STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey and complaint investigation on July 23, 27, 28, 2015 with an exit conference via telephone on July 29, 2015.	C 000		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 2 staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a Supervisor-in-Charge (SIC) on 4/12/08. -Staff B's first day of work was on 4/26/08. -There was documentation of a Health Care Personnel Registry (HCPR) check dated 4/9/08 with no substantiated findings. Telephone interview on 7/29/15 at 9:45am with the Administrator revealed: -Staff B was hired in 2008 as a "live-in" staff. -Staff B was a full-time employee. -Staff B switched to part-time employment (the administrator could not remember the date when	C 145		

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C 145	Continued From page 1 this change in employment status occurred). -She was aware that Staff B had also worked part-time at another health care facility. -Staff B returned to full-time status in August 2013. -She had not received any resident complaints or concerns pertaining to Staff B's performance. -The facility's property managers regularly interview residents about staff performance and completion of their job duties. Review of a HCPR check completed on 7/28/15 by the Administrator for Staff B revealed two substantiated findings entered on the registry on 11/21/13. Telephone interview on 7/28/15 at 3:00pm with the Administrator revealed: -She was not aware of Staff B's substantiated findings. -Staff B had not made her aware of the findings. -On 7/27/15 following a discussion with the surveyors, she had instructed a property manager to begin annual HCPR checks on all employees. Staff B was not available for interview.	C 145		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by:	C 367		

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C 367	Continued From page 2 TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure accurate reconciliation and readily retrievable records for the receipt, administration, and disposition of controlled substances which included oxycodone, morphine sulfate ER, clonazepam, Adderall and lorazepam resulting in amounts which ranged from 8 to 357 tablets of controlled substances being unaccounted for 4 of 4 sampled residents (Residents #1, #2, #3, and #4). The findings are: A. Review of Resident #2's current FL2 dated 12/2/14 revealed: -Diagnoses included: chronic pain, quadriplegia, sacral pressure ulcers, and neurogenic bladder. -Non-ambulatory -Indwelling catheter -Incontinent of bowel -Admitted to the facility on 11/25/14 1. Review of a physician's order for Resident #2 dated 2/26/15 revealed oxycodone 10mg every four hours at 8am, 12noon, 4pm, and 8pm. Review of a physician's order for Resident #2 dated 3/23/15 revealed oxycodone (used to control pain) 10mg every four hours at 8am, 12noon, 4pm, and 8pm and every four hours as needed from 8pm to 8am. Review of Resident #2's February, March, April, May, and June 2015 Electronic Medication Administration Records (EMARs) revealed: -Oxycodone 10mg take 1 tablet every four hours at 8am, 12noon, 4pm, and 8pm. -Oxycodone 10mg take 1 tablet every four hours	C 367		

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

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C 367	Continued From page 3	C 367		

as needed from 8pm to 8am.
-Scheduled dose administration was documented as four times a day as ordered.
-A total of 505 scheduled and as needed doses were documented as administered from 2/26/15 to 6/30/15.

Review of a physician's order for Resident #2 dated 7/23/15 revealed oxycodone 10mg every four hours at 8am, 12noon, 4pm, and 8pm then may give 1 tablet at 12midnight and 4am.

Review of Resident #2's July 2015 EMAR revealed:
-Oxycodone 10mg take 1 tablet every four hours at 8am, 12noon, 4pm, and 8pm.
-Oxycodone 10mg take 1 tablet every four hours as needed from 8pm to 8am from 7/1/15 to 7/22/15.
-Oxycodone 10mg may give 1 tablet at 12midnight and 4am starting 7/23/15.
-Scheduled dose administration was documented as four times a day as ordered.
-A total of 127 scheduled and as needed doses were documented as administered from 7/1/15 to 7/27/15.

Review of Resident #2's Delivery Manifest for oxycodone 10mg tablets revealed:
-1,260 tablets of oxycodone 10mg were dispensed to the resident by the pharmacy from 2/26/15 to 7/24/15.
-180 doses of oxycodone 10mg tablets were delivered on the following dates: 2/26/15, 3/23/15, 4/20/15, 5/12/15, 6/4/15, 7/7/15, and on 7/24/15.

Observation of Resident #2's oxycodone 10mg tablet supply on hand on 7/27/15 at 8:45am revealed there were 271 tablets of oxycodone 10mg on hand.

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

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SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 4 Review of the discrepancy records for the pharmacy, EMAR and observation of medication on hand for Resident #2 revealed: -A total of 1,260 tablets of oxycodone 10mg were dispensed to the resident by the pharmacy from 2/26/15 to7/24/15. -A total of 632 scheduled and as needed tablets were documented as administered from 2/26/15 to 7/24/15. -271 tablets were on hand in the medication cart. -Resulting in a discrepancy of 357 oxycodone 10mg tablets. -There was no documentation of any tablets returned to the pharmacy. Review of the controlled substance (CS) logs on hand for Resident #2's oxycodone 10mg tablets revealed: -CS logs were unavailable for oxycodone 10mg tablets delivered on 2/26/15, 3/23/15, 5/12/15, 6/4/15, and 7/7/15. -CS log dated 4/20/15, pharmacy labeled with quantity dispensed of 180 tablets, entries documented on CS log as administered was for 60 tablets (5/17/15 8pm to 6/1/15 4pm). No further documentation concerning the other 120 tablets. -A second handwritten CS log with administration dates of 6/1/15 8pm to 6/30/15 12pm (documented entries for 90 tablets) was undated, had no prescription number, and had no documented quantity received for administration. -A third handwritten CS log with administration dates of 6/30/15 4pm to 7/6/15 8am (documented entries for 23 tablets) was undated, had no prescription number, and had no documented quantity received for administration. -CS log dated 7/7/15, pharmacy labeled with quantity dispensed of 180 tablets, entries	C 367		

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 5 documented on CS log as administered was for 5 tablets (7/27/15 7pm to 7/28/15 7am). No further documentation concerning the other 175 tablets. -CS log dated 7/24/15 had two sheets with quantity dispensed 90 tablets, pharmacy labeled, no entries documented as administered on either log. Interview with Resident #2 on 7/28/15 at 9:30am revealed: -"I'm being cared for." -"I get my pain meds on time." -"I have chronic lower back pain, since I broke my neck 2 years ago." -"My legs ache like hell" from chronic pain and edema. -Recently one of his physician's had adjusted his pain medications and had discontinued his fentanyl patch (used to control pain) and Percocet (used to control pain) and said "if I could talk, I wasn't in pain." -"I'm losing weight and can't sleep" because of the pain. -Another physician adjusted his pain medication regimen "about a month or more ago" and the regimen now helps for about 45 minutes after taking the pain medication "then the pain is back." -"I need to be put back on the fentanyl patch." -"I got no life. I'm being tortured." -He had no problems with the care he received in the facility. "They do what they can." -The resident was able to accurately identify the shape, size, and color of each of his ordered controlled substance medications. -Staff were administering his controlled medications as they were ordered by the physician. -A urine drug screen was performed by his new physician on his first visit and the test did not show any of his ordered controlled medications	C 367		

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

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SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 6	C 367		

being in his urine.
-He had a repeat urine test "2 to 3 weeks ago" and it "had meds in it."
-"I have to sit in pain all the time."
-"Pain stresses me out and causes me to take more [anti-anxiety medication]".
-"I glance at my meds each time I get them."

Interview with the Administrator on 7/28/15 at 10:00am revealed:
-Resident #2's urine drug screen completed on 6/18/15 was negative for any controlled medications.
-Resident #2's repeat urine drug screen completed on 7/21/15 was positive for controlled medications.

Telephone interview with the facility pharmacy on 7/28/15 at 10:10am revealed they had no record of any returned oxycodone 10mg tablets for Resident #2.

Refer to the interview with the Administrator on 7/27/15 at 10:46am.

Refer to the interview with the Administrator on 7/27/15 at 3:11pm.

Refer to the interview with the Property Manager on 7/27/15 at 4:00pm.

Refer to telephone interviews with the facility's pharmacy on 7/28/15 at 11:00am and 1:45pm.

Refer to telephone interview with the facility's contracted Licensed Health Professional Support (LHPS) nurse on 7/28/15 at 11:11am.

2. Review of a physician's order for Resident #2 dated 3/23/15 revealed morphine sulfate ER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 7 (used for slow release pain control) 15mg 1 tablet two times daily. Review of a physician's order for Resident #2 dated 6/18/15 revealed "discontinue morphine sulfate ER 15mg 1 tablet every 12 hours." Review of Resident #2's March, April, May, and June 2015 EMARs revealed: -Morphine ER 15mg 1 tablet twice daily at 8am and 8pm. -Scheduled dose administration was documented twice daily as ordered. -A total of 174 scheduled doses were documented as administered from 3/23/15 at 8pm to 6/18/15 at 8am. Review of Resident #2's Delivery Manifest for morphine sulfate ER 15mg tablets revealed: -240 tablets of morphine sulfate ER 15mg were dispensed to the resident by the pharmacy from 3/23/15 to 6/4/15. -60 tablets of morphine sulfate ER 15mg tablets were delivered on the following dates: 3/23/15, 4/21/15, 5/12/15, and 6/4/15. -On 5/13/15, delivered 54 tablets. Review of the CS logs on hand for Resident #2's morphine sulfate ER 15mg tablets revealed: -CS logs were unavailable for deliveries made on 3/23/15, 4/21/15, and 6/4/15. -CS log dated 5/12/15, pharmacy labeled with quantity dispensed of 60 tablets, entries documented on CS log as administered was for 27 tablets (6/5/15 8am to 6/18/15 8am). No further documentation concerning the other 33 tablets. -CS log with a handwritten date of 4/27/15, pharmacy labeled with quantity dispensed of 54 tablets, entries documented on CS log as	C 367		

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 8 administered was for 53 tablets (5/8/15 8am to 6/4/15 8pm). No further documentation concerning the other tablet. Observation of Resident #2's medications on hand on 7/27/15 at 8:45am revealed there was no morphine sulfate ER 15mg tablets on hand. Review of Resident #2's Drugs Returned to Pharmacy form dated 6/18/15 revealed: -33 tablets of morphine sulfate ER 15mg were documented as returned to the pharmacy due to discontinuation. -There were two signatures on the bottom of the form verifying the accuracy of amount to be returned to the pharmacy. Telephone interview with the facility pharmacy on 7/28/15 at 10:10am revealed: -They had no record of any returned morphine sulfate ER 15mg tablets for Resident #2. -They could not find a copy of the Drugs Returned to Pharmacy form dated 6/18/15. Review of the discrepancy records for pharmacy, EMAR, and observation of medication on hand for Resident #2 revealed: -A total of 240 tablets of morphine sulfate ER 15mg tablets were dispensed to the facility for Resident #2 from 3/23/15 to 6/4/15. -0 doses were on hand in the medication cart. -174 doses were documented as administered from 3/23/15 to 6/18/15. -Pharmacy denies receiving any returned morphine sulfate ER 15mg tablets per interview. -Resulting in a discrepancy of 66 morphine sulfate ER 15mg tablets. Interview with the Administrator on 7/27/15 at 10:46am revealed:	C 367		

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 9 -There were 33 unaccounted for morphine sulfate ER 15mg tablets for Resident #2. -"We have documentation where they were returned on our side, but the pharmacy says they did not receive the medication." Interview with Resident #2 on 7/28/15 at 9:30am revealed: -"I'm being cared for." -"I get my pain meds on time." -"I have chronic lower back pain, since I broke my neck 2 years ago." -"My legs ache like hell" from chronic pain and edema. -Recently one of his physician's had adjusted his pain medications and had discontinued his fentanyl patch (used to control pain) and Percocet (used to control pain) and said "if I could talk, I wasn't in pain." -"I'm losing weight and can't sleep" because of the pain. -Another physician adjusted his pain medication regimen "about a month or more ago" and the regimen now helps for about 45 minutes after taking the pain medication "then the pain is back." -"I need to be put back on the fentanyl patch." -"I got no life. I'm being tortured." -He had no problems with the care he received in the facility. "They do what they can." -The resident was able to accurately identify the shape, size, and color of each of his ordered controlled substance medications. -Staff were administering his controlled medications as they were ordered by the physician. -A urine drug screen was performed by his new physician on his first visit and the test did not show any of his ordered controlled medications being in his urine. -He had a repeat urine test "2 to 3 weeks ago"	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 10 and it "had meds in it." -"I have to sit in pain all the time." -"Pain stresses me out and causes me to take more [anti-anxiety medication]". -"I glance at my meds each time I get them." Interview with the Administrator on 7/28/15 at 10:00am revealed: -Resident #2's urine drug screen completed on 6/18/15 was negative for any controlled medications. -Resident #2's repeat urine drug screen completed on 7/21/15 was positive for controlled medications. Refer to the interview with the Administrator on 7/27/15 at 10:46am. Refer to the interview with the Administrator on 7/27/15 at 3:11pm. Refer to the interview with the Property Manager on 7/27/15 at 4:00pm. Refer to telephone interviews with the facility's pharmacy on 7/28/15 at 11:00am and 1:45pm. Refer to telephone interview with the facility's contracted LHPS nurse on 7/28/15 at 11:11am. B. Review of Resident #1's current FL2 dated 3/30/15 revealed: -Diagnoses included: cardiopulmonary disease, adrenal mass, osteoporosis, history of mood disorder, pneumonia, history of chronic opiate use, history of stable pericardial effusion, hypertension, and gastroesophageal reflux disease. -Admitted to the facility on 7/1/11.	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 11 Review of physician's order for Resident #1 dated 2/24/15 revealed oxycodone (used to control pain) 5mg every 6 hours as needed for pain. Review of physician's order for Resident #1 dated 3/30/15 revealed oxycodone 10mg every 4 hours at 8am, 12noon, 4pm and 8pm. Review of Resident #1's March, April, May, June, and July 2015 EMARs revealed: -Oxycodone 5 mg discontinued on 3/2/15. -There was no documentation of any oxycodone 5mg tablets returned to the pharmacy. -Order on 3/3/15 for oxycodone 10mg one tablet every 4 hours at 8am, 12noon, 4pm and 8pm. -A total of 581 scheduled dosages were documented on the EMAR as administered from 3/4/15 to 7/27/15. -The EMAR indicated Resident #1 was admitted to the hospital March 12 and 13, 2015 and March 27, 28, 29 and 30, 2015. Review of Resident #1's records revealed the CS logs were missing for the oxycodone 10mg tablets from 4/3/12 to 5/16/15 and 6/2/15 to 7/13/15. -Review of CS logs for Resident #1's oxycodone 10mg tablet did not match the EMARS for the number of times the medication was administered. -The CS logs dated 3/2/15 to 4/2/15 did not have the official prescription label and the prescription was handwritten on the CS log. -According to the available CS logs, out of 588 opportunities, 165 tablets of oxycodone 10mg were administered from 3/3/15 to 7/27/15. Review of Resident #1's Delivery Manifest for oxycodone 10mg revealed: -600 tablets were dispensed by the pharmacy	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 367	Continued From page 12 from 3/3/15 to 6/29/15 and delivered to the facility. -Prescription delivery dates and quantity were 120 tablets were delivered on 3/3/15, 4/2/15, 5/1/15, 5/30/15 and 6/29/15. Review of the discrepancy record for the paharmacy, EMAR and observation of medication on had for Resident #1 revealed: -A total of 600 tablets of oxycodone 10mg were dispensed to the resident by the pharmacy from 3/3/15 to 6/29/15. -A total of 581 tablets scheduled were documented on the EMARs as administered from 3/3/15 to 7/27/15. -A total of 165 tablets were documented on the available CS logs, as administered from 3/3/15 to 7/27/15. -11 tablets were on-hand in the medication cart. -There was no documentation of any tablets returned to the pharmacy. -Resulting in a discrepancy of 8 oxycodone 10mg tablets. Interview with Resident #1 on 7/23/15 at 10:30am revealed: -"I have never ran out of my medications and I do not miss any of my medication." -"I cannot tell you what every pill is, but we can look at them if we want." -"If there is an emergency and we run out of medication the pharmacy will bring it." -"If I saw anything inappropriate I would report it and they would be fired." -Resident #1 revealed no concerns about not receiving medications or any concerns due to pain other than the normal aging process. Interview with the Administrator on 7/27/15 at 9:00am revealed:	C 367		

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	FCL011327	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW ASSISTED LIVING # 1	36 SMITH GRAVEYARD ROAD ASHEVILLE, NC 28806

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C 367	Continued From page 13 -CS logs missing for Resident #1's oxycodone cannot be found. -The Administrator stated the control sheets are not accurate and do not match the EMARS because they are done by hand and not scanned into the computer. -The Administrator stated the control sheets look as if they were completed in a hurry and not at the time they were administering the medications as policy states. -The Administrator acknowledged the CS logs are expected to be in the notebook designated for control logs at all times once they are completed. -The Administrator would expect the property manager to monitor this process. Refer to the interview with the Administrator on 7/27/15 at 10:46am. Refer to the interview with the Administrator on 7/27/15 at 3:11pm. Refer to the interview with the Property Manager on 7/27/15 at 4:00pm. Refer to telephone interviews with the facility's pharmacy on 7/28/15 at 11:00am and 1:45pm. Refer to telephone interview with the facility's contracted LHPS nurse on 7/28/15 at 11:11am. C. Review of Resident #4's current FL2 dated 1/5/15 revealed: -Diagnoses included: Crohn's disease, abdominal ascites, small micro perforation, abdominal pain, diarrhea, anxiety, thought disorder and insomnia. -Admitted to the facility on 12/26/14. 1. Review of a physician's order for Resident #4 dated 3/25/15 revealed clonazepam 1mg at	C 367		

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C 367	Continued From page 14 breakfast, lunch and bedtime (clonazepam is used to treat seizure disorders or panic disorder). Review of Resident #4's March, April, May and June 2015 Electronic Medication Administration Records (EMARs) revealed: -Clonazepam 1mg at breakfast, lunch and bedtime. -Scheduled dose administration was documented as 8am, 12pm and 8pm. -A total of 253 scheduled doses were documented as administered from 3/25/15 to 6/17/15. Review of a physician's order for Resident #4 dated 6/17/15 revealed: -Discontinue clonazepam 1mg at breakfast, lunch and bedtime. -Clonazepam 1mg every day at bedtime. -Clonazepam 1mg every day, as needed for agitation. Review of Resident #4's June and July 2015 EMARs revealed: -Clonazepam 1mg every day at bedtime. -Clonazepam 1mg every day as needed for agitation. -Scheduled dose administration was documented 8pm and every day as needed. -A total of 53 scheduled and as needed tablets were documented as administered from 6/18/15 to 7/27/15. Review of Resident #4's Delivery Manifest for clonazepam 1mg tablets revealed: -390 tablets of clonazepam 1mg were dispensed to the resident by the pharmacy from 3/20/15 to 6/18/15. -Prescription delivery dates and quantities were; 3/20/15 delivered 60 tablets, 4/13/15 delivered 90	C 367		

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C 367	Continued From page 15 tablets, 4/29/15 delivered 90 tablets, 5/30/15 delivered 90 tablets and 6/18/15 delivered 60 tablets. Observation of Resident #4's clonazepam 1mg tablet supply on hand on 7/27/15 at 2:45pm revealed there were 57 tablets of clonazepam 1mg on hand. Review of the discrepancy records for the pharmacy, EMAR and observation of medication on hand for Resident #4 revealed: -A total of 390 tablets of clonazepam 1mg were dispensed to the resident by the pharmacy from 3/20/15 to 6/18/15. -57 tablets were on hand in the medication cart. -306 tablets were documented as administered from 3/25/15 to 7/27/15. -Resulting in a discrepancy of 27 clonazepam 1mg tablets. -There was no documentation of any tablets returned to the pharmacy. Interview with Resident #4 on 7/28/15 at 10:05am revealed: -He knew what his medications looked like. -He gets his meds on time. -Staff were administering his controlled medications as they were ordered by the physician. -He recalled not taking 2 or 3 prn tablets of the clonazepam and is working with his doctor to take clonazepam just once per day. -He had no problems with the care he received. Review of the "Drugs Returned to Pharmacy" records provided by the facility's pharmacy revealed no record of returned clonazepam 1mg tablets for Resident #4.	C 367		

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C 367	Continued From page 16 Refer to the interview with the Administrator on 7/27/15 at 10:46am. Refer to the interview with the Administrator on 7/27/15 at 3:11pm. Refer to the interview with the Property Manager on 7/27/15 at 4:00pm. Refer to telephone interviews with the facility's pharmacy on 7/28/15 at 11:00am and 1:45pm. Refer to telephone interview with the facility's contracted LHPS nurse on 7/28/15 at 11:11am. 2. Review of a physician's order for Resident #4 dated 6/22/15 revealed Adderall 10mg every morning. Review of a physician's order for Resident #4 dated 6/26/15 revealed an order to discontinue Adderall 10mg every morning. Review of Resident #4's June 2015 EMARs revealed: -Adderall 10mg every morning. -Scheduled dose administration was documented as 8am. -A total of 2 scheduled doses were documented as administered on 6/25/15 and 6/26/15. Review of Resident #4's Delivery Manifest for Adderall 10mg tablets revealed 30 tablets were dispensed and delivered to the resident by the pharmacy on 6/25/15. Interview with Resident #4 on 7/28/15 at 10:05am revealed: -He knew what his medications looked like. -He gets his meds on time.	C 367		

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C 367	Continued From page 17 -Staff were administering his controlled medications as they were ordered by the physician. -He had quit taking the Adderall because it was upsetting his stomach. -He had no problems with the care he received. Observation on 7/27/15 at 2:45pm revealed there were no Adderall 10mg tablets for Resident #4's on-hand in the medication cart or in the locked storage awaiting return to the pharmacy. Interview with the Administrator on 7/28/15 at 10:20am revealed: -There was no CS log for Resident #4's Adderall. -She did not know the reason for the missing CS log. -There was no documentation of the Adderall being returned to the pharmacy. -She did not know the reason for the missing 28 Adderall tablets. Review of the "Drugs Returned to Pharmacy" records provided by the facility's pharmacy revealed no record of returned Adderall 1mg tablets for Resident #4. Refer to the interview with the Administrator on 7/27/15 at 10:46am. Refer to the interview with the Administrator on 7/27/15 at 3:11pm. Refer to the interview with the Property Manager on 7/27/15 at 4:00pm. Refer to telephone interviews with the facility's pharmacy on 7/28/15 at 11:00am and 1:45pm. Refer to telephone interview with the facility's	C 367		

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C 367	Continued From page 18 contracted LHPS nurse on 7/28/15 at 11:11am. D. Review of Resident #3's current FL2 dated 6/5/15 revealed: -Diagnoses included: high blood pressure, gastroesophageal reflux disease (GERD), thyroid disorder, chronic pain, schizoaffective disorder. -Lorazepam 0.5 mg twice daily (lorazepam is used to treat anxiety disorders). -Admitted to the facility on 7/1/11. Review of a physician's order for Resident #3 dated 3/9/15 revealed lorazepam 1mg twice daily. Review of Resident #3's March, April, May and June 2015 EMARs revealed: -Lorazepam 1mg twice daily. -Scheduled dose administration was documented as 8am and 8pm. -A total of 194 scheduled doses were documented as administered from 3/1/15 to 6/5/15. Review of Resident #3's Delivery Manifest for lorazepam 1mg tablets revealed: -300 tablets of lorazepam 1mg were dispensed to the resident by the pharmacy from 3/7/15 to 5/29/15. -Prescription delivery dates and quantities were 60 tablets delivered on 3/7/15, 3/21/15, 4/13/15, 5/7/15 and 5/29/15. Review of the discrepancy records for the pharmacy, EMAR and observation of medication on hand for Resident #3 revealed: -A total of 300 tablets of lorazepam 1mg were dispensed to the resident by the pharmacy from 3/7/15 to 5/29/15. -194 tablets were documented as administered from 3/1/15 to 6/5/15.	C 367		

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C 367	Continued From page 19 -There were no lorazepam 1mg tablets on hand in the medication cart. -There was documentation dated 6/18/15 of 24 lorazepam 1mg tablets returned to the pharmacy. -Resulting in a discrepancy of 82 lorazepam 1mg tablets. Review of the CS logs on hand for Resident #3's lorazepam 1mg tablets revealed CS logs were unavailable for lorazepam 1mg tablets delivered on 3/7/15, 3/21/15, 4/13/15, 5/7/15 and 5/29/15. Review of Resident #3's June 2015 and July 2015 EMARs revealed: -Lorazepam 0.5mg twice daily. -Scheduled dose administration was documented as 8am and 8pm. -A total of 89 scheduled tablets were documented as administered from 6/6/15 to 7/27/15. Review of Resident #3's Delivery Manifest for lorazepam 0.5mg tablets revealed: -180 tablets of lorazepam 0.5mg were dispensed to the resident by the pharmacy from 6/5/15 to 7/20/15. -Prescription delivery dates and quantities were 60 tablets delivered on 6/5/15, 6/24/15 and 7/20/15. Observation of Resident #3's lorazepam 0.5mg tablet supply on hand on 7/27/15 at 1:40pm revealed there were 85 tablets of lorazepam 0.5mg on hand. Review of the discrepancy records for the pharmacy, EMAR and observation of medication on hand for Resident #3 revealed: -A total of 180 tablets of lorazepam 0.5mg were dispensed to the resident by the pharmacy from 6/5/15 to 7/20/15.	C 367		

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C 367	Continued From page 20 -85 tablets were on hand in the medication cart. -89 tablets were documented as administered from 6/6/15 to 7/27/15. -Resulting in a discrepancy of 6 lorazepam 0.5mg tablets. -There was no documentation of any tablets returned to the pharmacy. Review of the CS logs on hand for Resident #3's lorazepam 0.5mg tablets revealed: -CS logs were available for lorazepam 0.5mg tablets delivered on 6/5/15, 6/24/15 and 7/20/15. -No discrepancies noted. Interview with Resident #3 on 7/23/15 at 11:30am revealed: -He knew what his medications looked like. -He gets his meds on time. -Staff were administering his controlled medications as they were ordered by the physician. -He had no problems with the care he received. Refer to the interview with the Administrator on 7/27/15 at 10:46am. Refer to the interview with the Administrator on 7/27/15 at 3:11pm. Refer to the interview with the Property Manager on 7/27/15 at 4:00pm. Refer to telephone interviews with the facility pharmacy on 7/28/15 at 11:00am and 1:45pm. Refer to telephone interview with the facility's contracted LHPS nurse on 7/28/15 at 11:11am. _____ Interview with the Administrator on 7/27/15 at 10:46am revealed:	C 367		

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C 367	Continued From page 21 -"We have a meeting setup with the pharmacy to work out how to tighten up control [substance] handling." -There were "holes" in the system with the procedure of returning controlled substances to the facility pharmacy. -When a controlled substance needed to be returned to the facility pharmacy, staff were instructed to fill out a return sheet and staple it to the control sheet and place in pharmacy tote. -When the driver from the pharmacy arrived to the facility, the driver would remove numbered ties securing tote for staff to remove medications for the facility. -Then returns were to be put back in the tote and facility staff and driver watched as numbered ties are put back on the tote. -"Holes" in the system for managing controlled substances could occur if the driver says he/she didn't have a set of ties to re-secure the tote in front of facility staff, but had "extra ties in the car" and staff don't actually watch the tote being properly secured. -Drivers could take advantage of staff who did not know what they should watch with medication returns. -The return tote securing numbered ties are not two person verified. -Staff and driver should witness tie numbers applied on return tote and document, otherwise the driver could cut ties and reapply different ties gaining access to the tote. Interview with the Administrator on 7/27/15 at 3:11pm revealed: -She had confronted the former full-time Supervisor In Charge (SIC) in the facility back on 7/22/15 and asked him why some of the control sheets were missing. -The SIC was "very fidgety."	C 367		

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C 367	Continued From page 22 -"That's when he told me he had some of control sheets in the kitchen and something was spilled on some of them so he threw them out." -When the Administrator asked the SIC about why there was white out on some of the control sheets the SIC told her 'I need more training.' -The Administrator told the SIC that was "not an excuse since he had been a med tech for 8 years." Interview with the Property Manager on 7/27/15 at 4:00pm revealed: -She looked at the controlled medication bubble packs and CS logs "weekly" for all the controlled substances stored in the facility medication cart. -She checked the tablets given on the CS log matched the ordered tablets on the EMAR. -"Sometimes" she checked controlled substance supplies on hand, and at other times she checked the supplies of all medications on hand in the medication cart. -CS logs should have a pharmacy label. -A handwritten CS log would only occur when a medication was supplied by the Veterans Administration. -"We have had the pharmacy not send a control sheet" when they sent a bubble pack of a controlled substance. -She had been unaware of the missing CS logs, handwritten CS logs, and inaccurate count down CS logs for all the residents with orders for controlled substances in the facility. Telephone interview with the facility pharmacy on 7/28/15 at 11:00am revealed: -Returned medications from non-skilled facilities are destroyed at the pharmacy. -May 20, 2015 was the last time medications were destroyed. -He would look for medications returned from the	C 367		

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C 367	Continued From page 23 facility and provide documentation of his findings. -"If any medications were returned they should be in our possession." Second telephone interview with the facility pharmacy on 7/28/15 at 1:45pm revealed: -He had found "some" documentation of returned medications from the facility to the pharmacy. -"There still are some items missing." -He had no explanation for the discrepancies between what the facility was reporting and what they had at the pharmacy. Telephone interview with the facility's contracted nurse who performed medication reviews on 7/28/15 at 11:11am revealed: -She started employment at the facility's contracted pharmacy in June 2015 and just recently began completing the pharmacy reviews. -She did recall being at the facility and completing the medication reviews. -She would review medications quarterly. -She would compare the EMARs to the orders. -She would check on medication availability, counts and date. -She would check lab work for any diabetic residents or other residents as needed. -She would check controlled substances counts, documentation and what medications were on-hand matched what was documented. -If there were any issues, she would note that on the pharmacy review form. -She would also conduct any LHPS reviews while at the facility. _____ A plan of protection was received from the facility on 7/27/15 and included the following: -Controlled medications will be monitored by administrative staff weekly with copies of records faxed to main office for reconciliation during	C 367		

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C 367	Continued From page 24 follow-up monitoring. -Administrative staff will communicate directly with the pharmacy each time a controlled medication is returned. -Staff in the home have been removed. -Administrative staff will do documented visits to residents weekly. -Staff will sign control sheet whenever the (medication) cart is released between medication aides. -A (control) sheet without any releases or signatures from a second medication aide will be an alert for administrative staff to investigate further. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2015.	C 367		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that every resident received care and services which are adequate, appropriate and in compliance with relevant federal and State laws and rules and regulations as related to accurate reconciliation of controlled medications. The findings are:	C 912		

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C 912	Continued From page 25 Based on observation, interview, and record review, the facility failed to assure accurate reconciliation and readily retrievable records for the receipt, administration, and disposition of controlled substances which included oxycodone, morphine sulfate ER, clonazepam, adderall and lorazepam resulting in amounts which ranged from 8 to 357 tablets of oxycodone of the controlled substances being unaccounted for 4 of 4 sampled residents (Residents #1, #2, #3, and #4) [Refer to Tag 367, 10A NCAC 13G .1008(a) Controlled Substances (Type B Violation)].	C 912		