAs to contact the PCP. Based on observations, interviews and record reviews, Resident #5 was not interviewable.	D 375		
D 380	10A NCAC 13F .1006 (d) Medication Storage 10A NCAC 13F .1006 Medication Storage (d) Locked storage areas for medications shall only be accessible by staff responsible for medication administration, the administrator, or the administrator-in-charge. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure that the medication carts containing controlled substances were only accessible by staff responsible for medication administration creating the potential of putting all residents' health at risk. The findings are:	D 380		

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D 380	Continued From page 20 Observation of a resident's medications on hand on 02/22/24 at 1:30pm revealed: -The Activity Director (AD) approached and asked a medication aide (MA) for the second-floor bathroom key. -The MA handed the AD a key ring that contained both the second-floor bathroom key and the key for the second-floor medication carts containing controlled substances. Interview with a medication aide (MA) on 02/22/24 at 1:30pm revealed the second-floor hallway bathroom key was maintained on the same key ring as the medication carts where residents' controlled substances were located. Interview with the AD on 03/22/24 at 10:44am revealed: -She was not employed at the facility as a MA, Administrator, or an Administrator in charge. -She typically used the first-floor bathroom due to it being unlocked. -She had been employed at the facility for one year and always asked the MAs for the keys. Interview with the Administrator on 02/22/24 at 3:30pm revealed: -The bathroom key should not be maintained on the same key ring with the medication cart keys that contained controlled substances. -Staff were to be notified immediately to terminate the practice of maintaining bathroom keys on the same key ring of the medication cart keys containing controlled substances.	D 380		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of	D 392		

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controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 7 sampled residents with orders for two controlled substances to treat pain (#1) and to treat seizures (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 12/29/23 revealed:
-Diagnoses included cerebrovascular accident (stroke) and frequent falls secondary to severe neuropathy (nerve pain).
-There was an order for methadone (a medication to treat pain) 5mg, one tablet twice daily.
-There was an order for pregabalin (a medication to treat nerve pain) 75mg, one tablet twice daily.

a. Review of Resident #1's Primary Care Provider's (PCP) order dated 02/07/24 revealed an order for methadone 5mg, one tablet twice daily.

Review of Resident #1's PCP order dated 02/21/24 revealed an order for methadone 5mg, one tablet three times daily.

Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed:

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-There was an entry for methadone 5mg, one tablet twice daily at 7:00am and 7:00pm.
-Methadone 5mg, one tablet was documented as administered 45 times from 01/06/24 to 01/31/24.

Review of Resident #1's January 2024 controlled substance count sheets (CSCS) revealed:
-There was no CSCS for methadone 5mg, one tablet twice daily from 01/06/24 to 01/17/24.
-From 01/18/24 to 01/31/24 there were 7 times the medication aide (MA) who administered methadone 5mg, one tablet according to Resident #1's eMAR was not the MA who signed the CSCS.

Review of Resident #1's February 2024 eMAR revealed:
-There was an entry for methadone 5mg, one tablet twice daily at 7:00am and 7:00pm.
-The entry for methadone 5mg, one tablet twice daily was discontinued on 02/21/24.
-Methadone 5mg, one tablet twice daily was documented administered 41 times from 02/01/24 to 02/21/24.
-There was an entry dated 02/22/24 for methadone 5mg, one tablet three times daily at 7:00am, 1:00pm and 7:00pm.
-Methadone 5mg, one tablet three times daily was documented as administered 24 times from 02/22/24 to 02/29/24.

Review of Resident #1's February 2024 CSCS revealed:
-From 02/01/24 to 02/16/24 there were 8 times the MA who administered methadone 5mg, one tablet twice daily according to Resident #1's eMAR was not the MA who signed the CSCS.
-There was no CSCS for methadone 5mg, one tablet twice daily from 02/17/24 to 02/21/24.
-From 02/22/24 to 02/29/24 there were 3 times

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the MA who administered methadone 5mg, one tablet three times daily according to Resident #1's eMAR was not the MA who signed the CSCS.

Telephone interview on 03/20/24 at 3:21pm with a Pharmacist from the facility's contracted pharmacy revealed:
-Methadone 5mg, 60 tablets were dispensed for Resident #1 on 01/17/24 and 02/16/24.
-On 02/21/24 Resident #1's order for methadone 5mg was changed from one tablet twice daily to one tablet three times daily.
-Methadone 5mg, 30 tablets were dispensed for Resident #1 on 02/21/24.

Refer to the interview with a Medication Aide (MA) on 03/22/24 at 3:15pm.

Refer to the interview with the Supervisor on 03/22/24 at 3:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 03/22/24 at 3:51pm.

Refer to interview with the Administrator on 03/22/24 at 4:30pm.

b. Review of Resident #1's January 2024 eMAR revealed:
-There was an entry for pregabalin 75mg, one capsule twice daily at 7:00am and 7:00pm.
-Pregabalin 75mg, one capsule was documented as administered 52 times from 01/05/24 to 01/31/24.

Review of Resident #1's January 2024 CSCS revealed from 01/05/24 to 01/31/24 there were 18 times the MA who administered pregabalin 75mg, one capsule according to Resident #1's eMAR was not the MA who signed the CSCS.

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D 392	Continued From page 24 Review of Resident #1's February 2024 eMAR revealed: -There was an entry for pregabalin 75mg, one capsule twice daily at 7:00am and 7:00pm from 02/01/24 to 02/14/24. -The entry for pregabalin 75mg, one capsule twice daily at 7:00am and 7:00pm was discontinued on 02/14/24. -There was an entry dated 02/14/24 for pregabalin 75mg, one capsule twice daily at 6:00am and 8:00pm. -Pregabalin 75mg, one capsule was documented as administered 57 times from 02/01/24 to 02/29/24. Review of Resident #1's February 2024 CSCS revealed from 02/01/24 to 02/29/24 there were 13 times the MA who administered pregabalin 75mg, one capsule according to Resident #1's eMAR was not the MA who signed the CSCS. Review of Resident #1's March 2024 eMAR revealed: -There was an entry for pregabalin 75mg, one capsule twice daily at 6:00am and 8:00pm. -Pregabalin 75mg, one capsule was documented as administered 33 times from 03/01/24 to 03/20/24. -The entry was documented as not administered from 03/01/24 at 8:00pm to 03/04/24 at 6:00am because the resident was not in the facility. Review of Resident #1's March 2024 CSCS revealed from 03/01/24 to 03/20/24 there were 2 times the MA who administered pregabalin 75mg, one capsule according to Resident #1's eMAR was not the MA who signed the CSCS. Telephone interview on 03/22/24 at 8:36am with a	D 392		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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Pharmacist from the facility's contracted pharmacy revealed:
-Pregabalin 75mg, 30 capsules were dispensed for Resident #1 on 01/04/24.
-Pregabalin 75mg, 60 capsules were dispensed for Resident #1 on 01/17/14.
-Pregabalin 75mg, 4 capsules were dispensed for Resident #1 on 02/14/24.
-Pregabalin 75mg, 34 capsules were dispensed for Resident #1 on 02/27/24.
-Pregabalin 75mg, 22 capsules were dispensed for Resident #1 on 03/18/24.

Refer to the interview with a MA on 03/22/24 at 3:15pm.

Refer to the interview with the Supervisor on 03/22/24 at 3:20pm.

Refer to interview with the RCC on 03/22/24 at 3:51pm.

Refer to interview with the Administrator on 03/22/24 at 4:30pm.

2. Review of Resident #2's current FL2 dated 09/15/23 revealed diagnoses included hypothyroidism and schizo-affective disorder.

Review of Resident #2's signed physician orders dated 01/17/24 revealed:
-Resident had a diagnoses of seizure disorder.
-There was an order for Phenobarbital (a medication to control and prevent seizures) 64.8mg, take one tablet by mouth twice a day.

Review of Resident #2's controlled substance count sheet for January 2024 revealed there was no controlled substance count sheet.

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Review of Resident #2's controlled substance count sheet for February 2024 revealed:
-From 02/03/24-02/29/24 there were 54 opportunities for the controlled substance count sheet to be signed by the medication aide (MA) giving the Phenobarbital 64.8mg twice a day to Resident #2.
-From 02/03/24-02/29/24 there were 28 times the MA who gave the Phenobarbital 64.8mg twice a day, according to Resident #2's February 2024 MAR, was not the MA who signed the controlled substance count sheet.

Review of Resident #2's controlled substance count sheet for March 2024 revealed:
-From 03/01/24-03/20/24 there were 39 opportunities for the controlled substance count sheet to be signed by the MA giving the Phenobarbital 64.8mg twice a day to Resident #2.
-From 03/01/24-03/20/24 there were 19 times the MA who gave the Phenobarbital 64.8mg twice a day, according to Resident #2's March 2024 MAR, was not the MA who signed the controlled substance count sheet.

Telephone interview on 03/20/24 at 2:45pm with a pharmacist from the facility's contracted pharmacy revealed:
-Resident #2 had an order for Phenobarbital 64.8mg twice a day for seizures.
-The fill dates were 12/18/23 for 18 tablets, 01/03/24 for 60 tablets, 01/27/24 for 60 tablets, and 02/21/24 for 60 tablets.
-If Phenobarbital was not taken as prescribed seizures could worsen or cause a severe seizure that would be difficult to treat.
-Cart audits are completed by a Registered Nurse (RN) who consults with the pharmacy.

Telephone interview with the RN pharmacy

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consultant on 03/21/24 at 10:45am revealed:
-Each cart and cart medication was audited quarterly on all residents.
-An audit to compare controlled drugs and control substance count sheets was not done by the RN pharmacy consultant unless the facility asks for them to do it.
-This was done when a facility suspected any drug diversion.

Interview with a MA on 03/22/24 at 2:55pm revealed:
-When Phenobarbital was given to Resident #2, the MA was to sign the MAR showing the medication was given and would immediately sign the controlled substance count sheet which showed the controlled drug was given.
-There were times when the MA's forgot to sign the controlled substance count sheets and the next person coming on or the SIC's would fill in the blanks.
-The MAs did a count at the end of the shift but there were times it was not done correctly.
-We have had several in-services lately to clarify how the controlled substance count sheets were to be used.
-The January 2024 controlled substance count sheet was sent back to the pharmacy, and they discarded it, but we have now been told to put them on the resident's charts immediately after the month was over with.
-She was not aware if anyone did chart audits or not.

Interview with a second MA on 03/22/24 at 3:10pm revealed:
-If there were open places on the controlled substance count sheets she would sign off if she saw it was given, even if she was not the one who gave the medication.

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D 392	Continued From page 28 -She thought all the MA's had quit doing that since the in-service. -She thought the January 2024 controlled substance count sheet was sent back to the pharmacy but now they were to put it in the resident's chart immediately after the count was at zero. -Audits were done but she was not aware of who did them or how often. Refer to the interview with the MA on 03/22/24 at 3:15pm. Refer to the interview with the Supervisor on 03/22/24 at 3:20pm. Refer to interview with the RCC on 03/22/24 at 3:51pm. Refer to interview with the Administrator on 03/22/24 at 4:30pm. _____ Interview on 03/22/24 at 3:15pm with a MA revealed: -There were times in the past when MAs signed the CSCS for another MA because that MA forgot to sign it. -She saw blanks on the CSCS before but it should not be happening any longer. -All MAs were trained recently how to accurately document on the CSCS and the residents' eMARs but she could not recall when the training occurred. Interview with the Supervisor on 03/22/24 at 3:20pm revealed: -Since the in-service, the MAs were doing better with signing the controlled substance count sheets. -She was aware the January 2024 controlled	D 392		

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substance count sheet was sent back to the Pharmacy, and was discarded, but it would now be put in the resident's chart immediately.
-She was aware the MAs would sign the controlled substance count sheets even if they did not give the medication.
-She tried to audit the charts monthly or every other month.
-She did not do audits on the controlled substance count sheets.

Interview with the RCC on 03/22/24 at 3:51pm revealed:
-She was not aware the MAs signed the controlled substance count sheets even if they did not give the medication.
-She had heard the shift change controlled substance count was not being done but now it was done before and after each shift.
-Training was done recently by the Administrator and the Pharmacy.
-Any audits being done prior to the Department of Social Services (DSS) complaint was done by the SIC.
-Audits were to be done weekly but no documentation was sent to the RCC.
-Controlled substance count sheets were being sent back to the Pharmacy but now are placed in the resident's chart immediately after completion.

Interview with the Administrator on 03/22/24 at 4:30pm revealed:
-He was not aware the controlled substance count sheets were not being signed by the MA giving the medication.
-The person giving the medication should be signing the controlled substance count sheet because it was a requirement.
-Audits were not being done on a regular basis prior to the DSS complaint.

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D 392	Continued From page 30 -The SIC will check behind the MAs to make sure the controlled substance count sheets were signed by the MA who have the medication. -Auditing would be done by the SIC, Business Office Manager (BOM), and the RCC at least weekly with the Administrator auditing behind them. -Controlled substance count sheets were to be put on the resident's chart immediately after the medication was completed.	D 392		