STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL012038	A. BUILDING: _____ B. WING _____	03/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA'S COTTAGE FAMILY CARE HOME # 1	5820 HOLLAND STREET MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Burke County Department of Social Services conducted a Complaint Investigation on March 10, 2015 and March 11, 2015.	C 000		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: PAST CORRECTED A2 VIOLATION Based on record reviews and interviews, the facility Administrator failed to assume responsibility for the total operation of the facility and to ensure systems were in place to identify issues of noncompliance within the facility in the areas of resident rights, medication administration, and pharmaceutical care. The findings are:	C 185		

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C 185	Continued From page 1 A. Interview with the facility Administrator on 3/10/15 at 9:10am revealed: - Staff A and B (former supervisors-in-charge) had left the facility on 1/15/15 with 2 residents. - Staff A and B took the 2 residents records and all their medications, narcotic medications for Resident #1, and all the medication administration records (MARs) prior to January 2015. - Staff A had worked for the licensee of the facility for over 5 years and the Administrator had no prior concerns about Staff A. - The Administrator hadn't spent as much time at the facility in the past year as she normally would due to serious illness. - The Administrator's relative, also an Administrator came to Facility #1 (Clara's Cottage Family Care Home #1) and #2 (Clara's Cottage Family Care Home #2) weekly during the time of her illness, to assist the Administrator in the operation of the facility. - The facility Administrator was totally unaware of the diversion of narcotics from residents in the facility. - The Administrator and her husband moved into the facility fulltime on 1/15/15 to manage the facility. - The Administrator did not realize anything was wrong until the facility received a bill of $3.00 for a copayment from a physician's office facility residents do not use. - At that time, around 1/19/15, the Administrator began to "put the pieces together" concerning the scope of the diversion in the facility. - The Administrator compiled a spreadsheet documenting obtained narcotics from various pharmacies and physicians. - The Administrator had a copy of a fraudulent FL2 for a resident supposedly residing at the facility. (This FL2 contained orders for narcotic	C 185		

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C 185	Continued From page 2	C 185		

medications and was written for a resident who had never resided in the facility.)

Interview on 3/10/15 at 10:15am with the facility Administrator's relative, who filled in while the Administrator was ill, revealed:
- She was in Facility #1 and #2 every 1 to 2 weeks over the past year due to the Administrator's illness.
- "There was no way we could have known about this," (the diversion.)
- Staff A was using other pharmacies and other physicians.
- The consultant pharmacist came in, but did not check the med cart, and did not pick up on any discrepancy.
- "I checked the MARs and med cart for problems, but did not see anything unusual."

Review of an e-mail from the consultant pharmacist to the facility Administrator dated February 24, 2015 revealed:
- "Staff A did not open her med room/cart to me (consultant pharmacist) with my reviews."
- "Also (named resident who was taken from the facility by Staff A) chart was not always given to me to review.
- "I have noted in my computer the (named resident) refused to let me review her chart."
- "Staff A explained to me that as private pay resident, it was her right to not allow me to review it. I was under the impression that management was aware, and did not question." [Refer to Tag 375 10A NCAC 13G .1009(a) Pharmaceutical Care. (Type B Violation.)]

B. Based on observations, record reviews and interviews, the facility failed to assure 1 of 3 sampled residents (#1), and 2 residents with closed records who no longer reside in the facility

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C 185	Continued From page 3 were free from exploitation by diversion of their controlled medications. (Percocet, Lorazepam, and Duragesic.) [Refer to Tag 311 10A NCAC 13G .0909 Resident Rights. (Past corrected Type A2 Violation.)] C. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 3 residents (#1) sampled. (Combivent Inhaler, ProAir Inhaler, and Advair Inhaler.) [Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration.] D. Based on observations, record reviews, and interviews, the facility failed to assure provision of a adequate drug regimen review that identified medication related problems for 1 of 3 (Resident #1) residents sampled. [Refer to Tag 375 10A NCAC 13G .1009(a) Pharmaceutical Care (Type B Violation.)] _____ One 3/11/15, the facility provided the following plan of protection, already implemented, that states: -The Administrator is and will be responsible for the total care of the facility. - The police, narcotics task force, SBI, DSS, DEA, Health Care Personnel Registry have been notified of all findings within the facility from missing drugs, missing paperwork, and drug diversion. - The Administrator is living in the facility as of 1/15/15. - All missing documentation had been, or has been attempted to be obtained by the	C 185		

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C 185	Continued From page 4 Administrator. - Any missing paperwork, or paperwork requiring an update was completed. - All residents have a new FL2, care plan, and standing orders. - An Administrator will check all MARs to ensure medications are on site, and MARs properly completed. - Random chart audits will be done. - A request for monthly monitoring by a licensed pharmacist will be requested. - A refresher course regarding proper medication management for all facilities will be requested from a licensed pharmacist. - For the foreseeable future, the Administrator will manage all operations of the facility.	C 185		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: PAST CORRECTED A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to assure 1 of 3 sampled resident (#1), and 2 residents with closed records who no longer reside in the facility were free from exploitation by diversion of their controlled medications. (Percocet, Lorazepam, and Duragesic.) The findings are:	C 311		

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C 311	Continued From page 5 On March 9, 2015, a complaint was made against the facility related to abuse, exploitation and diversion of narcotic medications. A. Interview with the facility Administrator on 3/10/15 at 9:10am revealed: - Staff A and B had left the facility on 1/15/15 with 2 residents. - Staff A and B took the 2 residents' records, all their medications, narcotic medications for Resident #1, and all the medication administration records (MARs) prior to January 2015. - The Administrator hadn't spent as much time at the facility in the past year as she normally would due to serious illness. - The Administrator's relative, also an Administrator came to Facility #1 and #2 (Clara's Cottage Family Care Homes #1 and #2) weekly during the time of her illness, to assist the Administrator in the operation of the facility. - The facility Administrator was totally unaware of the diversion of narcotics from residents in the facility. - The Administrator and her husband moved into the facility fulltime on 1/15/15 to manage the facility. - The Administrator did not realize anything was wrong until the facility received a bill of $3.00 for a copayment from a physician's office facility residents do not use. (At that time, around 1/19/15, the Administrator began to "put the pieces together" concerning the scope of the diversion in the facility.) - The Administrator compiled a spreadsheet documenting obtained narcotics from various pharmacies and physicians. - The Administrator had a copy of a fraudulent FL2 for a resident supposedly residing at the	C 311		

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facility. (This FL2 contained orders for 3 narcotic medications and was written for a resident who had never resided in the facility.)

Interview on 3/10/15 at 10:15am with the facility Administrator's relative, who filled in while the Administrator was ill, revealed:
- She was in Facility #1 and #2 every 1 to 2 weeks over the past year due to the Administrator's illness.
- "There was no way we could have known about this," (the diversion.)
- Staff A was using other pharmacies and other physicians.
- The consultant pharmacist came in, but did not check the med cart, and did not pick up on any discrepancy.
- "I checked the MARs and med cart but did not see anything unusual."

Review of documentation from Facility #1 revealed:
- The medications on the fraudulent FL2 (for an individual that did not reside in the facility) dated 12/5/14 included narcotic orders for Xanax 0.5mg (an anxiolytic use to treat anxiety and panic disorders), 1 twice daily, Percocet 10/325 (Brand name Oxycodone) 1 tablet every 4 hours as needed for chronic pain, and Duragesic 50mcg patches, change every 3 days.
- Narcotic orders and copies of those narcotic orders for Percocet 10/325 and Duragesic 25mcg for 1 of the residents that was taken from the facility. (The dates on those orders were 1/16/13 and 2/26/14.)
- The copies of two of the orders dated 2/26/14 for Duragesic and Percocet had been dispensed at a pharmacy, and a line through the script, with a notation "COPY" on the face of the script.
- Someone had attempted to "white out" the line

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and the word COPY on those scripts.
- From the spreadsheet created by the Administrator, the fraudulent FL2 resident received 720 doses of Percocet 10/325 and 20 Duragesic 50mcg patches from 11/18/14 through 12/30/14. (The Xanax was not noted on the spreadsheet.)
- From the spreadsheet, one resident (who no longer resided in the facility) received 360 tablets of Percocet 10/325 from 11/18/14 through 12/12/14, and the second resident (who no longer resided in the facility) received 4874 doses of Percocet 10/325 and 300 doses of Fentanyl 25mcg patch from 9/24/13 through 1/19/15.
- Resident #1, who still resides in Facility #1, received 2410 doses of Percocet 7.5/325 and Percocet 10/325 from 10/19/12 through 12/29/14.

Interview with a law enforcement officer investigating the case on 3/11/15 at 9:13am revealed:
- The investigation was not complete.
- The charges will be related to obtaining controlled substances by fraud.
- Staff A and B would fax a copy of a narcotic order into one pharmacy, and take the other copy to another pharmacy.
- The agent hasn't had a chance to talk to the 2 residents who left the facility with Staff A and B.
- She had no evidence the Administrator was aware of drug diversion in the facility.
- The Administrator seemed to be proactive after the fact in trying to figure out what happened.
- The agent was not certain of the number of doses of narcotic involved in this diversion, but "it would be safe to say the number of doses of Oxycodone was in the thousands."

Interview with the consultant pharmacist on 3/11/15 at 3:20pm revealed:

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C 311	Continued From page 8	C 311		

- She was unaware of any drug diversion at the facility.
- She routinely checked the medication administration records and the medications available in the med cart.

Review of an e-mail from the consultant pharmacist to the facility Administrator dated February 24, 2015 revealed:
- "Staff A did not open her med room/cart to me with my reviews."
- "Also (named resident who was taken from the facility by Staff A) chart was not always given to me to review."
- "I have noted in my computer the (named resident) refused to let me review her chart."
- "Staff A explained to me that as private pay resident, it was her right to not allow me to review it. I was under the impression that management were aware, and did not question."

B. Review of Resident #1's most recent FL2 dated 9/22/14 revealed:
- Diagnoses of dementia and depression.
- An admission date of 10/3/11.

Further review of the resident's record revealed:
- An additional diagnosis of chronic obstructive pulmonary disease and a history of pancreatitis.
- A medication order dated 5/19/14 for Oxycodone 10/325 (Generic Percocet 10/325) 1 tablet every 4 hours as needed for pain, not to exceed 5 tablets per day. (Percocet is a potent narcotic analgesic.)
- A subsequent order to discontinue all Percocet on 1/19/15.
- A medication order dated 1/19/15 to continue Lorazepam 0.5mg every 6 hours as needed for anxiety and insomnia.

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C 311	Continued From page 9 Review of Resident #1's MARs for January, February, and March 2015 revealed: - An entry on all three months 2015 MARs for Lorazepam 0.5mg every 6 hours as needed for anxiety and insomnia, with 2 tablets documented as administered in January. - An entry for Oxycodone 10/325, 1 tablet every 4 hours as needed for pain on the February 2015 MAR, with a notation "discontinued 1/19/15." - There was no entry on either the January or March 2015 MAR for Oxycodone 10/325. (The second page of the January 2015 MAR that would contain the Oxycodone was not available.) Review of dispensing records from the pharmacy of contract revealed: - One hundred and fifty (150) tablets of Oxycodone 10/325 were dispensed on 9/11/14, 8/15/14, 7/15/14, 6/17/14, and 5/19/14. - Sixty (60) tablets of Lorazepam 0.5mg dispensed on 9/11/14, 6/17/14, and 5/7/14. Review of dispensing records from a local superstore pharmacy revealed: - One hundred and fifty (150) tablets of Oxycodone 10/325 were dispensed on 12/29/14, 12/3/14, 11/6/14, and 10/10/14. - Sixty (60) tablets of Lorazepam 0.5mg dispensed on 1/16/15, 12/3/14, and 11/7/14. Review of facility records revealed: - There were no MARs (Medication Administration Records) prior to January 2015 to determine if Resident #1 was administered any of the Oxycodone noted above. (Two tablets of Lorazepam were documented as administered in January 2015.) - After Staff A left the facility, Resident #1 required no narcotic pain medications.	C 311		

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C 311	Continued From page 10 Interview with the facility Administrator on 3/10/15 at 9:10am revealed: - Resident #1 had no Lorazepam 0.5mg or Oxycodone 10/325 available to administer on 1/15/15 when she moved into the facility. - The Administrator believed Staff A took Resident #1's controlled medications, Lorazepam and Oxycodone, when she left the facility on 1/15/15 and took 2 residents with her. Based on the maximum prescribed usage of the Oxycodone 10/325, and 150 tablets dispensed on 12/29/14, Resident #1 should have had at least 60 tablets remaining on 1/15/15. Review of a progress note dated 1/19/15 by the palliative care nurse practitioner (NP) revealed: - She had a lengthy discussion today with the facility's Administrator and her relative. - "(Named staff) Staff A is no longer at the facility, Resident #1's pain medications are missing, and he hasn't had any Percocet (brand Oxycodone) at least in 5 days." - "Resident #1 has not had any signs of withdrawal, and he has not shown any signs such as clinching his abdomen, facial grimace, etc of pain. Will check controlled substance registry." - Discontinue all Percocet orders, and use standing orders for pain. Interview with Resident #1's NP on 3/10/15 at 3:40pm revealed: - Staff A may have exaggerated Resident #1's pain. - Staff A told the NP Resident #1 would grimace with pain. - Resident #1 had no pain after Staff A left the facility. - The NP had some concerns about Staff A, but "I had no proof."	C 311		

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C 311	Continued From page 11 - There wasn't anything on the controlled substance registry to indicate a problem. Interview with Resident #1's family member who was also his power of attorney (POA) on 3/10/15 at 2:15pm revealed: - She visited Resident #1 twice a week and called daily. - Prior to this incident, she had no concerns with Resident #1's care in the facility. - The POA believed Resident #1 was having some pain, but "that was what Staff A was telling me." - The POA hoped Resident #1 received his medications as ordered, but now she wasn't sure if he did or not. - Staff A encouraged the POA to allow her (Staff A) to obtain Resident #1's medications from a local superstore pharmacy. - Staff A would pick up Resident #1's medications at a local superstore pharmacy, and expect the POA to pay Staff A back in cash, frequently without any receipt. - The POA was upset Resident #1 may not have received his medications. - "Resident #1 was without his medications after Staff A left (on 1/15/15), and I had to pick up and pay for all Resident #1's medications." Review of dispensing records from the local superstore pharmacy revealed they dispensed 2 prescriptions for Resident #1 on 1/16/15, his ProAir and Lorazepam 0.5mg. (ProAir is a short acting bronchodilator used to treat asthma and chronic obstructive pulmonary disease.) Interview with Resident #1 on 3/11/15 at 2:40pm revealed: - He hasn't had any pain and didn't need any pain medications.	C 311		

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C 311	Continued From page 12 - He didn't take any medications he had to ask for, (prn medications.) _____ On 3/11/15, the facility provided the following plan of protection, already implemented, that states: - The Administrator is living in the facility as of 1/15/15. - All medications are ordered by the Administrator. - The medication cart is monitored daily. - Narcotics are counted and reconciled three times a day. - Once information was determined to be incorrect (from the audits), action will be taken immediately to correct the error. - Resident #1's medications in question were audited and a discontinue order was obtained from the prescribe. - Any missing paperwork, or paperwork requiring an update was completed. - All residents have a new FL2, care plan, and standing orders. - An Administrator will check all MARs to ensure medications are on site, and MARs properly completed. - Random chart audits will be done. - A request for monthly monitoring buy a licensed pharmacist will be requested. - A refresher course regarding proper medication management for all facilities will be requested from a licensed pharmacist. - For the foreseeable future, the Administrator will manage all operations of the facility.	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration	C 330		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 13 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 3 residents (#1) sampled. (Combivent Inhaler, ProAir Inhaler, and Advair Inhaler.) The findings are: Based on observations, interviews and record reviews, the facility: - Failed to obtain a Combivent Inhaler for Resident #1 ordered on 1/20/15 and not discontinued until 3/10/15, the day of the survey. - Administered ProAir routinely for Combivent and thought it was the same medication. - Failed to obtain an Advair Inhaler for Resident #1 ordered on 2/23/15 and not discontinued until 3/2/15. Review of Resident #1's most recent FL2 dated 9/22/14 revealed: - Diagnoses of dementia and depression. - An admission date of 10/3/11. Further review of the resident's record revealed an additional diagnosis of chronic obstructive pulmonary disease (COPD).	C 330		

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C 330	Continued From page 14 Review of a signed physician's progress note dated 1/19/15 revealed an order for ProAir Inhaler, 2 puffs four times a day as needed for shortness of breath and wheezing. (ProAir is a short acting bronchodilator used to treat asthma and COPD.) Continued review of Resident #1's record revealed a hospital discharge summary dated 1/20/15 with a medication order for Ipratropium/Albuterol Inhaler (generic Combivent), 1 puff four times a day. (Combivent is a combination bronchodilator used to treat asthma and COPD.) Review of Resident #1's Medication Administration Records (MARs) for January, February, and March 2015 revealed no entry for Combivent. Review of Resident #1's MARs for January and February 2015 revealed: - A handwritten entry for ProAir, 1 puff four times a day, and scheduled for administration at 8am, 12 noon, 4pm, and 8pm. - The ProAir had been initialed as administered routinely from 1/20/15 through 2/22/15. There was no routine ProAir entry on the March 2015 MAR. Review of the resident's record revealed: - No order to change the ProAir to a routine dose. - A medication order dated 2/23/15 to change the ProAir to 2 puffs four times day as needed for shortness of breath or wheezing. - A medication order for Advair 100/50, 1 puff twice daily for COPD. (Advair is a combination inhaler containing a long acting bronchodilator and a steroid, and is used to treat asthma and	C 330		

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C 330	Continued From page 15 COPD.) Review of Resident #1's MAR for February and March 2015 revealed no entry for Advair. Interview with the facility Administrator/Medication Aide on 3/11/15 at 10:30am revealed: - Resident #1 never had any Combivent Inhaler or Advair at the facility. - She thought the ProAir was the same medication as the Combivent. - They did not obtain the Combivent or Advair from the pharmacy because the copay was too high on both medications. - She was responsible for faxing medication orders to the pharmacy. Interview with Resident #1 on 3/11/15 at 2:40pm revealed: - He was not having any shortness of breath or wheezing. - He had used an inhaler in the past for his breathing, but he was "breathing good now." - The resident was not sure which inhaler he used in the past. - As far as he knew, he received his medications as ordered by his physician. Interview with the nurse practitioner (NP) on 3/10/15 at 3:50pm revealed: - Resident #1 was doing well on just the Albuterol (ProAir) inhaler, and used it as needed. - She discontinued the Advair on 3/2/15 and ordered a Combivent Inhaler on 2/23/15. (She was not aware the Combivent had been ordered on 1/20/15 on the hospital discharge summary.) - She had wanted to try some other inhalers but the copay amounts were too expensive. - The facility called to let the NP know on 2/23/15 the Advair copayment was very expensive and	C 330		

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C 330	Continued From page 16 the family could not afford it. On 3/10/15, the NP wrote an order to discontinue the Combivent. Review of Resident #1's medications on hand on the afternoon of 3/10/15 revealed: - No Combivent or Advair. - A ProAir Inhaler, labeled 2 puffs every 4 hours as needed for shortness of breath/wheezing. Interview with the pharmacist at the facility's pharmacy of contract on 3/10/15 at 3:45pm revealed: - They had an Advair prescription of file for Resident #1 dated 2/23/15, but it was never filled due to a copay of $216.61. - They had no Combivent order for Resident #1, but the copayment on it was expensive also, (no amount specified.) Review of a dispensing record for Resident #1 from a local chain pharmacy revealed the ProAir was last dispensed on 1/16/15. Review of the MARs for January, February, and March 2015 revealed; - An order for ProAir, 2 puffs four times a day as needed for shortness of breath/wheezing. - No documented use of the prn (as needed) ProAir.	C 330		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for	C 375		

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C 375	Continued From page 17 residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure provision of a adequate drug regimen review that identified medication related problems for 1 of 3 (Resident #1) residents sampled, and 2 residents (no longer in the facility) whose medications were diverted.	C 375		

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C 375	Continued From page 18 The findings are: Review of Resident #1's most recent FL2 dated 9/22/14 revealed: - Diagnoses of dementia and depression. - An admission date of 10/3/11. Further review of the resident's record revealed an additional diagnosis of chronic obstructive pulmonary disease (COPD). A. Review of a signed physician's progress note dated 1/19/15 revealed an order for ProAir Inhaler, 2 puffs four times a day as needed for shortness of breath and wheezing. (ProAir is a short acting bronchodilator used to treat asthma and COPD.) Continued review of Resident #1's record revealed a hospital discharge summary dated 1/20/15 with a medication order for Ipratropium/Albuterol Inhaler (generic Combivent), 1 puff four times a day. (Combivent is a combination bronchodilator used to treat asthma and COPD.) Review of Resident #1's Medication Administration Records (MARs) for January, February, and March 2015 revealed no entry for Combivent. Review of Resident #1's MARs for January and February 2015 revealed: - A handwritten entry for ProAir, 1 puff four times a day, and scheduled for routine administration at 8am, 12 noon, 4pm, and 8pm. - The ProAir had been initialed as administered routinely from 1/20/15 through 2/22/15. There was no routine ProAir entry on the March	C 375		

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C 375	Continued From page 19 2015 MAR. Review of the resident record revealed no order to change the ProAir from prn (as needed) to a routine dose. Interview with the facility Administrator/Medication Aide on 3/11/15 at 10:30am revealed: - Resident #1 never had any Combivent Inhaler at the facility. - She thought the ProAir was the same medication as the Combivent. Refer to e-mail from consultant pharmacist to the Administrator on February 24, 2015. Refer to review of drug regimen review dated 2/19/15. Refer to interview with consultant pharmacist on 3/11/15 at 3:20pm. B. Further review of the resident's record revealed: - An additional diagnosis of pancreatitis. - A medication order dated 5/19/14 for Oxycodone 10/325 (Generic Percocet 10/325) 1 tablet every 4 hours as needed for pain, not to exceed 5 tablets per day. (Percocet is a potent narcotic analgesic.) - A subsequent order to discontinue all Percocet on 1/19/15. - A medication order dated 1/19/15 to continue Lorazepam 0.5mg every 6 hours as needed for anxiety and insomnia. Review of Resident #1's MARs for January, February, and March 2015 revealed: - An entry on all three months 2015 MARs for Lorazepam 0.5mg every 6 hours as needed for	C 375		

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C 375	Continued From page 20	C 375		

anxiety and insomnia, with 2 tablets documented as administered in January.
- An entry for Oxycodone 10/325, 1 tablet every 4 hours as needed for pain on the February 2015 MAR, with a notation "discontinued 1/19/15."
- There was no entry on either the January or March 2015 MAR for Oxycodone 10/325. (The second page of the January 2015 MAR that would contain the Oxycodone was not available.)

Review of dispensing records from the pharmacy of contract revealed:
- One hundred and fifty (150) tablets of Oxycodone 10/325 were dispensed on 9/11/14, 8/15/14, 7/15/14, 6/17/14, and 5/19/14.
- Sixty (60) tablets of Lorazepam 0.5mg dispensed on 9/11/14, 6/17/14, and 5/7/14.

Review of dispensing records from a local superstore pharmacy revealed:
- One hundred and fifty (150) tablets of Oxycodone 10/325 were dispensed on 12/29/14, 12/3/14, 11/6/14, and 10/10/14.
- Sixty (60) tablets of Lorazepam 0.5mg dispensed on 1/16/15, 12/3/14, and 11/7/14.

Interview with the facility Administrator on 3/10/15 at 9:10am revealed:
- Resident #1 had no Lorazepam 0.5mg or Oxycodone 10/325 available to administer on 1/15/15 when she moved into the facility.
- The Administrator believed Staff A took Resident #1's controlled medications, Lorazepam and Oxycodone, when she left the facility on 1/15/15 and took 2 residents with her.

Interview on 3/10/15 at 10:15am with the Administrator's relative who filled in while the administrator was ill, revealed the consultant pharmacist "came in, but did not pick up on any

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C 375	Continued From page 21 discrepancies." Refer to e-mail from consultant pharmacist to the Administrator on February 24, 2015. Refer to review of drug regimen review dated 2/19/15. Refer to interview with consultant pharmacist on 3/11/15 at 3:20pm. _____ Review of an e-mail from the consultant pharmacist to the facility Administrator dated February 24, 2015 revealed: - "Staff A (former supervisor-in-charge) did not open her med room/cart to me (consultant pharmacist) with my reviews." - "Also (named resident who was taken from the facility by Staff A) chart was not always given to me to review. - "I have noted in my computer the (named resident) refused to let me review her chart." - "Staff A explained to me that as private pay resident, it was her right to not allow me to review it. I was under the impression that management was aware, and did not question." Review of the drug regimen review (DRR) for Resident #1 by the consultant pharmacist dated 2/19/15 revealed: - No mention of the lack of the Combivent in the facility. - No mention of the lack of documentation of the administration of the Combivent on the January, February and March 2015 Medication Administration Records (MARs). - No mention of the routine administration of the ProAir from 1/20/15 through 2/22/15. - No mention of the diversion of Resident #1's	C 375		

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C 375	Continued From page 22 medication by Staff A. Interview with the consultant pharmacist on 3/11/15 at 3:20pm revealed: - She routinely reviewed MARs and medications in the med cart during her DRR. - She did not recall seeing an order in Resident #1's record for a Combivent Inhaler. - She was unaware of any drug diversion at the facility. _____ PLAN OF PROTECTION REQUESTED. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2015.	C 375		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the area of management of the facility and Pharmaceutical Care. The findings are:	C 912		

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C 912	Continued From page 23 A. Based on record reviews and interviews, the facility Administrator failed to assume responsibility for the total operation of the facility and to ensure systems were in place to identify issues of noncompliance within the facility in the areas of resident rights, medication administration, and pharmaceutical care. [Refer to Tag 185 10A NCAC 13G .0601(a) Management and Other Staff. (Past Corrected A2 Violation.)] B. Based on observations, record reviews, and interviews, the facility failed to assure provision of a adequate drug regimen review that identified medication related problems for 1 of 3 (Resident #1) residents sampled. [Refer to Tag 375 10A NCAC 13G .1009(a) Pharmaceutical Care (Type B Violation.)]	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents remained free from exploitation. The findings are: Based on observations, record reviews and interviews, the facility failed to assure 1 of 3 sampled residents (#1), and 2 residents who no longer reside in the facility were free from exploitation by diversion of their controlled medications. (Percocet, Lorazepam, and Duragesic.) [Refer to Tag 311 10A NCAC 13G	C 914		

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C 914	Continued From page 24 .0909 Resident Rights. (Past corrected Type A2 Violation.)]	C 914		