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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 conducted a follow up survey and complaint investigation on June 1, 2015 to June 5, 2015 with an exit conference via telephone on June 5, 2015.	{D 000}		
{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: UNABATED B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure hydro-codone/acetaminophen and Lorazepam were administered as ordered for 3 of 7 sampled residents (Resident #4, #6, and #7). The findings are: A. Review of Resident #4's current FL2 dated 5/15/15 revealed diagnoses included: -Dementia -Left hand contracture -Chronic left foot pain. -Chronic left foot drop -Osteoarthritis. -Cerebral aneurysms Continued review of Resident #4's current FL2	{D 358}		

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{D 358}	Continued From page 1 dated revealed: -Medication included Hydrocodone/APAP (Norco), 5mg/325mg, QID (four times a day), 8:00am, 12:00pm, 4:00pm and 8:00pm (given for pain). -Admission date of 3/3/09. Record review on 6/1/15 at 3:45pm of Resident #4's Alzheimer's Special Care Resident Profile revealed: -Document dated 11/28/14. -Pain management documented as a "special management need". (History of chronic pain in left foot, ankle, arm and hand post stroke. Chronic pain due to Osteoarthritis). Review on 6/1/15 of Resident #4's current physician order's dated 5/15/15 revealed Hydrocodone/APAP (Norco) 5/325mg, QID, 8am-12pm-4pm-8pm. Review of Resident #4's Electronic Medical Record (EMAR) for January 18-31, 2015 revealed: -An entry for Norco 5/325mg, take one tablet orally, QID, 8am-12pm-4pm-8pm. -There were 55 doses documented as administered out of 56 opportunities. -The one dose not administered was documented as "given to family to give later". -Eleven doses of 56 opportunities were documented as administered outside the guidelines of scheduled times with no reason given. Example: On 1/25/15 the 8:00pm dose administered at 10:00pm. Review of Resident #4's EMAR for February 2015 revealed: -An entry for Norco 5/325mg, take one tablet orally, QID, 8am-12pm-4pm-8pm.	{D 358}		

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{D 358}	Continued From page 2 -There were 110 doses documented as administered out of 112 opportunities. -Two doses were documented as not administered with no reason given. -On 2/5/15, an extra dose documented as administered at 5:22pm with no reason given. -On 2/7/15, five doses documented as administered with no reason given (No dose at 8:00am, two doses for 12:00pm and two doses for 4:00pm and one dose for 8:00pm). -Thirty-five doses of 112 opportunities were documented as administered outside the guidelines of scheduled times with no reason given. Example: On 2/19/15 the 8:00am dose administered at 10:43am. Review of Resident #4's EMAR for March 2015 revealed: -An entry for Norco 5/325mg, take one tablet orally QID 8am-12pm-4pm-8pm. -There were 111 doses documented as administered out of 124 opportunities. -Five doses were documented as "awaiting delivery" (unavailable for administration). -Five doses were documented as" resident refused" but had been unavailable for administration. -One dose was documented as" withheld per DR/RN orders" however an order could not be located and the dose had been unavailable for administration. -Two doses were documented as "given to family to give later" one dose but (3/27/15 at 9:06pm) had been unavailable for administration. -Forty-four doses of 124 opportunities were documented as administered outside the guidelines of scheduled times with no reason given. Examples: 3/4/15, the 12:00pm dose at 2:33pm and 3/28/15, the 8:00pm dose at 10:19pm..	{D 358}		

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{D 358}	Continued From page 3 Review of Resident #4's EMAR for April 2015 revealed: -An entry for Norco 5/325mg, take one tablet orally QID 8am-12pm-4pm-8pm. -There were 117 doses documented as administered out of 120 opportunities. -Three doses were not administered due to the resident being "out of facility" for 1 dose, 1 dose unavailable for administration but documented as "resident refused" and 1 dose had no reason given. -On 4/9/15, no dose administered at 8:00am and two doses documented as administered at 12:00pm. -Seventy-nine doses of 120 opportunities were documented as administered outside the guidelines of scheduled times with no reason given. Examples: 4/7/15 the 8:00pm dose at 10:24pm, 4/20/15 the 12:00pm dose at 2:41pm and 4/22/15, the 8:00am dose at 10:59am. Review of Resident #4's EMAR for May 2015 revealed: -An entry for Norco 5/325mg, take one tablet orally, QID, 8am-12pm-4pm-8pm. -There were 81 doses documented as administered out of 124 opportunities. -Forty-three doses of 124 opportunities were not administered due to 3 resident refusals, the resident being out of the facility for 8 doses, 28 doses awaiting delivery (11 doses of the 28 were documented as" resident refused" however, the doses had been unavailable for administration) and 4 doses with no reason given. -One extra dose administered on 5/30/15 with no reason given. -Ten doses of 124 opportunities were documented as administered outside the guidelines of	{D 358}		

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{D 358}	Continued From page 4 scheduled times with no reason given. Examples: 5/9/15, the 8:00am dose at 10:06am and 5/12/15 the 8:00pm dose at 10:21pm. Interview with Resident #4 on 6/1/15 at 9:30am revealed: -She was pleasant, cooperative and smiling. -She experienced difficulty expressing herself. -She had left-sided weakness especially the left arm. -She acknowledged she had pain but they (Medication Aides) gave her "pills". -The pills helped "sometimes" but unable to give details. -She had pain for a long time, but could not describe how long or how severe. Confidential staff interview on 6/1/15 at 10:45am revealed: -Resident #4 had a stroke in the past and became paralyzed on her left side. -The stroke affected her speech and it was hard to understand her at times. -She had pain medication routinely scheduled to be given at 8:00am, 12:00pm, 4:00pm and 8:00pm because she had chronic headaches and pain in her left foot, leg and arm as a result of the stroke. Interview with Staff C, Medication Aide, on 6/2/15 at 3:05pm revealed: -Resident #4 had missed multiple scheduled doses of medication, because the medication had not come from the pharmacy. -When a controlled medication didn't come from the pharmacy, it was usually because the prescriber had not sent a new prescription. -She had no knowledge of a "Refusal Policy" (when to call the prescriber if a resident is refusing their medication).	{D 358}		

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{D 358}	Continued From page 5 -She could not explain why the resident had multiple doses of medication to make up for a missed earlier scheduled dose. -Could not explain why documentation of missed doses of medication stated "Resident refused" when the medication had not been refilled by the pharmacy and was unavailable for administration. -Resident #4 "very rarely" refused her pain medication. Interview on 6/3/15 at 1:45pm with the Memory Care Manager (MCM) revealed: -The Medication Aides were to call the pharmacy if residents were without medication. -She was not aware Resident #4 had been without pain medication from 1 to 8 days on several occasions, because it had not come from the pharmacy. -She was unaware Resident #4 had pain management documented as a special management need on the Alzheimer's Special Care Resident Profile dated 11/28/15 in her record. -She was aware Resident #4 had scheduled pain medication to treat her chronic pain. -She had no knowledge of a "Refusal Policy"(when to call the prescriber if a resident is refusing their medication). -She had not notified the prescriber when Resident #4 had not received her pain medication, because she did not know the medication had not come from the pharmacy. -She could not explain why documentation of missed doses of Resident #4's scheduled narcotic medication stated, "Resident refused" when her medication had not been refilled and none available in the facility. -When a medication had not been administered and the reason stated: "Given to family to give later", she was unable to explain what that meant.	{D 358}		

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{D 358}	Continued From page 6 -She was not aware Resident #4 had missed doses of medication, had received more and/or less than the QID dosages and dosages that had more and/or less time intervals between each dose. Interview on 6/2/15 at 3:55pm with a pharmacy representative revealed: -Norco 5/325mg tablets for Resident #4 were sent to the facility on 1/21/15 (120 tablets), 2/20/15 (120 tablets), 3/27/15 (12 tablets), 3/30/15 (120 tablets) and 5/6/15 (120 tablets) -Four hundred ninety two tablets total were delivered to the facility (123 days at 4 doses per day) between 1/21/15 and 5/6/15. Interview on 6/3/15 at 2:00pm with the Administrator revealed: -Special resident needs documented on the "Alzheimer's Special Care Resident Profile" helped the facility to individualize that residents care. -She was unaware Resident #4 had pain management documented as a special management need on the Alzheimer's Special Care Resident Profile dated 11/28/15 in her record. -She was unaware the resident had been without pain medication from 1 to 8 days on several occasions because it had not come from the pharmacy. -She was unaware missed doses of medication stated "Resident refused" when the medication had not been refilled. -When a medication had not been administered and the reason stated: "Given to family to give later", she was unable to explain what that meant. -It was the responsibility of the MCM to monitor medication management and inform her of any concerns or irregularities such as unavailable	{D 358}		

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{D 358}	Continued From page 7	{D 358}		

medication.
-The prescriber of the medication should be notified when a resident refused medication two days in a row.
-She could not explain why documentation of the reason missed doses of Resident #4's scheduled narcotic medication stated "Resident refused" when the medication had not been refilled and none was in the facility.

Attempted telephone interviews with the prescribing Family Nurse Practitioner on 6/3/15 at 4:20pm and 6/4/15 at 10:20am were not returned prior to exit.

Refer to the confidential interviews with five residents.

Refer to the facility's Medication Administration Policy.

B. Review of Resident #7's current FL2 dated 5/11/15 revealed:
-Diagnoses including OBS (Organic Brain Syndrome)/Dementia and anxiety.
- Medication including Lorcet 10/325mg, one every 4 hours PRN (as needed, a pain medication) and Lorazepam 1mg TID (three times a day), PRN (as needed, an anti-anxiety medication).
-Intermittently disorientated.
-Wandering as a behavior.

Review of Resident #7's Resident Roster revealed an admission date of 5/18/15.

Observations on 6/1/15 of Resident #7 revealed he was determined not to be interviewable.

Review on 6/1/15 of Resident #7's physician's

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orders revealed an order written 5/11/15 for Lorcet 10/325mg one every 4 hours PRN (as needed).

Review of Resident #7's EMAR for May 18-31, 2015 and June 1, 2015 revealed:
-An entry for Lorcet 10/325mg, take one tablet orally, every four hours as needed.
-No Lorcet had been documented as administered.

Observation on 6/2/15 at 7:20am the shift to shift narcotic reconciliation revealed Resident #7 had no Lorcet 10/325mg tablets on hand.

Interview on 6/2/15 at 7:20am with the Medication Aides (MA's) reconciling the narcotics revealed:
-They verified there were no Lorcet 10/325mg tablets on hand for Resident #7.
-The discrepancy may have been the result of narcotic medication, if received from Resident #7's family at the time of admission, not entered into the EMAR system.
-The discrepancy may have been the result of no narcotic medication received from Resident #7's family at the time of admission.
-The Memory Care Manager (MCM) was responsible for entering the amount of narcotics brought in with a resident at admission, into the EMAR system.

Interview on 6/3/15 at 2:00pm with Resident #7's family member revealed:
-Lorcet 10/325mg had been prescribed for pain resulting from multiple surgeries (a total knee replacement, a partial knee replacement and spinal surgery).
-Prior to admission, the resident was asking for at least a pill every day for pain.
-He would take more if the person who had the

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pills would give him more.
-The person who had the pills was careful not to give him too many.
-The medication taken by the resident was put in a bag and brought to the facility at admission.
-The bag was left with the "nurses" who said they would take care of it.
-The family were not sure of what medications were in the bag and the amount of each.
-The staff did not look at what was in the bag.

Interview on 6/3/15 at 2:10pm with the Regional Operations Director and the Administrator revealed:
-When medications come from somewhere other than the facility pharmacy, the medication should be identified and counted with the MCM and with the person delivering it.
-A form is filled out identifying the medication, the dosage, and the amount.
-The deliverer and the facility staff person signed the form.
-A copy of the form went in the record and one given to the deliver.
-Prescribed medications should always be in the facility and available to the resident.

Interview on 6/3/15 at 3:45pm with the Memory Care Manager revealed:
-She was not aware of a policy/procedure regarding the handling of medication brought in by families at the time a resident was admitted.
-The Medication Aide (MA) on duty was responsible for ordering medication from the pharmacy for new residents.
-Any MA could enter medications, including narcotics, into the EMAR system.
-She had not reconciled narcotics for "at least" 2 weeks, because she just hadn't had the time to do it.

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{D 358}	Continued From page 10 Interview on 6/2/15 at 2:10pm with a representative of the facility pharmacy revealed: -The facility had sent Resident #7's FL2 to the pharmacy upon admission. -The pharmacy was instructed by Staff C to "Profile Only" (enter the resident's information into the computer, but not to send medications). -No medication had been delivered to the facility for Resident #7. Interview on 6/3/15 at 11:20am with a local pharmacy representative revealed: -A prescription for Lorcet 10/325mg tablet, orally, every 4 hours, if needed, had been filled at their pharmacy on 5/7/15. -The prescription had been written by Resident #4's primary care physician. -The prescription was filled for 180 tablets. Attempted telephone interviews with the prescribing Family Nurse Practitioner on 6/3/15 at 4:20pm and 6/4/15 at 10:20am were not returned prior to exit. Refer to the confidential interviews with five residents. Refer to the facility's Medication Administration Policy. C. Review of Resident #6's current FL2 dated 9/4/14 revealed: -Diagnoses included: dementia due to multiple etiologies with behavioral disturbance, history of a cerebral vascular accident, and hypertension. -Constantly disoriented. Review of a order for Resident #6 dated 12/1/14	{D 358}		

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revealed lorazepam (used to treat anxiety) paste apply to arm every 12 hours as needed for anxiety.

Review of an order for Resident #6 dated 1/28/15 revealed "Stop Xanax (medication used to treat anxiety)-only use [lorazepam twice daily] the paste please."

Review of an order for Resident #6 dated 5/5/15 revealed "Apply only one [milliliter] twice a day of [lorazepam] no more than that."

Telephone interview with Resident #6's Primary Care Provider's (PCP) nurse on 6/3/15 at 2:15pm revealed:
-Original order on 12/1/14 was for lorazepam gel 0.5mg/ml twice daily as needed.
-On 3/13/15 a prescription was renewed for lorazepam 0.5mg/ml gel twice daily as needed.
-On 5/5/15 a prescription was renewed for lorazepam 0.5mg/ml gel twice daily as needed.

Review of Resident #6's January 2015 EMAR revealed:
-An entry for Lorazepam 0.5mg/ml gel apply topically to arm every twelve hours as needed for anxiety with an order origination date of 12/2/14.
-Documented as administered 7 occurrences for "agitation."
-An entry for Lorazepam 0.5mg/ml gel apply topically to arm twice a day at 8am and 8pm with an order origination date of 1/30/15.
-Documented as "Given to family to give later" for 1 occurrence on 1/30/15.

Review of Resident #6's February, March, April, May, and June 2015 EMAR's revealed:
-An entry for Lorazepam 0.5mg/ml gel apply topically to arm twice a day at 8am and 8pm.

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{D 358}	Continued From page 12 -Documented as administered 172 occurrences. -There was no documented reason/justification for the lorazepam administrations. Observation of Staff B, Medication Aide, during the morning medication pass on 6/2/15 at 8:39am revealed: -Staff B administered lorazepam gel onto Resident #6's left arm. -Staff B administered the appropriate dose utilizing appropriate infection control measures. Observation of Resident #6 on 6/2/15 at 8:39am revealed: -The resident was calmly watching television seated on a couch with another resident. -The resident did not appear agitated. -The resident was determined not to be interviewable. Interview with the Administrator on 6/4/15 at 1:30pm revealed: -The Memory Care Manager is responsible for ensuring EMAR accuracy. -By policy the EMARs should be checked daily. Interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm revealed: -A medication order comes in from a medical provider. -The Memory Care Manager looks at the order and we fax it to the facility pharmacy. -The facility pharmacy enters the medication order into the EMAR for the resident. -Once the pharmacy entered the order, the Memory Care Manager checked the order in the EMAR for accuracy. Interview with the Memory Care Manager on 6/4/15 at 2:05pm revealed:	{D 358}		

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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
{D 358}	Continued From page 13 -The Medication Aides were not showing her all the new orders. -If the Medication Aides did not give her the orders she would have had no way of knowing the EMAR needed to be changed. -If she received an order for a resident, she went in "that day" and changed it. -There was no routine reconciliation process by any staff where each residents orders were checked against their EMAR entries. Attempted telephone interviews with Resident #6's Primary Care Provider were not returned by exit. Refer to the confidential interviews with five residents. Refer to the review of the facility's Medication Administration Policy. _____ Confidential interviews with five residents revealed: -5 of 5 residents had no complaints about how their medications were being administered. -4 of 5 residents had no issues with medication availability. -5 of 5 resident received as needed medications timely and with effective relief. Review of the facility's Medication Administration Policy revealed: -Medications, both prescription and non-prescription, will be administered in accordance with the prescribing practitioner's orders. -The Medication Administration Record (MAR) will include the reason for use and results of use to the resident for as needed medications.	{D 358}		

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{D 358}	Continued From page 14 The facility provided a plan of protection on 6/3/15 and included: -A regional care team will be assembled and brought into the community as soon as possible to audit every resident chart and MAR. This team will consist of experienced Executive Directors and Care Managers. All medication administration orders will be verified and brought into compliance as quickly as possible. -All Medication Aides will be retrained on medication administration on Thursday, June 4, 2015 by the facility RN consultant. -The Executive Director and Memory Care Manager will perform random resident chart and MAR audits daily for one week and three times per week for one month thereafter. DATE OF CORRECTION PROVIDED BY THE FACILITY FOR THE UNABATED TYPE B VIOLATION JUNE 12, 2015.	{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; (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;	D 367		

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D 367	Continued From page 15 (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 interview and record review, the facility failed to assure Electronic Medication Administration Records (EMARs) were accurate and complete for 1 of 7 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 4/14/15 revealed diagnoses included vascular dementia, memory loss, and adenocarcinoma. Review of a physician's order for Resident #2 dated 5/21/15 revealed lorazepam saline gel (used for agitation) 1mg/ml apply 2mg topically every 4 hours as needed for agitation monitor for sedation. Review of a physician's order for Resident #2 dated 5/30/15 revealed: -Discontinue lorazepam saline gel 1mg/ml apply 2mg every 4 hours as needed for agitation. -Lorazepam gel 2mg/ml apply 1ml as needed every 2 hours for agitation. Review of Resident #2's May 2015 EMAR revealed: -An entry for lorazepam 1mg/ml gel apply 2mg topically every two hours as needed for agitation	D 367		

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with an origination date of 5/28/15.
-An entry for lorazepam 1mg/ml gel apply 2mg topically every four hours as needed for agitation with an origination date of 5/26/15.
-No entry for lorazepam gel 2mg /ml 1ml as needed every 2 hours
-On 5/27/15, 3 occurrences of 2mg doses of lorazepam 1mg/ml was documented as administered.
-On 5/28/15, 2 occurrences of 2mg doses of lorazepam 1mg/ml was documented as administered.
-On 5/29/15, 2 occurrences of 2mg doses of lorazepam 1mg/1ml was documented as administered.

Review of Resident #2's June 2015 EMAR revealed :
-An entry for lorazepam 1mg/ml gel apply 2mg every two hours as needed for agitation.
-No documented administrations.

Interview with the Administrator on 6/4/15 at 1:30pm revealed:
-The Memory Care Manager is responsible for ensuring EMAR accuracy.
-By policy the EMARs should be checked daily.

Interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm revealed:
-A medication order comes in from a medical provider.
-The Memory Care Manager looks at the order and "we fax it" to the facility pharmacy.
-The facility pharmacy enters the medication order into the EMAR for the resident.
-Once the pharmacy enters the order, the Memory Care Manager checked the order in the EMAR for accuracy.

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D 367	Continued From page 17 Interview with the Memory Care Manager on 6/4/15 at 2:05pm revealed: -The Medication Aides were not showing her all the new orders. -If the Medication Aides did not give her the orders she would have had no way of knowing the EMAR needed to be changed. -If she received an order for a resident, she went in "that day" and changed it. -There was no routine reconciliation process by any staff where each residents orders were checked against their EMAR entries.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure an accurate reconciliation record for six controlled medications (alprazolam, fentanyl, hydrocodone/acetaminophen, lorazepam, and zolpidem) prescribed for 6 of 7 sampled residents with orders for controlled medications (Resident #1, #2, #3, #5, #6, and #7). The findings are: Review of the current census revealed there were	D 392		

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D 392	Continued From page 18 49 residents who resided in the facility which was a special care unit for Alzheimer's and dementia care. Observation on 6/2/15 at 7:20am of a two staff narcotic reconciliation of the medication carts revealed: -There were 13 narcotic discrepancies on the 100 hall medication cart which affected 9 residents. -There were 24 narcotic discrepancies on the 200-300 hall medication cart which affected 19 residents. Review of the facility Narcotic Discrepancy Logs dated 4/29/15 to 6/1/15 revealed: -Daily narcotic discrepancies were documented affecting multiple residents. -On multiple occasions, the narcotic discrepancies were documented as having been verified by only one staff member (5/9/15, 5/11/15, 5/21/15, 5/31/15, and 6/1/15). A. Review of Resident #3's current FL2 dated 4/29/15 revealed: -Diagnoses included: progressive dementia, severe depression, diabetes, hypertension, and weight loss. -An order for alprazolam 0.25mg 1 tab three times a day as needed for anxiety. Record review revealed Resident #3 was admitted to the facility on 4/29/15. Observation of Staff C, Medication Aide, during medication pass on 6/1/15 at 11:11am revealed: -Staff C stated "I am just getting ready to give an [as needed] medication to [Resident #3's name]." -She took a bottle of alprazolam 0.25 mg tablets labeled with Resident #3's name out of the locked narcotic drawer in the medication cart.	D 392		

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D 392	Continued From page 19 -She tapped one tablet from the bottle into a paper souffle cup and then emptied the remaining tablets in the bottle onto a pill counter on top of the medication cart. -She proceeded to count all the alprazolam tablets and then poured them back into the bottle and placed the bottle back into the locked narcotic storage on the cart. -She then entered the number counted into the EMAR system. Interview with Staff C on 6/1/15 at 11:13am revealed: -When surveyor asked Staff C why she was counting the remaining tablets she stated "I always double check myself and recount them." -When asked had she counted with the off going shift that morning when she took possession of the keys to the cart she stated "Yes." -When asked was she the only one of the staff in possession of the medication cart keys she stated "Yes." Observation of Staff C on 6/1/15 at 11:15am revealed: -A staff person came into the medication room asking for her assistance. -Staff C took the paper souffle cup with the alprazolam tablet with her as she left the room where the medication cart was located. -At 11:21am, she returned back to the medication cart without the souffle cup. Interview with Staff C on 6/1/15 at 11:20am revealed: -She had already administered the alprazolam tablet to Resident #3. -She was unaware the surveyor needed to observe the medication actually being taken by the resident.	D 392		

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D 392	Continued From page 20 Observation of Resident #3 on 6/1/15 at 11:32am revealed: -The resident sat calmly on his bed. -Resident #3 was determined not to be interviewable. Review of Resident #3's May 2015 Electronic Medication Administration Record (EMAR) revealed: -An entry for alprazolam 0.25mg 1 tablet three times a day as needed for anxiety. -On 5/5/15, one documented administration. Review of Resident #3's June 2015 EMAR revealed: -An entry for alprazolam 0.25 mg 1 tablet three times a day as needed for anxiety. -On 6/1/15, one documented administration . -On 6/2/15, two documented administrations. Observation of Resident #3's medications on hand on 6/3/15 at 8:42am revealed: -There were 86 alprazolam tablets on hand for the resident in the medication cart. -The alprazolam tablets were in a bottle filled by an outside pharmacy. -The bottle label directions were alprazolam 0.25mg 1 tablet four times a day as needed for anxiety. -Original prescription was dated 3/30/15. -Fill date 4/29/15 with 4 refills remaining. -Quantity dispensed on 4/29/15 was 120 tablets. Interview with at pharmacist at a local pharmacy on 6/3/15 at 8:58am which had filled the alprazolam 0.25mg tablets for Resident #3 revealed 120 tablets were dispensed on 4/29/15 and there were 4 refills left on the prescription.	D 392		

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Review of Resident #3's alprazolam Inventory History revealed:
-On 4/30/15, two staff reconciliation at 10:56pm 0 documented for supply on hand.
-On 6/1/15 at 11:14am, delivery of 88 tablets entered (during observed medication pass on 6/1/15).

Review of Resident #3's record revealed:
-A total of 120 alprazolam had been dispensed from a local pharmacy on 4/29/15.
-4 tablets were documented as administered to the resident in May and June 2015.
-86 were on hand in the medication cart.
-A discrepancy of 30 alprazolam tablets.
-There was no documentation of any tablets returned to the pharmacy.

Interview with Resident #3's family member on 6/3/15 at 3:55pm revealed:
-As far as she knew there were no problems with the residents medications.
-"He only gets the [alprazolam] when I'm here and I go ask for it for him."

Refer to the review of the Medication Aide job description.

Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm.

Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm.

Refer to the interview with the Administrator on 6/1/15 at 5:16pm.

Refer to the interview with the Administrator on 6/1/15 at 5:45pm.

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D 392	Continued From page 22 Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm. Refer to interview with the Administrator on 6/3/15 at 9:44am. Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. B. Review of Resident #2's current FL2 dated 4/14/15 revealed: -Diagnoses included: vascular dementia, memory loss, and adenocarcinoma. -An order for lorazepam 1mg 1 to 2 tablets as directed. Record review for Resident #2 revealed the resident was admitted to the facility on 4/15/15. 1. Review of Resident #2's April 2015 EMAR revealed: -There was no entry for lorazepam. -There were no documented administrations of lorazepam during April 2015. Review of a physician's order for Resident #2 dated 5/5/15 revealed lorazepam 0.5mg 2 tablets as needed for agitation. Review of Resident #2's May 2015 EMAR revealed: -An entry for lorazepam 0.5mg take 2 tablets (1mg) twice a day as needed for agitation.	D 392		

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-Eight documented administrations (5/9/15, 5/10/15, 5/11/15, 5/14/15, 5/16/15, 5/19/15, 5/20/15, and 5/23/15).
-13 lorazepam 0.5mg tablets documented as administered.

Review of Resident #2's June 2015 EMAR revealed no documented administrations of lorazepam 0.5mg tablets

Observation of Resident #2's lorazepam on hand in the facility on 6/2/15 at 9:45am revealed:
-One bottle of lorazepam 0.5mg containing 40 tablets (tablets were uniform in size, shape, and color) that was filled by a local pharmacy.
-The label directions on the bottle were lorazepam 0.5mg take 1 tablet sublingual as needed three times a day.
-30 tablets were dispensed on 4/15/15.
-One bubble pack of lorazepam 0.5mg filled by the facility pharmacy containing 24 tablets.
-The label directions on the bubble pack were lorazepam 0.5mg take 2 tablets twice a day as needed for agitation.

Review of the facility pharmacy dispensing record for Resident #2 revealed lorazepam 0.5mg 30 tablets were sent to the facility on 5/7/15.

Telephone interview with the local pharmacy on 6/2/15 at 11:00am that had dispensed the lorazepam 0.5mg tablets for Resident #2 revealed:
-The order was for lorazepam 0.5mg 1 tablet 3 times daily prn agitation.
-30 tablets were dispensed on 4/15/15.

Interview with Staff B, Medication Aide, on 6/2/15 at 9:47am revealed:
-The bottle of lorazepam 0.5mg tablets filled by

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the local pharmacy had been brought in by the family when Resident #2 was admitted.
-She was unsure why there were 40 tablets in the bottle when the label documented 30 tablets were dispensed.
-She was unsure what the extra 10 tablets might be that were stored in the bottle.

Review of the Inventory History for Resident #2's lorazepam 0.5mg tablets revealed:
-There was no documented supply of lorazepam 0.5mg tablets brought in by the family on 4/15/15.
-A supply entry was documented on 5/8/15 for a delivery of 30 tablets from the facility pharmacy.

Review of an entry for Resident #2 on the Narcotic Count Discrepancy Form dated 6/2/15 revealed:
-There were 24 tablets of lorazepam 0.5mg tablets on hand.
-There were 17 tablets documented as the quantity available in the EMAR for the resident.

Review of Resident #2's record revealed a discrepancy of 57 lorazepam 0.5mg tablets.

Telephone interview with Resident #2's family member on 6/1/15 at 1:32pm revealed:
-The family had been sitting with the resident 24 hours a day 7 days a week.
-He stated staff had been "pretty good about" administering the resident's medications.
-As far as he knew, the resident had received the lorazepam as ordered by the physician.
-The care the resident had received had been "above standard."

Interview with a second family member of Resident #2 on 6/1/15 at 2:30pm revealed:
-There had been only one incident when the

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family member had asked for anxiety medication for Resident #2 three times before it was administered by the Medication Aide an hour and a half later.
-The family member had spoken with the Administrator about the incident and there had been no problems since.
-"Very responsive staff."

Refer to the review of the Medication Aide job description.

Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm.

Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm.

Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm.

Refer to the interview with the Administrator on 6/1/15 at 5:16pm.

Refer to the interview with the Administrator on 6/1/15 at 5:45pm.

Refer to interview with the Administrator on 6/3/15 at 9:44am.

Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am.

Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager.

Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm.

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2. Review of a physician's order for Resident #2 dated 5/26/15 revealed fentanyl 12mcg/hr (used to control pain) transdermal patch apply 1 patch every 72 hours.

Review of Resident #2's May 2015 EMAR revealed:
-An entry for fentanyl 12mcg/hr apply 1 patch topically every 72 hours at 8am.
-On 5/30/15, one patch documented as administered.

Review of Resident #2's June 2015 EMAR revealed:
-An entry for fentanyl 12mcg/hr apply 1 patch topically every 72 hours at 8am.
-No documented administrations.

Observation of Resident #2's fentanyl 12mcg/hr patches on hand in the facility on 6/2/15 at 9:50am revealed:
-There was 1 unopened box containing 5 patches.
-There was 1 open box containing 3 patches.
-The boxes of patches had been provided by a local pharmacy.

Review of the Inventory History for Resident #2 for the fentanyl 12 mcg patches revealed:
-On 5/27/15, a documented delivery of 10 patches.
-On 5/30/15, a documented administration of 1 patch.
-No other documented occurrences of administration.

Review of an entry for Resident #2 on the Narcotic Count Discrepancy Form dated 6/1/15 revealed:
-There were 8 fentanyl patches on hand.

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D 392	Continued From page 27 -There were 9 fentanyl patches documented as the quantity available in the EMAR for the resident. Review of Resident #2's record revealed no documented return of a fentanyl patch to the pharmacy. Review of Resident #2's record revealed a discrepancy of 1 fentanyl 12mcg/hr. patch. Interview with the Memory Care Manager on 6/2/15 at 10:45am revealed: -The fentanyl patch was administered to Resident #2 on 5/27/15, even though it was not documented on the EMAR. -"I'm not sure why it wasn't documented as administered." -She was unable to find documentation of staff disposal of any patches for the resident. -Two staff were supposed to witness and document the disposal of a fentanyl patch per facility policy. Refer to the review of the Medication Aide job description. Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm. Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm. Refer to the interview with the Administrator on 6/1/15 at 5:16pm. Refer to the interview with the Administrator on 6/1/15 at 5:45pm.	D 392		

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D 392	Continued From page 28 Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm. Refer to interview with the Administrator on 6/3/15 at 9:44am. Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. 3. Review of a physician's order for Resident #2 dated 5/21/15 revealed lorazepam saline gel (used for agitation) 1mg/ml apply 2mg topically every 4 hours as needed for agitation. Review of a physician's order for Resident #2 dated 5/30/15 revealed: -Discontinue lorazepam saline gel 1mg/ml apply 2mg every 4 hours as needed for agitation. -Lorazepam gel 2mg/ml apply 1ml as needed every 2 hours for agitation. Review of Resident #2's May 2015 EMAR revealed: -An entry for lorazepam 1mg/ml gel apply 2mg topically every two hours as needed for agitation with an origination date of 5/28/15. -An entry for lorazepam 1mg/ml gel apply 2mg topically every four hours as needed for agitation with an origination date of 5/26/15. -No entry for lorazepam gel 2mg /ml 1ml as needed every 2 hours for agitation. -On 5/27/15, 3 occurrences of 2mg doses of lorazepam 1mg/ml were documented as administered.	D 392		

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D 392	Continued From page 29 -On 5/28/15, 2 occurrences of 2mg doses of lorazepam 1mg/ml were documented as administered. -On 5/29/15, 2 occurrences of 2mg doses of lorazepam 1mg/1ml were documented as administered. Review of Resident #2's June 2015 EMAR revealed no documented doses of lorazepam gel of either strengh administered to the resident. Observation of Resident #2's medications on hand in the facility on 6/2/15 at 9:45am revealed: -There was no lorazepam gel 1mg/ml strength available. -There was 16ml of lorazepam 2mg/ml gel on hand (8ml in 2 syringes). Review of an entry for Resident #2 on the Narcotic Count Discrepancy Form dated 6/2/15 revealed: -Lorazepam gel quantity on hand 16. -Lorazepam gel quantity in EMAR -1. Telephone interview on 6/2/15 at 3:50pm with the local pharmacy that filled prescription dated 5/21/15 for lorazepam saline gel for Resident #2 revealed: -They had dispensed 60ml of lorazepam 1mg/ml strenth on 5/21/15 for Resident #2. -The order allowed the resident to have 2ml per day. Telephone interview with a pharmacist on 6/2/15 at 11:15am with a second local pharmacy that filled a prescription dated 5/30/15 for lorazepam gel 2mg/ml apply 1 ml as needed every 2 hours for agitation revealed: -A Hospice nurse had called in an order for the lorazepam 2mg/ml every 2 to 4 hours.	D 392		

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-The resident needed enough to get through that weekend, so he compounded 3 syringes of 10ml 2mg/ml strength lorazepam gel for a total of 30ml on 5/30/15.

Review of Resident #2's record revealed:
-A total of 90 ml of lorazepam gel had been dispensed for Resident #2 on 5/21/15 and 5/30/15 by two separate pharmacies.
-14ml of lorazepam 1mg/ml was documented as administered to the resident.
-16ml of lorazepam 2mg/1ml strength gel was on hand in the medication cart.
-No documented return of any lorazepam gel to the pharmacy.
-A discrepancy of 60ml of lorazepam gel.

Confidential interview with an outside supportive services provider revealed:
-Resident #2 had been very agitated the prior week "getting up and down from couch to bed."
-The provider then informed the medication aide on duty at the time of the residents agitation and family's concern.

Refer to the review of the Medication Aide job description.

Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm.

Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm.

Refer to the interview with the Administrator on 6/1/15 at 5:16pm.

Refer to the interview with the Administrator on 6/1/15 at 5:45pm.

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D 392	Continued From page 31 Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm. Refer to interview with the Administrator on 6/3/15 at 9:44am. Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. C. Review of Resident #6's current FL2 dated 9/4/14 revealed: -Diagnoses included: dementia due to multiple etiologies with behavioral disturbance, history of a cerebral vascular accident, and hypertension. -Constantly disoriented. Review of a order for Resident #6 dated 12/1/14 revealed lorazepam (used to treat anxiety) paste apply to arm every 12 hours as needed for anxiety. Review of an order for Resident #6 dated 1/28/15 revealed "Stop Xanax (medication used to treat anxiety)-only use [lorazepam twice daily] the paste please." Review of an order for Resident #6 dated 5/5/15 revealed "Apply only one [milliliter] twice a day of [lorazepam] no more than that." Telephone interview with Resident #6's Primary Care Provider's (PCP) nurse on 6/3/15 at 2:15pm revealed:	D 392		

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D 392	Continued From page 32 -Original order on 12/1/14 was for lorazepam gel 0.5mg/ml twice daily as needed. -On 3/13/15 a prescription was renewed for lorazepam 0.5mg/ml gel twice daily as needed. -On 5/5/15 a prescription was renewed for lorazepam 0.5mg/ml gel twice daily as needed. Review of Resident #6's January 2015 EMAR revealed: -An entry for Lorazepam 0.5mg/ml gel apply topically to arm every twelve hours as needed for anxiety with an origination date of 12/2/14. -Documented as administered 7 occurrences for "agitation." -An entry for Lorazepam 0.5mg/ml gel apply topically to arm twice a day at 8am and 8pm with an order origination date of 1/30/15. -Documented as "Given to family to give later" for 1 occurrence on 1/30/15. Review of Resident #6's February, March, April, May, and June 2015 EMAR's revealed: -An entry for Lorazepam 0.5mg/ml gel apply topically to arm twice a day at 8am and 8pm. -Documented as administered 172 occurrences. -There was no documented reason/justification for the lorazepam administrations. Observation of Staff B, Medication Aide, during the morning medication pass on 6/2/15 at 8:39am revealed: -Staff B administered lorazepam gel onto Resident #6's left arm. -Staff B administered the appropriate dose utilizing appropriate infection control measures. Observation of Resident #6 on 6/2/15 at 8:39am revealed: -The resident was calmly watching television seated on a couch with another resident.	D 392		

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-The resident did not appear agitated.
-The resident was determined not to be interviewable.

Review of Resident #6's pharmacy review recommendation dated 1/6/15 revealed:
-"Please clarify the following order to help us meet assisted living guidelines."
-"Lorazepam 0.5mg/ml gel. Apply topically to arm every 12 hours as needed for anxiety not to exceed 2 (handwritten in) doses in 24 hours."

Total documented administrations of Lorazepam 0.5mg/ml gel for Resident #6 from January 2015 to June 3, 2015 was 186ml.

Observation on 6/3/15 at 10:40am of Resident #6's supply of Lorazepam gel on the medication cart revealed:
-4-10ml syringes of Lorazepam 0.5mg/ml gel containing a total of 28.6 ml of medication.
-Each syringe was labeled with the correct concentration of the medication and all 4 syringes were in a zippered plastic bag labeled with a pharmacy label complete with Resident #6's name, prescription number, dispense date of 5/4/15, and total dispensed of 60ml, and 3 refills remained before 11/3/15.

Telephone interview with the local pharmacy, on 6/3/15 at 11:35am,who had compounded the Lorazepam 0.5mg/ml gel for Resident #6 revealed:
-They had two prescriptions in their system for Resident #6.
-One prescription was dated 12/1/14 and it was for Lorazepam 0.5mg/ml gel apply topically to arm every 12 hours as needed for anxiety not to exceed 2 doses in 24 hours.
-The second prescription was dated 5/4/15 and it

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was for Lorazepam 0.5mg/ml gel apply topically to arm every 12 hours as needed for anxiety not to exceed 2 doses in 24 hours.
-The prescriptions from the physician had only been written to be used as needed.
-On 12/1/14, 60ml of Lorazepam 0.5mg/ml gel had been dispensed for Resident #6 (off original script 12/1/14).
-On 3/5/15, 60ml of Lorazepam 0.5mg/ml gel had been dispensed for Resident #6 (off original script 12/1/14).
-On 5/4/15, 60ml of Lorazepam 0.5mg/ml gel had been dispensed for Resident #6 (new script dated 5/4/15).
-The total amount of Lorazepam 0.5mg/ml gel dispensed for Resident #6 was 180ml.

Review of Resident #6's record revealed a discrepancy of 37.6ml of lorazepam 0.5mg/ml gel.

Attempted telephone interview with the guardian of Resident #6 on 6/4/15 at 11:33am was not returned by exit.

Attempted telephone interview with Resident #6's Primary Care Provider was not returned by exit.

Refer to the review of the Medication Aide job description.

Refer to the interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm.

Refer to the interview with the Administrator on 6/1/15 at 5:16pm.

Refer to the interview with the Administrator on 6/1/15 at 5:45pm.

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D 392	Continued From page 35 Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm. Refer to interview with the Administrator on 6/3/15 at 9:44am. Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. D. Review of Resident #1's current FL2 dated 12/15/14 revealed: -Diagnoses included multi-infarct dementia and degenerative joint disease. -An order for zolpidem 5mg (used to treat insomnia) one tablet daily at bedtime. Observation of Resident #1's zolpidem on hand in the facility on 6/1/15 at 3:25pm revealed: -There were 6 doses available on the medication cart. -The prescription was filled by an outside pharmacy. -According to the label, 30 tablets were last dispensed on 4/5/15 with one refill left on the prescription. Review of the Electronic Medication Administration Record (EMAR) control history for the zolpidem 5mg for Resident #1 documented 5 doses available for use. Telephone interview on 6/2/15 at 4:50pm with the local pharmacy who filled the prescription for zolpidem for Resident #1 revealed:	D 392		

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D 392	Continued From page 36 -30 tablets were dispensed on 2/3/15, 3/2/15, 4/5/15, and 5/4/15. -The directions were for 1 tablet daily at bedtime. Review of Resident #1's February, March, April, May, June 2015 EMAR's revealed 119 doses of zolpidem were documented as administered. Review of Resident #1's zolpidem inventory history revealed on 3/5/15 at 6:37pm a mathmatical error occurred when staff entered 30 tablets with 4 remaining and entered the count as 35 causing a narcotic discrepancy of 1 tablet. Interview with Resident #1 on 6/1/15 at 8:49am revealed she would know if she had not received the medication she took at night to help her sleep. Refer to the review of the Medication Aide job description. Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm. Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm. Refer to the interview with the Administrator on 6/1/15 at 5:16pm. Refer to the interview with the Administrator on 6/1/15 at 5:45pm. Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm. Refer to interview with the Administrator on 6/3/15 at 9:44am.	D 392		

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D 392	Continued From page 37 Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. E. Review of Resident #5's current FL2 dated 6/3/14 revealed: -Diagnoses included: dementia, anxiety, asthma and depression. -An order for Lorazepam 0.5mg tablet, one orally, every 8 hours as needed for anxiety. Record review for Resident #5 revealed: -The resident was admitted to the facility on 1/14/13. -She was admitted to Hospice on 1/6/15. -She had T-11, T-12 and L-1 fractures of undetermined age. -She expired on 3/30/15. Review of an order for Resident #5 dated 2/3/15 by the Primary Care Provider (PCP) revealed: -Lorazepam 0.5mg tablets, take 1 tablet orally every eight hours as needed for anxiety. -Hydrocodone/APAP 5/325mg tablets, take 1/2 tablet by mouth every 4 hours as needed for pain (tablets already broken). 1. Review of Resident 5's February 2015 and March 2015 EMAR revealed: -An entry for Lorazepam 0.5mg tablets, take 1 tablet orally every eight hours as needed for anxiety. -No Lorazepam had been documented as administered.	D 392		

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Review of Resident #5's Inventory History for Lorazepam 0.5mg tablet revealed:
-2/17/15, 28 tablets were documented on hand prior to the deliveries from the pharmacy.
-2/17/15, 30 tablets logged in as delivered from the facility pharmacy.
-3/27/15, 30 tablets logged in as delivered from the facility pharmacy.
-3/30/15, (Resident expired at 10:05am) - 88 tablets on hand.

Telephone interview with a representative from the facility pharmacy on 6/3/15 at 10:50am revealed:
-2/17/15, 30 tablets were delivered to the facility for Resident #5.
-3/24/15, 60 tablets were delivered to the facility.
-3/27/15, 15 tablets were delivered to the facility.
-3/27/15, 105 tablets total had been delivered to the facility from the pharmacy.
-4/1/15, 60 Lorazepam 0.5mg tablets were returned to the pharmacy.

Review of Resident #5's record revealed:
-2/17/15, 88 Lorazepam 0.5mg tablets was the documented supply on hand.
-3/27/15, 105 tablets total had been documented as dispensed by the pharmacy.
-4/1/15, 60 tablets were documented as returned to the pharmacy.
-6/2/15, there was a discrepancy of 73 Lorazepam 0.5mg tablets.

Review on 6/2/15 at 10:50am of a copy of a "Returned Drug Credit Form" in Resident #5's record revealed 60 Lorazepam 0.5mg tablets were returned to, and received by, the facility pharmacy on 4/1/15.

Interview on 6/2/15 at 8:00am with Staff B,

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D 392	Continued From page 39 Medication Aide, revealed: -She did not know why the amounts of Resident #5's Lorazepam entered into the EMAR did not match the amounts sent from the pharmacy. -She did not know why deliveries had not been documented correctly into the EMAR. -When controlled medication came from the pharmacy, the Medication Aide on duty had a witness watch the narcotic count and log their name into the EMAR system as the witness. -She did not know why there was no witness documented for those deliveries. -When narcotics were sent back to the pharmacy, the Memory Care Manager (MCM) and the Lead Supervisor in Charge (LSIC), a Medication Aide (MA), counted the medication together and both signed the "Returned Drug Credit Form" that went back to the pharmacy with the drugs. -A copy of the completed "Returned Drug Credit Form" was placed in the resident's record. Interview on 6/3/15 at 1:45pm with the MCM revealed: -She was unaware Resident #5's narcotic reconciliation revealed unaccounted for medication. -She was responsible for monitoring the Medication Aides and for overseeing medication administration and narcotic reconciliation. -She had not monitored or reconciled the narcotic discrepancies in "about 2 weeks". -Reconciliation should have been done on a daily basis. -She was aware there were residents who had been there several weeks and not had their narcotics entered into the EMAR system. -She could not explain why the reconciliation's had not been done especially with the number of narcotic discrepancies.	D 392		

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D 392	Continued From page 40 Interview on 6/3/15 at 2:00pm with the Administrator revealed: -She was unaware narcotic deliveries from the pharmacy had been entered incorrectly. -She was unaware narcotic deliveries from the pharmacy had not been logged into the EMAR system. -She was unaware 73 of Resident #5's Lorazepam 0.5mg tablets had not been returned to the pharmacy. -All medications returned to the pharmacy are written on a sheet that is signed by two staff. -One copy of the returned medications list goes with the medication to the pharmacy and the other filed in the resident's record. -It was the responsibility of the MCM to monitor medication management and inform her of any concerns or irregularities such as errors in narcotic receipt documentation, administration, and return to pharmacy. medication. Refer to the review of the Medication Aide job description. Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm. Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm. Refer to the interview with the Administrator on 6/1/15 at 5:16pm. Refer to the interview with the Administrator on 6/1/15 at 5:45pm. Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm.	D 392		

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D 392	Continued From page 41 Refer to interview with the Administrator on 6/3/15 at 9:44am. Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. 2. Review of Resident #5's February 2015 EMAR revealed: -An entry for hydrocodone/APAP (Norco) 5/325mg tablets, take 1/2 tablet orally every 4 hours as needed for pain. -No Norco documented as administered. Review of Resident #5's March 2015 EMAR revealed: -An entry for Norco 5/325mg tablets, take 1/2 tablet orally every 4 hours as needed for pain. -Thirteen doses had been documented as administered. Review of Resident #5's Norco 5/325mg tablet Inventory History revealed: -3/23/15, 19 half tablets were documented on hand in the medication cart. -3/24/15, 60 half tablets were logged as delivered from the pharmacy. -3/24/15, the 19 half tablets were not added to the balance on hand. -Balance on hand incorrectly documented as 60. Interview on 6/3/15 at 10:50am with a representative from the facility pharmacy revealed: -3/24/15, 60 half tablets of Norco 3/325mg were	D 392		

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sent to the facility for Resident #5.
-Each half tablet had been bubble packaged and each half tablet was one dose.
-3/31/15, actual count returned to pharmacy was the full card of 60 half tablets.

Review on 6/2/15 of the amount of Norco 5/325mg half tablets dispensed, administered and returned to the pharmacy for Resident #5 revealed:
-3/23/15, There were 19 half tablets on hand.
-60 half tablets were received from the pharmacy (Returned 3/31/15).
-Six doses were documented as administered.
-6/2/15, Thirteen half tablets of Norco 5/325mg could not be accounted for.

Review on 6/2/15 at 10:50am of Resident #5's record revealed there was no Norco 5/325mg tablets documented as returned to, and received by, the facility pharmacy.

Interview on 6/2/15 at 8:00am with Staff B, MA, revealed:
-She did not know why the amounts of Resident #5's Norco noted as on hand by the EMAR system did not match the narcotic count.
-When controlled medication came from the pharmacy, the Medication Aide on duty had a witness watch the narcotic count and log their name into the EMAR system as the witness.
-She did not know why there was no witness documented for those deliveries.
-When narcotics were sent back to the pharmacy, the Memory Care Manager (MCM) and the Lead Supervisor in Charge (LSIC), a Medication Aide (MA), counted the medication together and both signed the "Returned Drug Credit Form" that went back to the pharmacy with the drugs.
-A copy of the completed "Returned Drug Credit

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D 392	Continued From page 43 Form" was placed in the resident's record. Interview on 6/3/15 at 2:00pm with the Administrator revealed: -She was unaware narcotic deliveries from the pharmacy had been entered incorrectly. -She was unaware narcotic deliveries from the pharmacy had not been logged into the EMAR system. -She was unaware Resident #5's Norco had not been returned to the pharmacy. -All medications returned to the pharmacy are written on a sheet that is signed by two staff. -One copy of the returned medications list goes with the medication to the pharmacy and the other was filed in the resident's record. -It was the responsibility of the MCM to monitor medication management and inform her of any concerns or irregularities such as errors in narcotic receipt documentation, administration, and return to pharmacy. medication. Interview on 6/3/15 at 1:45pm MCM revealed: -She was unaware Resident #5's narcotic reconciliation revealed unaccounted for medication. -She was responsible for monitoring the Medication Aides and for overseeing medication administration and narcotic reconciliation. -She had not monitored or reconciled the narcotic discrepancies in "about 2 weeks" because she just hadn't had the time. -She was aware there were residents who had been there several weeks and not had their narcotics entered into the EMAR system. -She could not explain why the reconciliation's had not been done especially with the number of narcotic discrepancies being reported. Refer to the review of the Medication Aide job	D 392		

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D 392	Continued From page 44 description. Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm. Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm. Refer to the interview with the Administrator on 6/1/15 at 5:16pm. Refer to the interview with the Administrator on 6/1/15 at 5:45pm. Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm. Refer to interview with the Administrator on 6/3/15 at 9:44am. Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. F. Review of Resident #7's current FL2 dated 5/11/15 revealed: -Diagnoses including OBS (Organic Brain Syndrome)/Dementia and anxiety. - Medication including Lorcet 10/325mg, one every 4 hours PRN (as needed, a pain medication) and Lorazepam 1mg TID (three times a day), PRN (as needed, an anti-anxiety medication). -Intermittently disorientated.	D 392		

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D 392	Continued From page 45 -Wandering as a behavior. Review of Resident #7's Resident Roster revealed an admission date of 5/18/15. Following record review and observations on 6/1/15 of Resident #7, he was determined not to be interviewable. 1. Observation on 6/2/15 at 7:20am of a prescription bottle labeled for Resident #7 revealed: -Contents of seventeen 1mg tablets of Lorazepam. -Directions for one tablet PO (orally) three times a day, if needed. -The prescription had been written by his primary care physician -The prescription had been filled on 5/7/15 at a local pharmacy. -Original prescription date of 12/18/14. -Quantity dispensed was 90 tablets. -Two refills remained until 6/17/15. Observation on 6/2/15 at 7:20am of the shift to shift Electronic Medication Administration Record (EMAR) narcotic reconciliation revealed Resident #7 had 0 Lorazepam logged into the system at the time of admission or since. Review of Resident #7's EMAR for May 2015 revealed: -An entry for Lorazepam 1mg, take one tablet orally, three times a day as needed for anxiety. (540 tablets profiled, may refill until 11/21/15). -No Lorazepam had been documented as administered to Resident #7. Review of Resident #7's EMAR for June 1, 2015 revealed:	D 392		

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D 392	Continued From page 46 -An entry for Lorazepam 1mg, take one tablet orally, three times a day as needed for anxiety. (540 tablets profiled, may refill until 11/21/15). -No Lorazepam had been documented as administered to Resident #7. Interview on 6/2/15 at 7:am with the Medication Aides (MA's) reconciling the narcotics revealed: -They verified the EMAR showed 0 Lorazepam 1mg tablets in the system for Resident #7. -They verified there were 17 Lorazepam 1mg tablets present in the narcotic box on the medication cart labeled for Resident #7. -The discrepancy was a result of narcotic medication, received from Resident #7's family at the time of admission, had not been entered into the EMAR system. -On-going narcotic discrepancies were documented but had not been corrected by the MCM. -The Memory Care Manager was responsible for entering the amount of narcotics brought in with a resident at admission, into the EMAR system. -They had told the MCM "several times" Resident #7's Lorazepam and other narcotics had not been entered into the system. -They were unaware the Lorazepam had been administered and not documented in the EMAR system. Review on 6/2/15 at 10:00am of the Narcotic Count Discrepancy Form for 5/18/15 through 6/2/15 completed at shift change revealed: -An entry on 5/20/15 for Resident #7 documented there were 0 Lorazepam 1mg tablets logged in the EMAR system and a quantity of 23 on hand. -5/21/15, 0 Lorazepam 1mg tablets in the system and 20 on hand. -5/30/15-6/2/15, 0 Lorazepam 1mg tablets in the system and 17 on hand.	D 392		

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D 392	Continued From page 47 Interview on 6/3/15 at 11:20am with a local pharmacy representative revealed: -A prescription for Lorazepam tablet, orally, three times a day, if needed, had been filled at their pharmacy on 5/7/15. -The prescription had been written by Resident #4's primary care physician. -The prescription was filled for 90 tablets. Interview on 6/3/15 at 2:00pm with Resident #7's family member revealed: -Lorazepam had been prescribed for anxiety. -The person who had the pills was careful not to give him too many. -The medication taken by the resident was put in a bag and brought to the facility at admission. -The bag was left with the "nurses" who said they would take care of it. -They were not sure of what medications were in the bag and the amount of each. -The staff did not look at what was in the bag. Interview on 6/3/15 at 2:10pm with the Regional Operations Director and the Administrator revealed: -When medications come from somewhere other than the facility pharmacy, the medication should be identified and counted with the person delivering it. -A form is filled out identifying the medication, the dosage, and the amount. -The deliverer and the facility staff person signed the form. -A copy of the form went in the record and one given to the deliver. Interview on 6/3/15 at 3:45pm with the Memory Care Manager revealed: -She was not aware of a policy/procedure	D 392		

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regarding the handling of medication brought in by families at the time a resident was admitted.
-The Medication Aide (MA) on duty was responsible for ordering medication from the pharmacy for new residents.
-Any MA could enter medications, including narcotics, into the EMAR system.
-She had not reconciled narcotics for "at least" 2 weeks.
-She was aware Resident #7's Lorazepam needed to be entered into the EMAR system.

Telephone calls to the prescribing Family Nurse Practitioner on 6/3/15 at 4:20pm and 6/4/15 at 10:20am were not returned prior to exit.

Refer to the review of the Medication Aide job description.

Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm.

Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm.

Refer to the interview with the Administrator on 6/1/15 at 5:16pm.

Refer to the interview with the Administrator on 6/1/15 at 5:45pm.

Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm.

Refer to interview with the Administrator on 6/3/15 at 9:44am.

Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am.

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D 392	Continued From page 49 Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. 2. Review on 6/1/15 of Resident #7's physician's orders revealed an order written 5/11/15 for Lorcet 10/325mg one every 4 hours PRN (as needed). Observation on 6/2/15 at 7:20am of the shift to shift Electronic Medical Record(EMAR) narcotic reconciliation revealed Resident #7 had 0 Lorcet 10/325mg tablets logged into the system at the time of, and since, admission. Review on 6/2/15 at 10:00am of the Narcotic Count Discrepancy Form for 5/18/15 through 6/2/15 completed at shift change revealed: - 0 Lorcet 10/325mg tablets in the EMAR system Review of Resident #7's EMAR for May 18-31 2015 and June 1, 2015 revealed: -An entry for Lorcet 10/325mg, take one tablet orally, every four hours as needed (Need prescription). -No Lorcet had been documented as administered. Interview on 6/2/15 at 7:00am with the Medication Aides (MA's) reconciling the narcotics revealed: -They did not know who received the medication form Resident #7's family upon admission. -They verified the EMAR showed 0 Lorcet 10/325mg tablets in the system for Resident #7. -They verified there were 0 Lorcet 10/325mg tablets present in the narcotic box on the medication cart labeled for Resident #7.	D 392		

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D 392	Continued From page 50 -The discrepancy may have been the result of narcotic medication, if received from Resident #7's family at the time of admission, not entered into the EMAR system. -The discrepancy may have been the result of no narcotic medication received from Resident #7's family at the time of admission. -The Memory Care Manager was responsible for entering the amount of narcotics brought in with a resident at admission, into the EMAR system. -It had been"awhile" since the MCM had reconciled the narcotic discrepancies. -The Medication Aides stated they essentially "were signing the narcotic count was correct when in fact it was wrong". Interview on 6/3/15 at 2:00pm with Resident #7's family member revealed: -Lorcet 10/325mg had been prescribed for pain resulting from multiple surgeries (a total knee replacement, a partial knee replacement and spinal surgery). -Prior to admission, the resident was asking for at least a pill every day for pain. -He would take more if the person who had the pills would give him more. -The person who had the pills was careful not to give him too many. -The medication taken by the resident was put in a bag and brought to the facility at admission. -The bag was left with the "nurses" who said they would take care of it. -The family were not sure of what medications were in the bag and the amount of each. -The staff did not look at what was in the bag while they were . Interview on 6/3/15 at 2:10pm with the Regional Operations Director and the Administrator revealed:	D 392		

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-When medications come from somewhere other than the facility pharmacy, the medication should be identified and counted with the MCM and with the person delivering it.
-A form is filled out identifying the medication, the dosage, and the amount.
-The deliverer and the facility staff person signed the form.
-A copy of the form went in the record and one given to the deliver.
-Prescribed medications should always be in the facility and available to the resident.

Interview on 6/3/15 at 3:45pm with the Memory Care Manager revealed:
-She was not aware of a policy/procedure regarding the handling of medication brought in by families at the time a resident was admitted.
-The Medication Aide (MA) on duty was responsible for ordering medication from the pharmacy for new residents.
-Any MA could enter medications, including narcotics, into the EMAR system.
-She had not reconciled narcotics for "at least" 2 weeks.

Interview on 6/2/15 at 2:10pm with a representative of the facility pharmacy revealed:
-The facility had sent Resident #7's FL2 to the pharmacy upon admission.
-The pharmacy was instructed by Staff C to "Profile Only" (enter the resident's information into the computer but not to send medications).
-No medication had been delivered to the facility for Resident

Interview on 6/3/15 at 11:20am with a local pharmacy representative revealed:
-A prescription for Lorcet 10/325mg tablet, orally, every 4 hours, if needed, had been filled at their

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pharmacy on 5/7/15.
-The prescription had been written by Resident #4's primary care physician.
-The prescription was filled for 180 tablets.

Telephone calls to the prescribing Family Nurse Practitioner on 6/3/15 at 4:20pm and 6/4/15 at 10:20am were not returned prior to exit.

Interview on 6/2/15 at 2:10pm with a representative of the facility pharmacy revealed:
-The facility had sent Resident #7's FL2 to the pharmacy upon admission.
-The pharmacy was instructed by Staff C to "Profile Only" (enter the resident's information into the computer but not to send medications).
-No medication had been delivered to the facility for Resident

Refer to the review of the Medication Aide job description.

Refer to interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm.

Refer to the interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm.

Refer to the interview with the Administrator on 6/1/15 at 5:16pm.

Refer to the interview with the Administrator on 6/1/15 at 5:45pm.

Refer to telephone interview with the facility pharmacy on 6/1/15 at 3:45pm.

Refer to interview with the Administrator on 6/3/15 at 9:44am.

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D 392	Continued From page 53 Refer to interview with the Regional Operations Director on 6/3/15 at 9:45am. Refer to interview on 6/3/15 at 3:45pm with the Memory Care Manager. Refer to interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm. --- Review of the Medication Aide job description outlining facility expectation from staff who administered medications revealed: -"Accept responsibility for accurate medication counts and for security of the medication cart and medication storage room for assigned shifts." Interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm revealed: -The narcotic count in the EMAR did not match the narcotic medications on hand. -The problem with daily narcotic discrepancies had been occurring since February or March 2015. -Narcotic discrepancies occurred every shift and were not reconciled before the oncoming Medication Aide took responsibility for the medication carts. -Staff A stated she had been unable to count off all the narcotic medications on both medication carts with the off going first shift Medication Aide that day, because a resident had needed assistance and the offgoing Medication Aide had handed her the keys and left without counting with her. Telephone interview with the facility pharmacy on 6/1/15 at 3:45pm revealed: -The facility had the responsibility for maintaining	D 392		

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D 392	Continued From page 54 their narcotic inventory count. -"They shouldn't have [narcotic] discrepancies." -The pharmacy had not been notified the facility was experiencing narcotic count discrepancies. -There should be two staff witnessing narcotic supply counts when entering quantities into the EMAR. -There should be two staff witnessing narcotic counts shift to shift or when the medication cart keys were handed off. Interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm revealed: -She and the Medication Aides had rights in the EMAR application to add narcotic supply counts. -The EMAR system deducted what was used "automatically." -"On occasion the [narcotic] counts are off." -The problem with discrepancies in the narcotic counts had been occurring since 2012. -"And sometimes, I can't even tell you why the count is wrong, because it shows correctly when we administer, but then its wrong at shift change. Doesn't even show [the medication has] been administered. History of the medication doesn't show its was given..." -No paper based system of narcotic counts had been implemented when they discovered the narcotic discrepancy problem with the EMAR system. -There was a two person check whenever a narcotic supply came into the facility and either the Memory Care Manager and another Medication Aide or two Medication Aides would verify the amount and record narcotic count into the EMAR for the resident. -On the night shift, the Medication Aide and the delivery person from the pharmacy agreed on quantity counts of narcotics.	D 392		

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-"Anytime there's a [narcotic] count off, I will look and see why the counts off and I will call [the facility pharmacy] and try to reconcile why the counts are off."
-"When I correct [narcotic] count entries, I get the [Medication Aide] with me and correct the count."
-"We do not have a system in place to fix discrepancies shift to shift."
-She was unable to find the narcotic discrepancy logs dating from January 2015 to April 2015.

Interview with the Administrator on 6/1/15 at 5:16pm revealed:
-"If there's any discrepancy [in the narcotic counts] the Medication Aides are supposed to document it on the narcotic discrepancy log.
-They had contacted the software support vendor for the EMAR system and "..they say they can't see any problems with the software from their side."

Interview with the Administrator on 6/1/15 at 5:45pm revealed:
-She began her new position as the Administrator on 2/2/15.
-She had become aware of the discrepancies with the narcotic counts "sometime in March."
-The Medication Aides had not reported all the discrepancy issues to the Memory Care Manager.
-The Memory Care Manager knew to report narcotic discrepancy issues to her immediately.
-"I had seen the [narcotic] discrepancy sheets briefly. I had not followed up with the discrepancies because this was [the Memory Care Manager's name] position responsibility."
-She stated she had concerns that the narcotic counts were not accurate and "I would ask [Memory Care Manager's name] and she would try to explain the discrepancies."
-She had reiterated with Medication Aides in

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meetings not to accept responsibility for incoming supply of narcotics by themselves but have a second Medication Aide verify the count was correct.
-"When I came here the Medication Aides weren't even counting off the carts [at shift change], but just handing over the keys."
-"I had not honestly looked at the discrepancy logs in detail."
-"No family or resident has ever come to me saying they suspected medications not being given."

Interview with the Administrator on 6/3/15 at 9:44am revealed she had not notified the facility pharmacy when she had discovered there were narcotic discrepancies occurring.

Interview with the Regional Operations Director on 6/3/15 at 9:45am revealed:
-"No excuse, but [the Memory Care Manager's name and Administrator's name] didn't know how to handle the narcotic discrepancy problem."
-They had changed the EMAR software "yesterday" that required staff to count the medication cart and resolve narcotic discrepancies before moving forward.
-He was unsure how the EMAR software missed being setup properly.
-"No we had not called [the facility pharmacy's name]..." to report the narcotic discrepancies.

Interview on 6/3/15 at 3:45pm with the Memory Care Manager revealed:
-She was not aware of a policy/procedure regarding the handling of medication brought in by families at the time a resident was admitted.
-The Medication Aide (MA) on duty was responsible for ordering medications from the pharmacy for new residents.

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D 392	Continued From page 57 -Any MA could enter medication supplies, including narcotics, into the EMAR system. -She had not reconciled narcotics in "at least" 2 weeks. Interview with Staff B, Medication Aide, on 6/4/15 at 1:50pm revealed: -After narcotics come in from the facility pharmacy or an outside pharmacy "we have to go in and enter the count into EMAR." -"A lot of the narcotics come in at night and they have to be entered in at night." _____ A plan of protection was received from the facility on 6/2/15 and included: -All residents' controlled substances counts will be immediately reconciled by the Memory Care Manager and Executive Director. -Any discrepancies will be investigated and appropriate action will be taken. -All Medication Aides will be retrained immediately on proper reconciliation procedure regarding controlled substances. -This training will include guidelines on immediately reporting any discrepancies in the controlled substances count to the Memory Care Manager and Executive Director. -The Executive Director and Memory Care Manager will witness at least one shift change narcotic count per day for one week and three times per week for one month thereafter. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2015.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance	D 399		

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D 399	Continued From page 58 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure suspected drug diversion with Scheduled II and Scheduled IV medications was reported to the pharmacy. The findings are: Review of the current census revealed there were 49 residents who resided in the facility which was a special care unit for Alzheimer's and dementia care. Interview with Staff A, Medication Aide, on 6/1/15 at 3:23pm revealed: -The narcotic count in the EMAR did not match the narcotic medications on hand. -The problem with daily narcotic discrepancies had been occurring since February or March 2015. -Narcotic discrepancies occurred every shift and were not reconciled before the oncoming Medication Aide took responsibility for the medication carts. -Staff A stated she had been unable to count off	D 399		

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all the narcotic medications on both medication carts with the off going first shift Medication Aide that day, because a resident had needed assistance and the offgoing Medication Aide had handed her the keys and left without counting with her.

Observation on 6/2/15 at 7:20am of a two staff narcotic reconciliation of the medication carts revealed:
-There were 13 narcotic discrepancies on 100 hall medication cart which affected 9 residents.
-There were 24 narcotic discrepancies on 200-300 hall medication cart which affected 19 residents.

Review of the facility Narcotic Discrepancy Forms dated 4/29/15 to 6/1/15 revealed:
-Daily narcotic discrepancies were documented affecting multiple residents.
-On multiple occasions, the narcotic discrepancies were documented as having been verified by only one staff member (5/9/15, 5/11/15, 5/21/15, 5/31/15, and 6/1/15).

Interview on 6/2/15 at 7:00:am with the Medication Aides (MA's) reconciling the narcotics revealed:
-On-going narcotic discrepancies were documented with each shift reconciliation, but the discrepancies had not been corrected by the Memory Care Manager (MCM).
-The MCM was responsible for entering the amount of narcotics brought in with a resident on admission into the Electronic Medication Administration Record (EMAR).

Review of the Medication Aide job description outlining facility expectation from staff who administered medications revealed:

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-"Accept responsibility for accurate medication counts and for security of the medication cart and medication storage room for assigned shifts."

Interview with the Memory Care Manager on 6/1/15 at 2:19pm, 6/1/15 at 4:40pm, 6/1/15 at 5:18pm, and 6/1/15 at 5:34pm revealed:
-She had never had any reason to suspect drug diversion as a reason for the narcotic discrepancies.
-She and the Medication Aides had rights in the Electronic Medication Administration Record (EMAR) application to add narcotic supply counts. The EMAR system deducted what was used "automatically."
-"On occasion the [narcotic] counts are off."
-The problem with discrepancies in the narcotic counts had been occurring since 2012.
-She thought the narcotic discrepancy problem had been reported to the pharmacy in March 2015, but she had not personally reported the problem to the pharmacy.
-No paper based system of narcotic counts had been implemented when they discovered the narcotic discrepancy problem with the EMAR system.
-There was a two person check whenever a narcotic supply came into the facility and either the Memory Care Manager and another Medication Aide or two Medication Aides would verify the amount and record narcotic count into the EMAR for the resident.
-On the night shift, the Medication Aide and the delivery person from the pharmacy agreed on quantity counts of narcotics.
-"Anytime there's a [narcotic] count off, I will look and see why the counts off and I will call [the facility pharmacy] and try to reconcile why the counts are off."
-"When I correct [narcotic] count entries, I get the

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D 399	Continued From page 61 [Medication Aide] with me and correct the count." -"We do not have a system in place to fix discrepancies shift to shift." -She was unable to find the narcotic discrepancy logs that were normally stored in the medication room dating from January 2015 to April 2015. -The only discrepancy logs available were May 2015 and June 2015. Interview with the Administrator on 6/1/15 at 5:16pm revealed "If there's any discrepancy [in the narcotic counts] the Medication Aides are supposed to document it on the narcotic discrepancy log." Interview with the Administrator on 6/1/15 at 5:45pm revealed: -She began her new position as the Administrator on 2/2/15. -She had become aware of the discrepancies with the narcotic counts "sometime in March." -She had not suspected drug diversion as a possible cause of the narcotic discrepancies. -The Medication Aides had not reported all the discrepancy issues to the Memory Care Manager. -The Memory Care Manager knew to report the discrepancy issues to her immediately. -"I had seen the [narcotic] discrepancy sheets briefly. I had not followed up with the discrepancies because this was [the Memory Care Manager's name] position's responsibility." -She stated she had concerns that the narcotic counts were not accurate and "I would ask [Memory Care Manager's name] and she would try to explain the discrepancies." -She had reiterated with Medication Aides in meetings not to accept responsibility for incoming supply of narcotics by themselves, but have a second Medication Aide verify the count was correct.	D 399		

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D 399	Continued From page 62 -"When I came here the Medication Aides weren't even counting off the carts [at shift change], but just handing over the keys." -"I had not honestly looked at the discrepancy logs in detail." -"No family or resident has ever come to me saying they suspected medications not being given." Telephone interview with the facility pharmacy on 6/1/15 at 3:45pm revealed: -The facility had the responsiblity for maintaining their narcotic inventory count. -"They shouldn't have [narcotic] discrepancies." -The pharmacy had not been notified the facility was experiencing narcotic count discrepancies. -There should be two staff witnessing narcotic supply counts when entering quantities into the EMAR. -There should be two staff witnessing narcotic counts shift to shift or when the medication cart keys were handed off. Interview on 6/3/15 at 1:45pm with the Memory Care Manager (MCM) revealed: -She was responsible for monitoring the Medication Aides and for overseeing medication administration and narcotic reconciliation. -She had not monitored or reconciled the narcotic descrepancies in "about 2 weeks". -She was aware there were residents who had been there several weeks and not had their narcotics entered into the EMAR system. -She could not explain why reconciliations had not been done. Review of the quarterly pharmacy review conducted on 4/21/15 revealed: -On medication cart inspection, 15 syringes of narcotic topical cream were found stored on the	D 399		

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cart.
-The syringes were not properly labeled with the resident they belonged to, expiration dates, dispense dates, etc.
-The pharmacy recommended to destroy the syringes of narcotic topical creams.

Observation on 6/3/15 at 2:10pm with the Regional Operations Director revealed:
-He carried two plastic zip locked bags he had found on the medication cart.
-One bag contained 10 syringes filled with a white cream.
-A second bag contained 3 syringes filled with white cream.
-The syringes were unlabeled and undated.

Interview with the Administrator and the Regional Operations Director on 6/3/15 at 2:10pm revealed:
-The bags of syringes were found on the medication cart.
-Both the Regional Operations Director and the Administrator were unaware of the pharmacy review findings on 4/21/15.
-The syringes should have been returned to the pharmacy as soon as they were found to ensure proper disposal.
-They had no idea where the 2 syringes that were unaccounted for could have gone.
-They were sending the syringes to the facility pharmacy that day for destruction.

Interview with the Memory Care Manager on 6/3/15 at 3:30pm revealed:
-She had been aware 15 syringes of topical narcotic creams had been found on the medication cart during a pharmacy review and the syringes had not been properly labeled.
-She stated at that time she had discussed with

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the Medication Aides about requesting new labels from the pharmacy for the syringes.
-She was unsure what had finally been done with the syringes.

Interview with the Administrator on 6/4/15 at 1:30pm revealed:
-"I have not seen any of the pharmacy reviews."
-The Memory Care Manager is responsible for following up on the pharmacy review recommendations.
-Any returns or disposal of controls were supposed to be sent back to the pharmacy timely (within 48 hours).
-It was the facility's policy there would be a two person verification of any controlled substances being sent back to the pharmacy.
-Disposal of controls should involve two staff and be documented with time, date and two signatures.
-She was unaware 15 syringes filled with narcotic topical creams had been found by the pharmacy during a review of the medication carts on 4/21/15.
-The Memory Care Manager had not reported anything to her about the 15 unlabeled syringes of narcotic topical creams being found during the review.

Interview with the Administrator on 6/3/15 at 9:44am revealed she had not notified the facility pharmacy when she had discovered there were narcotic discrepancies occurring daily in the facility.

Interview with the Regional Operations Director on 6/3/15 at 9:45am revealed:
-"No excuse, but [the Memory Care Manager's name and Administrator's name] didn't know how to handle the narcotic discrepancy problem."

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D 399	Continued From page 65 -They had changed the EMAR software "yesterday" that required staff to count the medication cart and resolve narcotic discrepancies before moving forward. -"No we had not called [the facility pharmacy's name]..." to report the narcotic discrepancies. _____ A plan of protection was provided on 6/3/15 and included the following: -The facility has contacted the pharmacy to report the suspected diversion(s) and to ask for onsite support in reconciling the controlled substance counts. -If after investigation, the suspected diversion(s) is substantiated to be an actual diversion(s) the facility will complete reporting requirements to local law enforcement agency and Health Care Personnel Registry. -All Med Techs will undergo reasonable cause drug testing in accordance with company guidelines. -The facility's RN Consultant will be on site Thursday, 6/4/15, to review reporting requirements for suspected and known drug diversions with Executive Director and Memory Care Manager. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2015.	D 399		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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
D914	Continued From page 66 This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure residents were free of exploitation as related to medication administration and controlled substances. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure hydro-codone/acetaminophen and Lorazepam were administered as ordered for 3 of 7 sampled residents (Resident #4, #6, and #7). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Unabated B Violation).] 2. Based on observation, interview, and record review, the facility failed to assure an accurate reconciliation record for six controlled medications (alaprazolam, fentanyl, hydrocodone/acetaminophen, lorazepam, and zolpidem) prescribed for 6 of 7 sampled residents with orders for controlled medications (Resident #1, #2, #3, #5, #6, and #7). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation).] 3. Based on observation, interview, and record review, the facility failed to assure suspected drug diversion with Scheduled II and Scheduled IV medications was reported to the pharmacy. [Refer to Tag D399 10A NCAC 13F .1008(h) Controlled Substance (Type B Violation).]	D914		