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D 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted an annual, follow-up survey, and complaint investigation on May 4 - 9, 2016, and May 12, 2016. The complaint investigation was initiated by the Iredell County Department of Social Services on February 2, 2016.	D 000		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility related to health care, nutrition and food service, activities, medication	D 176		

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administration, medication storage, controlled substances, resident rights, and medication aide testing and competency.

The findings are:

Interview with the Resident Care Coordinator (RCC) on 4/26/16 at 3:45pm revealed:
-She is in the facility Monday through Wednesday each week.
-Administrator B is in the facility Wednesday through Friday, and some weekends.

Interview with Administrator A on 5/5/16 at 4:15pm revealed she tried to come to the facility once every two weeks.

A. Based on interviews and record reviews, the facility failed to notify the physician for 2 of 5 sampled residents (#3, #10) for refusing medications Zoloft [A drug used to treat depression], Amantadine [A drug used to treat Parkinson], Risperidone [A drug used to treat [A drug used to treat mental disorders], Dilantin [A drug used to prevent and manage seizure activity], and Depakote [A drug used to treat both seizures and bipolar disorder] (Resident #10) and (Resident #3) not being administered Lyrica, a medication used to treat diabetic nerve pain. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care, (Type A1 Violation)].

B. Based on observations and interviews, the facility failed to assure beverages and food items served by the facility were protected from contamination by storing food items and beverages in a refrigerator containing 2 biohazard samples. [Refer to Tag D283 10A NCAC 13F .0904(a)(2) Nutrition and Food Service].

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D 176	Continued From page 2 C. Based on observations and interviews, the facility failed to provide the residents with 14 hours of scheduled activities per week. [Refer to Tag D317 10A NCAC 13F .0905(d) Activities Program]. D. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 3 of 5 sampled residents (Resident #3, #5, and #6) regarding MS Contin (an extended release medication used to treat moderate to severe pain), Lyrica (a medication used to treat diabetic nerve pain), and Advair (an inhaled medication used to prevent flare-ups or worsening of chronic obstructive pulmonary disease). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration, (Type Unabated B Violation)]. E. Based on observations, record reviews, and interviews, the facility failed to assure the Medication Administration Records were accurate for 2 of 5 sampled residents (Residents #5, and #6) regarding MS Contin Extended Release tablets and Advair diskus inhaler. [Refer to Tag D367 10A NCAC 13F .1004(j) Medication Administration]. F. Based on observations and interviews, the facility failed to assure medications for 7 residents were stored in separate locked containers by storing medications in a refrigerator containing 2 biohazard samples and various non-medication related items. [Refer to Tag D383 10A NCAC 13F .1006(g) Medication Storage]. G. Based on observations, interviews, and record reviews the facility failed to assure a readily retrievable record of controlled substances for 2	D 176		

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D 176	Continued From page 3 of 6 sampled residents (Resident #6 and #16), that were prescribed MS Contin (an extended release medication used to treat moderate to severe pain) by documenting the receipt, administration and disposition of the controlled substances. [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances, (Type Unabated B Violation)]. H. Based on observations, interviews, and record reviews the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to management of facilities, health care, medication aide qualifications, medication administration and controlled substances. [Refer to Tag D912 G.S. 131D-21(2) Declaration of Residents' Rights]. I. Based on observations, interviews, and record reviews the facility failed to assure 1 of 4 sampled Medication Aides (Staff A) had completed the medication written examination within 60 days of hire as a medication aide.[Refer to Tag D935 G.S. 131D-4.5(b) ACH Medication Aides; Training and Competency, (Type B Violation)]. _____ The facility provided the following Plan of Protection: -The Administrator / Manager shall ensure that the facility Administrator and Co-Administrator shall be responsible for the total operation of the adult care home. -The Administrator and Co-Administrator shall be responsible for meeting and maintaining rules of the Division of Health Service Regulation and the County Department of Social Services. -The Administrator will meet in person bi-weekly at the facility with the Manager to review the	D 176		

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D 176	Continued From page 4 operations of the facility, to be available to residents and families and to assure compliance with the plan of correction. -Documentation of the communication meeting will be kept at the facility for review. THE FACILITY PROVIDED A CORRECTION DATE OF MAY 20, 2016 FOR THIS TYPE UNABATED B VIOLATION.	D 176		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type A1 Violation Based on interview and record review, the facility failed to notify the physician for 2 of 5 sampled residents (#3, #10) for refusing medications Zoloft [A drug used to treat depression], Amantadine [A drug used to treat Parkinson], Risperidone [A drug used to treat mental disorders], Dilantin [A drug used to prevent and manage seizure activity], and Depakote [A drug used to treat both seizures and bipolar disorder] (Resident #10) and (Resident #3) not being administered Lyrica, a medication used to treat diabetic nerve pain. The findings are: A. Review of Resident #10's current FL-2 dated 2/23/16 documented: -Diagnoses included dementia, chronic	D 273		

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obstructive pulmonary disease, seizures, Parkinson, anxiety and depression.
-The medications included Zoloft, Amantadine, Risperidone, Dilantin, and Depakote.
-Under additional information "OK to use liquid medications if available".

Review of a physician assessment for Resident #10 dated 2/27/16 documented:
-Diagnoses included paranoid schizophrenia, chronic; dyspepsia.
-Under history and physical it was noted the "paranoia was diagnosed years ago. The patient continues to have paranoia and was not over sedated by increasing his Risperdal. Concerning dyspepsia, the discomfort is fairly diffuse and does not localize. He describes the pain as burning. The current symptoms have been present for 2 months."

Review of Resident #10's record revealed:
-A communication / order sheet undated which documented "Has had a weight loss from 175 to 158. Resident refuses to eat. DSS notified. Very Picky" The physician dated and signed 2/13/16 with no written instructions.
-An order sheet dated 2/27/16 which documented "increase Risperdal to 1mg three times per day. Discontinue all previous orders on Risperdal." Signed by the physician.
-A resident care note dated 3/4/16 that documented "Resident refused meds tonight! Said his stomach hurt and the meds just make it worse!"
-A resident care note dated 3/27/16 that documented "Resident fell at 8:00am hit his head had a cut on forehead and nose sent him to hospital he got stitches."

Review of a discharge summary from a local

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D 273	Continued From page 6 hospital dated 4/24/16 provided by Resident #10's Guardian on 5/5/16 revealed: -Resident #10 presented to the emergency room after being found unresponsive. -Resident #10 was found by Emergency Medical Services personnel at the facility to have a 59 percent oxygen saturation on room air. -Resident #10 was placed on a nonrebreather with improvement of his oxygen status. -Resident #10 had regained consciousness upon arrival to the emergency room. -"No further seizure activity was seen. No seizure was witnessed at the facility." -Discharge diagnoses included hypokalemia, transient hypoxic respiratory failure, seizure, Parkinson's, chronic obstructive pulmonary disease, anxiety and depression and deconditioning. -Potassium level was 2.4 [normal range 3.5 to 5.0]. -"Valproic acid level and Depakote levels were low, probably indicated that the patient was not taking" . -"The patient is very deconditioned [A loss of muscle tone and endurance due to chronic disease, immobility, or loss of function] and would benefit from skilled nursing facility at discharge and would not be a good candidate to return to assisted living at this time." -"I believe the patient's problem was not taking medications consistently. His hypoxic event was probably related to a seizure." -As per the emergency medical services report, the patient was initially found unresponsive at his skilled nursing facility, [name of facility]. The patient was noted to be obtunded [A reduction of alertness and a diminished sensation of pain] and his initial oxygen saturation per emergency medical services documentation was only 59 percent on room air.	D 273		

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-"The valporic acid [Depakote] level and the Phenytoin [Dilantin] levels were undetectable suggesting that the patient had not been taking his anti-seizure medications. The Phenytoin level was less than 0.5 [normal range 10-20] and the Valproic acid level was less than 3 [normal range 50-125]".
-The patient was admitted to the telemetry floor for hypokalemia and transient hypoxemic respiratory failure, likely secondary to postictal state from an unwitnessed seizure.

Review of a "Facility - Physician interaction form" undated provided by the facility on 5/6/16 documented "[Resident name] has been refusing his meds. The med aides have attempted giving meds in apple sauce and pudding. Can we have an order for liquid meds for Risperdal 1mg three times per day, Amantadine 100mg twice per day and Ativan 0.5mg three times per day" which the physician approved and signed on 4/15/16.

Review of Resident #10's March 2016 Medication Administration Records documented:
-On 3/25/16 Resident #10 started refusing all of his medications almost daily.
-From 3/25/16 through 3/31/16 out of 18 opportunities it was documented he refused his Dilantin 8 times.
-From 3/25/16 through 3/31/16 out of 18 opportunities it was documented he refused his Depakote 8 times.

Review of Resident #10's April 2016 Medication Administration Records documented:
-From 4/1/16 through 4/21/16 out of 62 opportunities it was documented he refused his Dilantin 51 times.
-From 4/1/16 through 4/21/16 out of 62 opportunities it was documented he refused his

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D 273	Continued From page 8 Depakote 50 times. Telephone interview on 5/6/16 at 11:00am with Resident #10's Guardian revealed: -She had been notified by the facility in February Resident #10 had been sent out for a urinary tract infection and paranoia. -She had visited Resident #10 on 2/18/16 at the facility and he seemed his "usual self"; she had no concerns. -She had been notified by the facility that Resident #10 had fallen on 3/29/16 and was sent out to emergency department and received sutures to head. -She had been at the facility on 4/18/16 and Resident #10 was sleeping. He did not appear to be in any distress. -She had regularly visited Resident #10 at the facility and had no concerns about his care, "There were no red flags" . -She had not been notified by the facility that Resident #10 was refusing his medications. Interview on 5/9/16 at 11:45am with the Administrator B revealed: -It was Resident #10's right to refuse medications. -The Primary Care Provider for Resident #10 was notified that he was refusing his medications, but could not recall the date. -The staff continued to try and get Resident #10 to take his medications. -He [Resident #10] would sometimes take the medications, but not regularly. -No one had reported that Resident #10 had a seizure. -Resident #10 was a very "Picky eater" and would not eat much. -He stayed in his room a lot and did not interact with other residents.	D 273		

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-She felt the facility had done everything that they should have done.

Telephone interview on 5/9/16 at 12:20pm with Resident #10's Primary Care Provider revealed:
-The facility had notified him that Resident #10 was refusing his medications, but did not remember when he was notified.
-He did have concerns that Resident #10 was not taking his anti-seizure medication, but there was nothing that could be done.
-Resident #10 was "very paranoid, and had beliefs that his food and medications were being poisoned".
-He had not ordered any Dilantin or Depakote levels because the resident was refusing the medications.
-He had seen Resident #10 last on 2/27/16 and increased his Risperdal.
-He did not know how much more the facility could have done for Resident #10.
-He did not feel like an increased level of care was necessary because he was still following Resident #10 at the skilled facility where Resident #10 is continuing to refuse to take his medications and eat.
-Resident #10 has sutures in his head that need to be removed, but was refusing to let staff remove them.

Interview on 5/9/16 at 1:30pm with Staff B, Medication Aide revealed:
-She was on duty the morning of 4/21/16 when Resident #10 was sent out.
-The Personal Care Aides came and got her after changing Resident #10 because he was unresponsive.
-She called Emergency Medical Service to transport Resident #10 to the hospital because she could not get his vital signs and he was

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unresponsive.
-No one had reported to her that he had a seizure, nor had she witnessed a seizure.
-Resident #10 refused his medications most of the time, but on occasion she could get him to take his medications.

Review of the Emergency Medical Services documentation dated 4/21/16 provided by the local department of social services revealed:
-The patient was found sitting in a wheel chair leaning over and very pale.
-The vital signs were blood pressure 50/0, pulse 107 and respirations of 8.
-"After getting patient into the unit attempted to try to obtain a BP, thought it was heard at 50 systolic and no radial pulses present. Noted patients extremities were getting colder and also noted patients SP02 dropping."
-"Skin clammy and cold" .

Interview on 5/12/16 at 9:40am with the Resident Care Coordinator revealed:
-They had tried to get the resident to take liquid medications in applesauce, but he refused.
-It was the resident's right to refuse his medications.
-She did not know what else could have been done.

Interview on 5/12/16 at 9:50am with the Administrator B revealed:
-She was made aware of Resident #10 refusing medications around the first of April 2016.
-He had not refused his medications prior to that.
-He had not been previously referred to a mental health because he had no negative behaviors.
-Resident #10's dementia was caused by his Parkinson Disease.
-Resident #10's Primary Care Provider had

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ordered a psychiatric evaluation around the middle of April because he was refusing his medications.
-Resident #10 had left the facility before he could be seen by the mental health provider.
-Resident #10's primary care provider was ordering his mental health medications.
-The guardian was notified about resident refusing his medications.
-Resident #10 had not had any seizures over the past year.

Interview with Staff A, Medication Aide on 5/12/16 at 10:42am revealed:
-Resident #10 usually came to the medication room for administration of his medications.
-"About a 1/3 of the time, we (MAs) took (named Resident #10's) medications to him because he didn't come to the med room."
-Residents have the right to refuse medications.
-The MAs encouraged residents to take their medications, and if a resident will not take medications from one MA, another MA will try to get them to take their medications.
-If the resident still will not take their medications, the MA will tell the manager or Administrator and they will call the doctor.
-Reporting medication refusals by residents to the Manager or Administrator occurs after the first missed dose.

Interview of Resident #10's Guardian on 5/12/16 at 10:55am revealed:
-She did not feel like Resident #10 had the insight to know the importance of taking his medications.
-Due to his dementia related to his Parkinson Disease, he does not realize the importance of taking his seizure medications.
-Resident #10 was very suspicious and paranoid.
-She had never been notified by the facility that

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Resident #10 was not taking his medications.
-He [Resident #10] was still refusing his medications at the skilled nursing facility he is currently at.

Interview with Administrator B on 5/12/16 at 11:31am revealed:
-The facility would complete a mental health referral form for any resident that had a history of mental health diagnoses or behaviors.
-The mental health provider would see the resident in the facility and then a nurse would also make follow-up visits with the resident.

Refer to review of the facility's policy on medication administration.

B. Review of Resident #3's current FL2 dated 6/8/15 revealed:
-Diagnoses included anxiety and depression, seizure disorder, adult onset diabetes, schizophrenia, and chronic obstructive pulmonary disease.
-A medication order for Lyrica, 100mg three times a day. (Lyrica is a medication used to treat nerve pain associated with diabetes, anxiety disorders, and certain types of seizures.)

Record review revealed subsequent medication orders for Resident #3 for Lyrica 100mg three times a day dated 2/9/16, and 5/1/16.

Record review revealed a subsequent order dated 5/2/16 to increase the Lyrica to 150mg three times a day.

Review of Resident #3's Medication Administration Record (MAR) for May 2016 revealed:
-An entry for Lyrica 100mg, one capsule by mouth

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three times a day with scheduled administration times of 8am, 2pm, and 8pm.
-The Lyrica 100mg had been initialed as administered on 5/1/16 at 8am and 2pm.
-All other doses from 8pm on 5/1/16 through 8am on 5/5/16 had been initialed and circled as not administered.
-The back of the May 2016 MAR noted the reason for the circled doses of Lyrica 100mg as "drug temporarily unavailable."

Observation of Resident #3's medications on hand on the morning of 5/5/15 revealed no Lyrica 100mg or 150mg available to administer.

Interview with the dispensing Pharmacist at the pharmacy provider on 5/5/16 at 2:13pm revealed:
-He had received an order for Resident #3's Lyrica 150mg three times a day on 5/2/16 but did not order it from the drug wholesaler until the next day.
-The pharmacy did not normally stock the 150mg strength of Lyrica.
-The dispensing pharmacist did not know Resident #3 was completely out his Lyrica 100mg.
-The facility did not ask the dispensing pharmacist to call the Lyrica 100mg or 150mg in to a back-up pharmacy.

Observation of Resident #3's medications on hand on the morning of 5/6/16 revealed cassettes of Lyrica 150mg with a label noting 90 caps dispensed on 5/5/16, and 2 capsules used from the cassette.

Review of the Resident's #3's MAR for May 2016 revealed Lyrica 150mg capsules documented as administered on 5/5/16 at 8pm and 5/6/16 at 8am.

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D 273	Continued From page 14 Interview with Resident #3's physician on 5/5/16 at 2:35pm revealed: -He had increased Resident #3's Lyrica from 100mg to 150mg three times a day, but he was not sure what precipitated the dose increase. -Resident #3 had peripheral neuropathy (nerve pain). -The facility did not make the physician aware Resident #3 was out of his 100mg of Lyrica, and the 150mg Lyrica had not yet been started. -There would be "nothing dramatic" from Resident #3 missing his Lyrica, and "I will see him this Saturday," (5/7/16.) Interview with Resident #3 on 5/5/16 at 3:15pm revealed he believed he was receiving his medications as ordered by his physician including his Lyrica. Interview with the facility Administrator A on 5/5/16 at 2:35pm revealed: -She believed Resident #3's physician was contacted by facility staff regarding the resident not receiving his Lyrica. -The facility did not document in the resident's record contact with the resident's physician regarding Resident #3's Lyrica not being administered. Interview with the facility Administrator A on 5/6/16 at 3:40pm revealed: -The facility depended on the Pharmacist at the pharmacy provider to decide when the back-up pharmacy should to be contacted to provide an emergency refill of a medication. -She believed the pharmacist and the physician had been in contact about Resident #3 not receiving his Lyrica.	D 273		

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D 273	Continued From page 15 Interview with a Medication Aide (Staff A) on 5/12/16 at 10:42am revealed: -The Medication Aide (MA) duty or facility manager faxed new orders to the pharmacy. -The MAs checked the MARs from the pharmacy for accuracy. Refer to review of the facility's policy on medication administration. --- Review of the facility's policy on medication administration revealed: -No specific policy about when a resident's prescribing practitioner would be contacted regarding residents not receiving their medications. -Medications including prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioners orders. --- The facility provided the following Plan of Protection: -The Administrator/Manger shall assure referral and follow-up to meet the routine and acute healthcare needs of the residents in accordance to the rule. -The prescribing practitioner will be notified after 3 consecutive days of medication refusal. -A new policy will be written and reviewed with all supervisors. -The Administrator/Manager will contact the resident's family member/guardian when medications are refused for 3 consecutive days. -Documentation will be kept at the facility. THE DATE OF CORRECTION FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 11,	D 273		

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D 273	Continued From page 16 2016.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure beverages and food items served by the facility were protected from contamination by storing these items in a refrigerator containing 2 biohazard samples. The findings are: Observation of the facility refrigerator located in the medication room on 5/6/16 at 5:34pm and 6:07pm revealed: -A small plastic unlocked tote labeled "insulin" contained 1 vial of insulin and 6 insulin pens labeled with directions for use for 3 different residents. (Insulins are used to lower blood sugars in residents with diabetes and are considered a sterile injectable product.) -A small plastic uncovered bin contained 3 vials of Nitroglycerin Sublingual Tablets 0.4mg labeled with directions for use for 3 different residents. (Nitroglycerin is a medication used to treat chest pain and lower blood pressure.) -On the top shelf of the door of the refrigerator was an open box of Lorazepam Liquid labeled with directions for use and another resident's name. (Lorazepam is a medication used for	D 283		

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anxiety, seizures, and nausea.)
-The bottom shelf of the door of the refrigerator contained 2 biohazard bags with specimen bottles containing liquid that appeared to be urine samples.
-Two unopened juice blend bottles sitting next to the biohazard bags.
-At least 9 cans of nutritional supplements.
-Open and unopened 2 liter bottles of soda.
-Two open 16 ounce plastic bottles of soda.
-Two open 12 count boxes containing unopened cans of soda.
-One 6 pack of unopened 16 ounce soda bottles.
-At least 9 small sealed containers of applesauce, prepared from a bulk container.

Observation on 5/6/16 at 6:15pm of the refrigerator located in the medication room revealed:
-Two unlabeled urine sample bottles with a dark yellowish colored liquid with what appeared to be a milky growth.
-Each of the bottles were sealed in a biohazard bag with no identifying labels.

Interview with Administrator A on 5/6/16 at 6:15pm revealed:
-She was not sure why the urine samples were in the refrigerator in the medication room.
-She believed the samples were from residents and not staff.
-"We (administrative staff) take urine samples from staff directly to be tested."
-The facility has no specific policy on the storage of lab specimens.
-She believed the urine samples may have been placed in the refrigerator by home health staff.

Interview with the Home Health Nurse on 5/12/16 at 12:18pm revealed:

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-She kept a cooler and ice packs in her car to store specimens.
-She would not use the refrigerator in the facility to store specimens.
-There were recent orders for urine specimens at the facility, but she did not store them in the facility refrigerator.

Interview with Administrator A on 5/9/16 at 10:45am revealed:
-Canned sodas for residents were not usually kept in the medication refrigerator.
-The facility's vending drink machine had been broken since last Tuesday, (5/3/16), and they (soft drink company staff) came to fix it on Friday, (5/6/16.)
-The open drinks in the refrigerator belonged to staff not residents.

Throughout the survey, residents were observed buying sodas from the medication room refrigerator.

Confidential interview with a MA revealed:
-The first time she saw samples in biohazard bags in the refrigerator was on Friday, (5/6/16.)
-She was not sure where they came from.
-She had never seen biohazard bags with samples in the medication room refrigerator before.

Confidential interview with a second MA revealed:
-She first discovered a clear sealed container of urine in a biohazard bag in the refrigerator in the medication room on 4/25/16.
-On 4/29/16 she discovered a second clear sealed container of urine in a biohazard bag in the refrigerator in the medication room.
-She was not provided any details about the

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D 283	Continued From page 19 containers of urine, as who they belonged to, or who put them in the refrigerator. Interview with Administrator B on 5/12/16 at 11:30am revealed the facility doesn't have a specific policy on food storage in the med room refrigerator.	D 283		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide the residents with 14 hours of scheduled activities per week. The findings are: Observation on 4/29/16 at 3:20pm revealed: -The April 2016 activity calendar posted on the wall in the hallway near the medication aide room.	D 317		

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D 317	Continued From page 20 -The calendar listed various activities such as bingo, crafts, church, bird watching, word search and exercise. Confidential interviews with nine residents between 4/29/16 - 5/9/16 revealed the following: -"We don't do activities every day like the calendar says, we play bingo or color 2-3 times a week". -Two residents stated they had been at the facility two years and never had popcorn and a movie, but was "listed on the activity calendar every Saturday". -"We don't do activities", we only watch TV in the activity room". -"All we do is play bingo and have coloring contests". -"Two to three times a week play we play bingo, board games or color." -"Can't always hear numbers called during bingo because residents watch TV in the activity room". -"We color once a week, play bingo once a week, do word search once a week, and sometimes play board games, but not that often." -One resident stated they "do activities sometimes, but not every day, we play bingo about once a week". -"Sometimes staff calls the numbers for bingo and other times residents do it." Observation on 5/6/16 revealed: -An activity calendar posted on the wall in the hallway near the medication room which listed shopping as an activity 10:00am - 11:00am. -At 10:10am, one resident was sitting in a chair in the activity room working a crossword puzzle and two residents, were watching television. Interview with a Medication Aide (MA) on 5/6/16 at 10:17am revealed residents did not go	D 317		

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D 317	Continued From page 21 shopping today at 10:00am because "I accidentally put it on the calendar for today." Observation on 5/4/16 at 11:46am revealed: -The May 2016 activity calendar posted on the wall in the hallway near the medication room that listed various activities such as bingo, exercise, bible study, birdwatching, board games, ring toss, coloring and puzzles. -The activity calendar listed exercise from 9:00am - 10:00am. -At 9:15am, one resident was sitting in a chair in the activity room working a crossword puzzle - no other residents or staff were in the activity room. -The activity calendar listed board games from 10:00am - 11:00am. -At 10:05am and 10:30am the same resident sitting in the activity room working a crossword puzzle, and the same resident was lying on the sofa watching television - no other residents or staff were in the activity room. -No activities held outside within sight of the facility at 9:15am, 10:05am and 10:30am. Confidential interviews with four staff revealed: -Every day MAs, Personal Care Aides (PCAs) or housekeeping staff facilitated activities listed on the activity calendar. -"We try to follow the calendar." -The PCAs and MAs help residents get to and from activities. -Activities such as bingo, word search, board games or coloring were held twice daily day and matched the activity calendar. -Activities consisted of board games, coloring, bingo, exercise and church on Sunday and Tuesday mornings. -For exercise residents moved their arms up and down while standing in place and jumped up and down.	D 317		

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D 317	Continued From page 22 -Residents "color a lot", watch TV and work puzzles.	D 317		
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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 3 of 5 sampled residents (Resident #3, #5, and #6) regarding MS Contin (an extended release medication used to treat moderate to severe pain), Lyrica (a medication used to treat diabetic nerve pain), and Advair (an inhaled medication used to prevent flare-ups or worsening of chronic obstructive pulmonary disease). The findings are: A. Review of Resident #6's current FL2 dated 7/22/15 revealed diagnoses included history of neck surgery, anxiety, depression, insomnia,	D 358		

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bipolar disorder, and non-insulin dependent diabetes mellitus.

Record review revealed subsequent medication orders for Resident #6 for MS Contin (an extended release medication used to treat moderate to severe pain) 15mg tablets every 12 hours dated 1/9/16, 2/9/16 and 4/25/16.

Review of Resident #6's Medication Administration Records (MARs) for March and April 2016 revealed:
-An entry for MS Contin 15mg, one tablet every 12 hours with scheduled administration times of 8am and 8pm.
-The MS Contin 15mg had been documented as administered at 8am and 8pm daily from 3/1/16 through 4/30/16.
-An entry on 3/13/16 at 8:00am documenting one tablet was administered by Staff A, Medication Aide (MA).
-An entry on 3/13/16 at 8:00pm documenting one tablet was administered by Staff D, MA.
-There was no documentation on the back of the MAR related to MS Contin 15mg.

Confidential interview with a MA revealed:
-Resident #6 was ordered MS Contin 15mg at 8:00am and 8:00pm.
-On 3/13/16 the Controlled Drug Receipt/Record/Disposition form was signed twice for the resident's MS Contin 15mg at 8:00am.
-The MA was instructed by Administrator B to mark through the second 8:00am dose for 3/13/16, document administration of the 8:00pm dose for 3/13/16 on the Controlled Drug Receipt/Record/Disposition form and MAR, but not administer the 8:00pm dose on 3/13/16.
-When the MA arrived to work on 3/13/16, it was

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observed that Resident #6 had slept from 3:00pm to 5:30pm.
-Resident #6 woke up at 5:30pm, ate dinner, smoked a cigarette and went back to bed.
-The resident woke up around 9:30pm and took his other scheduled medications and went back to bed.

Interview with Resident #6 on 4/29/16 at 3:30 pm revealed:
-He took scheduled MS Contin 15mg for pain daily at 8:00am and 8:00pm.
-On 3/13/16 a MA told him he could not take the 8:00pm dose of MS Contin because he was administered two doses (30mg total) at 8:00am on 3/13/16.
-He was not aware of receiving two doses at 8:00am because his medications were mixed with applesauce.
-On 3/13/16 he was "tired and just wanted to sleep all day" .
-He thought he was tired due to the time change (daylight savings time).
-He did not discuss the medication error with the first shift MA or management.

Review of the Controlled Drug Receipt/Record/Disposition form dated 2/26/16 revealed:
-MS Contin 15mg had been documented as administered for 60 doses from 3/04/16 at 8:00pm to 4/03/16 at 8:00am.
-An entry on 3/13/16 at 8:00am documenting one tablet was administered by Staff B, MA.
-A second entry that had been marked out, on 3/13/16 at 8:00am documenting another tablet was administered by Staff B, MA.
-An entry on 3/13/16 at 8:00pm documenting one tablet was administered by Staff D, MA.

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D 358	Continued From page 25 Interview with Administrator B on 5/9/16 at 3:10pm revealed: -She was unaware of the medication error on 3/13/16. -She stated the second entry on 3/13/16 at 8:00am on the Controlled Drug Receipt/Record/Disposition form, dated 2/26/16, was made in error by Staff B, MA and the medication was not administered. Interview with Resident #6's Primary Care Physician (PCP) on 5/09/16 at 12:24pm revealed he was not notified of the medication error on 3/13/16. Review of Resident #6's MAR for May 2016 revealed: -An entry for MS Contin 15mg, one tablet by mouth twice daily with scheduled administration times of 8am and 8pm. -The MS Contin 15mg had been documented as administered at 8am and 8pm daily from 5/01/16 through 5/04/16 at 8:00am. -The MS Contin 15mg 5/04/16 8pm dose was initialed and circled (meaning it was not given). -The MS Contin 15mg had been documented as administered at 8am on 5/05/16. -There was no documentation on the back of the MAR related to MS Contin 15mg. Observation of Resident #6s medications on hand on 5/5/16 at 2:25pm revealed there was no MS Contin 15mg available to administer. Review of the Controlled Drug Receipt/Record/Disposition form dated 4/04/16 revealed the MS Contin 15mg had been documented as administered for 60 doses from 4/04/16 at 8:00pm to 5/04/16 at 8:00am.	D 358		

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Confidential interview with a MA revealed:
-Resident #6 ran out of MS Contin 15mg "last night" (5/4/16).
-She was told by Administrator B on 5/4/16 to take one MS Contin 60mg tablet from Resident #16's supply and cut it in half for Resident #6.
-The MA told Administrator B that Resident #6 was ordered 15mg twice daily and that half of Resident #16's tablet would be 30mg.
-The MA stated that Administrator B told her "he'll be alright."
-The MA stated she did not feel comfortable cutting the medication so Administrator B cut the 60mg tablet in half and gave it (30mg) to Resident #6 on 5/04/16 at 8:00pm.
-The MA was instructed by Administrator B on 5/04/16 to place the remaining half of the MS Contin 60mg in a medication cup and place it in a sealed plastic bag.
-The MA was instructed by Administrator B to put the remaining half tablet of MS Contin 60mg in the gray filing cabinet, located in the medication room, to give to Resident #6 the next morning on 5/05/16.

-The MA stated she had ordered medications for all residents on 5/02/16 and that Resident #6 would require a "hard script" for his MS Contin 15mg.

Review of the adult dosing information and medication guide for MS Contin revealed:
-Swallow MS Contin whole.
-Do not cut, break, chew, crush, dissolve, snort, or inject MS Contin because this may cause rapid release and absorption of a potentially fatal morphine dose.

Observation of the top drawer of the gray filing cabinet on 5/05/16 at 2:55pm revealed a sealed

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plastic bag with an empty paper medication cup.

Interview with the dispensing pharmacist at the pharmacy provider on 5/5/16 at 3:49pm revealed:
-The dispensing pharmacist did not know Resident #6 was completely out of the MS Contin 15mg.
-The last MS Contin 15mg dispensed for Resident #6 was 60 tablets on 4/04/16.
-Resident #6 should have had enough MS Contin 15mg through 5/5/16.
-The medication was on backorder until 5/4/16 and should be in the pharmacy today.

Observation of Resident #6's medications on hand on 5/06/16 at 12:00pm revealed:
-A cassette of MS Contin 15mg in the medication cart with a label noting a total of 60 tablets dispensed on 5/05/16.
-The cassette on the medication cart revealed 2 tablets had been administered and 14 tablets remained.
-3 additional cassettes of MS Contin 15mg in the storage area that contained a total of 44 tablets that were dispensed on 5/05/16.

Subsequent review of Resident's #6's MAR for May 2016 on 5/6/16 at 12:00pm revealed MS Contin 15mg tablets documented as administered on 5/05/16 at 8pm and 5/06/16 at 8am.

Review of the Controlled Drug Receipt/Record/Disposition form dated 5/05/16 revealed the MS Contin 15mg had been documented as administered for 2 doses from 5/05/16 at 8:00pm to 5/06/16 at 8:00am.

Review of a Medication Error Report dated 5/5/16 revealed:
-Resident #6 was administered morphine sulfate

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extended release 60mg (one half tablet to equal a 30mg dose).
-The error was made because the medication was not received from the pharmacy due to backorder of medication and staff borrowed medications from resident #16 MS Contin 60mg and gave one-half tablet (30mg) to Resident #6.
-The error was discovered by the state surveyor on 5/5/16.
-The PCP was notified via fax on 5/5/16 at 6:15pm.

Interview with Resident #6 on 5/06/16 at 3:00pm revealed:
-He stated he was "Ok, no problems" after taking the two MS Contin 30mg doses on 5/04/16 at 8pm and 5/06/16 at 8am.
-"If I felt weird I would let someone know."
-"It must have been an oversight."
-"I don't want to get anyone in trouble,...no harm, no foul."

Interview with Resident #6's PCP on 5/09/16 at 12:24pm revealed:
-"It seems like I told them to do that (administer MS Contin 30mg)."
-"I didn't write anything down, but I vaguely remember it."
-Resident #6 was "always asking for increased pain meds."

Interview with Administrator B on 5/9/16 at 3:10pm revealed:
-Staff D, MA called her stating Resident #6 was out of his MS Contin 15mg for the 8pm dose on 5/04/16.
-She asked Staff D, MA on 5/4/16 if any other residents were on the same medication as Resident #6.
-She was told by Staff D, MA on 5/4/16 that

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Resident #6 took MS Contin 30mg and that Resident #16 had MS Contin 60mg.
-She told Staff D, MA to split one of Resident #16's MS Contin 60mg tablets on 5/4/16 and give it to resident #6.
-The MA did not want to split the tablet, so Administrator B split the 60mg tablet in half and Staff D, MA gave the half tablet (30mg) to Resident #6 on 5/4/16 at 8:00pm.
-"I split the pill, [Staff D, MA] gave the med."
-The other half tablet was put in a cup for [Staff A, MA] to give on 5/5/16 at 8:00am.
-"I trusted what the MA told me, I should've known better."
-"I found out after the fact that [Resident #6] was on 15mg."
-She tried to contact the PCP on 5/05/16 after being notified of the error, but was unable to speak to him.
-A Medication Error Report was completed and faxed to the PCP on 5/05/16.
-She had not spoken to the PCP regarding the error and had not received a response from him.

Refer to interview with the facility Administrator A on 5/6/16 at 3:40pm.

Refer to review of the facility's policy on medication administration.

B. Review of Resident #3's current FL2 revealed:
-Diagnoses included anxiety and depression, seizure disorder, adult onset diabetes, schizophrenia, and chronic obstructive pulmonary disease.
-A medication order for Lyrica, 100mg three times a day. (Lyrica is a medication used to treat nerve pain associated with diabetes, anxiety disorders, and certain types of seizures.)

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D 358	Continued From page 30 Record review revealed subsequent medication orders for Resident #3 for Lyrica 100mg three times a day dated 2/9/16, and 5/1/16. Record review revealed another subsequent order dated 5/2/16 to increase the Lyrica to 150mg three times a day. Review of Resident #3's Medication Administration Records (MARs) for March and April 2016 revealed: -An entry for Lyrica 100mg, one capsule by mouth three times a day with scheduled administration times of 8am, 2pm, and 8pm. -The Lyrica 100mg had been documented as administered at 8am, 2pm and 8pm daily from 3/1/16 through 4/30/16. Review of Resident #3's MAR for May 2016 revealed: -An entry for Lyrica 100mg, one capsule by mouth three times a day with scheduled administration times of 8am, 2pm, and 8pm. -The Lyrica 100mg had been initialed as administered on 5/1/16 at 8am and 2pm. -All other doses from 8pm on 5/1/16 through 8am on 5/5/16 had been initialed and circled as not administered. -The back of the May 2016 MAR noted the reason for the circled doses of Lyrica 100mg as "drug temporarily unavailable." Observation of Resident #3's mediations on hand on the morning of 5/5/15 revealed no Lyrica 100mg or 150mg available to administer. Inteview with a Medication Aide (MA) on 5/5/16 at 11:45am revealed: -The MA on duty ordered medications from the pharmacy when needed.	D 358		

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D 358	Continued From page 31 -The MA believed Resident #3's Lyrica had been ordered, but was not sure why it was not here. Interview with the facility Manager on 5/5/16 at 11:50am revealed: -The pharmacy was out of the Lyrica 150mg and they would have to order it from their supplier. -The back up pharmacy would be used for medications such as antibiotics. Interview with the dispensing Pharmacist at the pharmacy provider on 5/5/16 at 2:13pm revealed: -He had received the order for Resident #3's Lyrica 150mg three times a day on 5/2/16 but did not order it from the drug wholesaler until the next day. -The pharmacy did not normally stock the 150mg strength of Lyrica. -The dispensing pharmacist did not know Resident #3 was completely out of the Lyrica 100mg. -The last Lyrica 100mg dispensed for Resident #3 was 32 capsules on 4/11/16. -The facility did not ask the dispensing pharmacist to call the Lyrica 100mg or 150mg in to a back up pharmacy. -The 150mg Lyrica for Resident #3 would be coming to the facility this evening on 5/5/16 with their regular order. Observation of Resident #3's medications on hand on the morning of 5/6/16 revealed cassettes of Lyrica 150mg with a label noting 90 caps dispensed on 5/5/16, and 2 capsules used from the cassette. Review of the Resident's #3's MAR for May 2016 revealed Lyrica 150mg capsules documented as administered on 5/5/16 at 8pm and 5/6/16 at 8am.	D 358		

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D 358	Continued From page 32 Interview with Resident #3's physician on 5/5/16 at 2:35pm revealed: -He had increased Resident #3's Lyrica from 100mg to 150mg three times a day, but he was not sure what precipitated the dose increase. -Resident #3 used the Lyrica for peripheral neuropathy. -The facility did not make the prescribing practitioner aware Resident #3 ran out of his 100mg of Lyrica, and the 150mg Lyrica had not yet been started. -There would be "nothing dramatic" from Resident #3 missing his Lyrica, and "I will see him this Saturday," (5/7/16.) Interview with Resident #3 on 5/5/16 at 3:15pm revealed: -He believed he received his medications as ordered by his physician. -He believed he ran out of his medications while at the facility, but believed it was over a year ago. -Resident #3 believed he had all his medications available now and was taking his Lyrica three times a day. Refer to interview with the facility Administrator A on 5/6/16 at 3:40pm. Refer to review of the facility's policy on medication administration. C. Review of Resident #5's current FL2 dated 6/8/15 revealed: -Diagnoses included gastroesophageal reflux disease, chronic obstructive pulmonary disease, bipolar disease, and hypertension. -A medication order for Advair 250-50 diskus, inhale 1 blister using diskus device every 12 hours. (A medication used to prevent flare-ups or	D 358		

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D 358	Continued From page 33 worsening of chronic obstructive pulmonary disease). Review of Resident #5's Medication Administration Record (MAR) for May 2016 revealed: -An entry for Advair 250-50 Diskus inhale the contents of 1 blister using diskus device every 12 hours. -The Advair had been documented as administered at 8am and 8pm from 5/1/16 through 5/4/16, and at 8am on 5/5/16. Observation of Resident #5's medications on hand on the morning of 5/5/16 at 10:00am revealed no Advair 250-50 diskus available to administer. Interview with Resident #5's on 5/5/16 at 11:45am revealed: -Her Advair inhaler had been on back order for a few days. -She had not received it since the 2nd. -She had not had any shortness of breath. Telephone interview with the Pharmacist at the pharmacy provider on 5/5/16 at 2:13pm revealed: -Resident #5's Advair was dispensed on 9/14/15, 10/9/15, 11/2/15, and 3/25/16 for a month's supply. -The facility ordered the Advair for Resident #5 on 4/25/16, but but the pharmacy was out of stock on that strength due to a shortage from the drug wholesaler. -The Advair could have been ordered from a backup pharmacy, but "I didn't know she was out of her Advair." -Resident #5's Advair would be delivered to the facility that evening, (5/5/16.)	D 358		

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D 358	Continued From page 34 Observation of Resident #5's medication on hand on 5/6/16 at 8:43am revealed her Advair was available to administer. Interview on 5/6/16 at 11:40am with the Resident Care Coordinator revealed: -The Medication Aides should have circled the entry as not available. -She did not know why it was not circled as not given and documented on back the reason not administered. Interview on 5/6/16 at 1:25pm with Staff B, Medication Aide revealed. She did not know why she did not circle the medication as not given. Refer to interview with the facility Administrator A on 5/6/16 at 3:40pm. Refer to review of the facility's policy on medication administration. _____ Interview with the facility Administrator A on 5/6/16 at 3:40pm revealed the facility depended on the Pharmacist at the contract pharmacy to decide when the back-up pharmacy should to be contacted to provide an emergency refill of a medication. Review of the facility's policy on medication administration revealed: -Emergency pharmaceutical services will be provided by the pharmacy. -No specifics about how those emergency services would be provided. -Medications including prescription and non-prescription, and treatments will be administered in accordance with the prescribing	D 358		

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D 358	Continued From page 35 practitioners orders. The facility provided the following Plan of Protection: -The Administrator / Manager shall ensure all medications (preparation and administration) by staff are in accordance with orders by a licensed Practioner and maintained in the Resident's record. -Administrator / Manager will send a "Medication Error Report" to the Primary Care Provider's office to report medication error. -The Administrator / Manager will contact the Primary Care Provider and Pharmacy when medications do not arrive and make sure medications are in the facility as soon as available, or contact the provider to discuss other alternatives. -The Administrator / Manager will provide training to all Medication Aides to ensure compliance in the Medication rule area. Documention of this training will be maintained on site for review. THE FACILITY PROVIDED A CORRECTION DATE OF MAY 20, 2016 FOR THIS UNABATED TYPE B VIOLATION.	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	D 367		

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administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews, the facility failed to assure the Medication Administration Records were accurate for 2 of 5 sampled residents (Residents #5, and #6) regarding MS Contin Extended Release tablets and Advair diskus inhaler.

The findings are:

A. Review of Resident #6's current FL2 dated 7/22/15 revealed diagnoses included history of neck surgery, anxiety, depression, insomnia, bipolar disorder, and non-insulin dependent diabetes mellitus.

Record review revealed subsequent medication orders for Resident #6 for MS Contin (an extended release medication used to treat moderate to severe pain) 15mg tablets every 12 hours dated 1/9/16, 2/9/16 and 4/25/16.

Review of Resident #6's Medication Administration Records (MARs) for March and

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D 367	Continued From page 37 April 2016 revealed: -An entry for MS Contin 15mg, one tablet every 12 hours with scheduled administration times of 8am and 8pm. -The MS Contin 15mg had been documented as administered at 8am and 8pm daily from 3/1/16 through 4/30/16. -An entry on 3/13/16 at 8:00am documenting one tablet was administered by Staff A, Medication Aide (MA). -An entry on 3/13/16 at 8:00pm documenting one tablet was administered by Staff D, MA. -There was no documentation on the back of the MAR related to MS Contin 15mg. Confidential interview with a MA revealed: -Resident #6 was ordered MS Contin 15mg at 8:00am and 8:00pm. -On 3/13/16 the Controlled Drug Receipt/Record/Disposition form was signed twice for the resident's MS Contin 15mg at 8:00am. -The MA was instructed by Administrator B to mark through the second 8:00am dose for 3/13/16, document administration of the 8:00pm dose for 3/13/16 on the Controlled Drug Receipt/Record/Disposition form and MAR, but not administer the 8:00pm dose on 3/13/16. -When the MA arrived to work on 3/13/16, it was observed that Resident #6 had slept from 3:00pm to 5:30pm. -Resident #6 woke up at 5:30pm, ate dinner, smoked a cigarette and went back to bed. -The resident woke up around 9:30pm and took his other scheduled medications and went back to bed. Interview with Resident #6 on 4/29/16 at 3:30 pm revealed: -He took scheduled MS Contin 15mg for pain	D 367		

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daily at 8:00am and 8:00pm.
-On 3/13/16 a MA told him he could not take the 8:00pm dose of MS Contin because he was administered two doses (30mg total) at 8:00am on 3/13/16.
-He was not aware of receiving two doses at 8:00am because his medications were mixed with applesauce.
-On 3/13/16 he was "tired and just wanted to sleep all day" .
-He thought he was tired due to the time change (daylight savings time).
-He did not discuss the medication error with the first shift MA or management.

Review of the Controlled Drug Receipt/Record/Disposition form dated 2/26/16 revealed:
-MS Contin 15mg had been documented as administered for 60 doses from 3/04/16 at 8:00pm to 4/03/16 at 8:00am.
-An entry on 3/13/16 at 8:00am documenting one tablet was administered by Staff B, MA.
-A second entry that had been marked out, on 3/13/16 at 8:00am documenting another tablet was administered by Staff B, MA.
-An entry on 3/13/16 at 8:00pm documenting one tablet was administered by Staff D, MA.

Interview with Administrator B on 5/9/16 at 3:10pm revealed:
-She was unaware of the medication error on 3/13/16.
-She stated the second entry on 3/13/16 at 8:00am on the Controlled Drug Receipt/Record/Disposition form, dated 2/26/16, was made in error by Staff B, MA and the medication was not administered.

Interview with Resident #6's Primary Care

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Physician (PCP) on 5/09/16 at 12:24pm revealed he was not notified of the medication error on 3/13/16.

Review of Resident #6's MAR for May 2016 revealed:
-An entry for MS Contin 15mg, one tablet by mouth twice daily with scheduled administration times of 8am and 8pm.
-The MS Contin 15mg had been documented as administered at 8am and 8pm daily from 5/01/16 through 5/04/16 at 8:00am.
-The MS Contin 15mg 5/04/16 8pm dose was initialed and circled (meaning it was not given).
-The MS Contin 15mg had been documented as administered at 8am on 5/05/16.
-There was no documentation on the back of the MAR related to MS Contin 15mg.

Observation of Resident #6s medications on hand on 5/5/16 at 2:25pm revealed there was no MS Contin 15mg available to administer.

Review of the Controlled Drug Receipt/Record/Disposition form dated 4/04/16 revealed the MS Contin 15mg had been documented as administered for 60 doses from 4/04/16 at 8:00pm to 5/04/16 at 8:00am.

Confidential interview with a MA revealed:
-Resident #6 ran out of MS Contin 15mg "last night" (5/4/16).
-She was told by Administrator B on 5/4/16 to take one MS Contin 60mg tablet from Resident #16's supply and cut it in half for Resident #6.
-The MA told Administrator B that Resident #6 was ordered 15mg twice daily and that half of Resident #16's tablet would be 30mg.
-The MA stated that Administrator B told her "he'll be alright."

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D 367	Continued From page 40 -The MA stated she did not feel comfortable cutting the medication so Administrator B cut the 60mg tablet in half and gave it (30mg) to Resident #6 on 5/04/16 at 8:00pm. -The MA was instructed by Administrator B on 5/04/16 to place the remaining half of the MS Contin 60mg in a medication cup and place it in a sealed plastic bag. -The MA was instructed by Administrator B to put the remaining half tablet of MS Contin 60mg in the gray filing cabinet, located in the medication room, to give to Resident #6 the next morning on 5/05/16. -The MA stated she had ordered medications for all residents on 5/02/16 and that Resident #6 would require a "hard script" for his MS Contin 15mg. Observation of the top drawer of the gray filing cabinet on 5/05/16 at 2:55pm revealed a sealed plastic bag with an empty paper medication cup. Interview with the dispensing pharmacist at the pharmacy provider on 5/5/16 at 3:49pm revealed: -The dispensing pharmacist did not know Resident #6 was completely out of the MS Contin 15mg. -The last MS Contin 15mg dispensed for Resident #6 was 60 tablets on 4/04/16. -Resident #6 should have had enough MS Contin 15mg through 5/5/16. -The medication was on backorder until 5/4/16 and should be in the pharmacy today. Observation of Resident #6's medications on hand on 5/06/16 at 12:00pm revealed: -A cassette of MS Contin 15mg in the medication cart with a label noting a total of 60 tablets dispensed on 5/05/16.	D 367		

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-The cassette on the medication cart revealed 2 tablets had been administered and 14 tablets remained.
-3 additional cassettes of MS Contin 15mg in the storage area that contained a total of 44 tablets that were dispensed on 5/05/16.

Subsequent review of Resident's #6's MAR for May 2016 on 5/6/16 at 12:00pm revealed MS Contin 15mg tablets documented as administered on 5/05/16 at 8pm and 5/06/16 at 8am.

Review of the Controlled Drug Receipt/Record/Disposition form dated 5/05/16 revealed the MS Contin 15mg had been documented as administered for 2 doses from 5/05/16 at 8:00pm to 5/06/16 at 8:00am.

Review of a Medication Error Report dated 5/5/16 revealed:
-Resident #6 was administered morphine sulfate extended release 60mg (one half tablet to equal a 30mg dose).
-The error was made because the medication was not received from the pharmacy due to backorder of medication and staff borrowed medications from resident #16 MS Contin 60mg and gave one-half tablet (30mg) to Resident #6.
-The error was discovered by the state surveyor on 5/5/16.
-The PCP was notified via fax on 5/5/16 at 6:15pm.

Interview with Resident #6 on 5/06/16 at 3:00pm revealed:
-He stated he was "Ok, no problems" after taking the two MS Contin 30mg doses on 5/04/16 at 8pm and 5/06/16 at 8am.
-"If I felt weird I would let someone know."
-"It must have been an oversight."

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D 367	Continued From page 42 -"I don't want to get anyone in trouble,...no harm, no foul." Interview with Resident #6's PCP on 5/09/16 at 12:24pm revealed: -"It seems like I told them to do that (administer MS Contin 30mg)." -"I didn't write anything down, but I vaguely remember it." -Resident #6 was "always asking for increased pain meds." Interview with Administrator B on 5/9/16 at 3:10pm revealed: -Staff D, MA called her stating Resident #6 was out of his MS Contin 15mg for the 8pm dose on 5/04/16. -She asked Staff D, MA on 5/4/16 if any other residents were on the same medication as Resident #6. -She was told by Staff D, MA on 5/4/16 that Resident #6 took MS Contin 30mg and that Resident #16 had MS Contin 60mg. -She told Staff D, MA to split one of Resident #16's MS Contin 60mg tablets on 5/4/16 and give it to resident #6. -The MA did not want to split the tablet, so Administrator B split the 60mg tablet in half and Staff D, MA gave the half tablet (30mg) to Resident #6 on 5/4/16 at 8:00pm. -"I split the pill, [Staff D, MA] gave the med." -The other half tablet was put in a cup for [Staff A, MA] to give on 5/5/16 at 8:00am. -"I trusted what the MA told me, I should've known better." -"I found out after the fact that [Resident #6] was on 15mg." -She tried to contact the PCP on 5/05/16 after being notified of the error, but was unable to speak to him.	D 367		

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-A Medication Error Report was completed and faxed to the PCP on 5/05/16.
-She had not spoken to the PCP regarding the error and had not received a response from him.

Refer to interview with the facility Administrator A on 5/6/16 at 3:40pm.

Refer to review of the facility's policy on medication administration.

B. Review of Resident #5's current FL2 dated 6/8/15 revealed:
-Diagnoses included gastroesophageal reflux disease, chronic obstructive pulmonary disease, bipolar disease, and hypertension.
-An admission date of 11/26/09.
-A medication order for Advair 250-50 diskus, inhale 1 blister using diskus device every 12 hours. (A medication used to prevent flare-ups or worsening of chronic obstructive pulmonary disease).

Review of Resident #5's Medication Administration Record (MAR) for May 2016 revealed:
-An entry for Advair 250-50 Diskus inhale the contents of 1 blister using diskus device every 12 hours.
-The Advair had been documented as administered at 8am and 8pm from 5/1/16 through 5/4/16, and at 8am on 8/5/16.

Observation of Resident #5's medications on hand on the morning of 5/5/16 revealed no Advair 250-50 diskus available to administer.

Interview on 5/6/16 at 11:40am with the Resident Care Coordinator revealed:
-The Medication Aides should have circled the

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entry as not given and documented on the back as reason not given.
-She did not know why it was documented as administered.

Interview with Resident #5's on 5/5/16 at 11:50am revealed:
-Her Advair inhaler had been on back order for a few days.
-She had not received it since 5/2/16.
-She had not had any negative effects from not having the inhaler.
-This was the only time she can remember not receiving her inhaler.

Refer to interview with the facility Administrator A on 5/6/16 at 3:40pm.

Refer to review of the facility's policy on medication administration.

Interview with the facility Administrator A on 5/6/16 at 3:40pm revealed the facility depends on the pharmacist at the contract pharmacy to decide when the back-up pharmacy should be contacted to provide an emergency refill of medication.

Review of the facility's policy on medication administration revealed:
-"Emergency pharmaceutical services will be provided by the pharmacy."
-No specifics about how those emergency services will be offered.
-Medications including prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioners orders.
-Documentation will be provided by staff who

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D 367	Continued From page 45 administers medications and performs treatments to the residents on the facility MAR.	D 367		
D 383	10a NCAC 13F .1006 (g) Medication Storage 10a NCAC 13F .1006 Medication Storage (g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications for 7 residents were properly stored by storing medications in unlocked or open containers in a refrigerator containing 2 biohazard samples and various non-medication related items. The findings are: Observation of the facility refrigerator located in the medication room on 5/6/16 at 5:34pm and 6:07pm revealed: -A small plastic unlocked tote labeled "insulin" contained 1 vial of insulin and 6 insulin pens. (Insulins are used to lower blood sugars in residents with diabetes and are considered a sterile injectable product.) -Two of the insulin pens were in a box labeled with directions for use and a resident's name, and the other 4 pens were in 2 plastic baggies labeled with directions for use and another resident's	D 383		

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name.
-The insulin vial was in a box by itself labeled with directions for use and a third resident's name.
-A small plastic uncovered bin contained 3 vials of Nitroglycerin Sublingual Tablets 0.4mg labeled with directions for use and 3 different residents' names. (Nitroglycerin is a medication used to treat chest pain and lower blood pressure.)
-On the top shelf of the door of the refrigerator was an open box of Lorazepam Liquid labeled with instructions directions for use and another resident's name. (Lorazepam is a medication used for anxiety, seizures, and nausea.)
-The bottom shelf of the door of the refrigerator contained 2 unlabeled biohazard bags with specimen bottles containing liquid that appeared to be urine samples.
-Two unopened juice blend bottles sitting next to the biohazard bags.
-At least 9 cans of nutritional supplements.
-Open and unopened 2 liter bottles of soda.
-Two open 16 ounce plastic bottles of soda.
-Two open 12 count boxes containing unopened cans of soda.
-One 6 pack of unopened 16 ounce soda bottles.
-At least 9 small sealed plastic containers of applesauce, prepared from a bulk container.

Observation on 5/6/16 at 6:15pm of the refrigerator located in the medication room revealed:
-Two unlabeled urine sample bottles with a dark yellowish colored liquid with what appeared to be a milky growth.
-Each of the bottles were sealed in a biohazard bag with no identifying labels.

Observation of the door to the medication room on 5/5/16 at 8:30am revealed:
-The door to the medication room was divided in

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the middle, and the top portion of the door could be opened separately from the bottom portion.
-Both the top and bottom of the door could be locked.
-Neither door was locked when the Medication Aides (MA) were administering medications to residents.

Interview with Administrator A on 5/6/16 at 6:15pm revealed:
-She was not sure why the urine samples were in the refrigerator in the medication room.
-She believed the samples were from residents and not staff.
-"We (administrative staff) take urine samples from staff directly to be tested."
-She believed the urine samples may have been placed in the refrigerator by home health staff.
-The facility has no specific policy on storing lab specimens.

Interview with the Home Health Nurse on 5/12/16 at 12:18pm revealed:
-She kept a cooler and ice packs in her car to store specimens.
-She would not use the refrigerator in the facility to store specimens.
-There were recent orders for urine specimens at the facility, but she did not store them in the facility refrigerator.

Interview with Administrator A on 5/9/16 at 10:45am revealed:
-Canned sodas for residents were not usually kept in the medication refrigerator.
-The facility's vending drink machine had been broken since last Tuesday, (5/3/16), and they (soft drink company staff) came to fix it on Friday, (5/6/16.)
-The open drinks in the refrigerator belonged to

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D 383	Continued From page 48 staff not residents. Throughout the survey, residents were observed buying sodas from the medication room refrigerator. Confidential interview with a MA revealed: -The first time she saw samples in biohazard bags in the refrigerator was on Friday, (5/6/16.) -She was not sure where they came from. -She had never seen biohazard bags with samples in the medication room refrigerator before. Confidential interview with a second MA revealed: -She first discovered a clear sealed container of urine in a biohazard bag in the refrigerator in the medication room on 4/25/16. -On 4/29/16 she discovered a second clear sealed container of urine in a biohazard bag in the refrigerator in the medication room. -She was not provided any details about the containers of urine, as who they belonged to, or who put them in the refrigerator. Review of the facility's policy on medication administration and storage revealed: -Medications will not be stored in a refrigerator with non-medication items, unless stored in a locked separate container. -The container will be locked if the refrigerator does not contain a lock. -Medications will not be stored with cleaning agents and hazardous chemicals.	D 383		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances	D 392		

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D 392	Continued From page 49 (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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews the facility failed to assure a readily retrievable record of controlled substances for 2 of 6 sampled residents (Resident #6 and #16), that were prescribed MS Contin (an extended release medication used to treat moderate to severe pain) by documenting the receipt, administration and disposition of the controlled substances. The findings are: A. Review of Resident #6's current FL2 dated 7/22/15 revealed diagnoses included history of neck surgery, anxiety, depression, insomnia, bipolar disorder, and non-insulin dependent diabetes mellitus. Record review revealed subsequent medication orders for Resident #6 for MS Contin (an extended release medication used to treat moderate to severe pain) 15mg tablets every 12 hours dated 1/9/16, 2/9/16 and 4/25/16. Review of Resident #6's Medication Administration Records (MARs) for March and	D 392		

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D 392	Continued From page 50 April 2016 revealed: -An entry for MS Contin 15mg, one tablet every 12 hours with scheduled administration times of 8am and 8pm. -The MS Contin 15mg had been documented as administered at 8am and 8pm daily from 3/1/16 through 4/30/16. -An entry on 3/13/16 at 8:00am documenting one tablet was administered by Staff A, Medication Aide (MA). -An entry on 3/13/16 at 8:00pm documenting one tablet was administered by Staff D, MA. -There was no documentation on the back of the MAR related to MS Contin 15mg. Confidential interview with a MA revealed: -Resident #6 was ordered MS Contin 15mg at 8:00am and 8:00pm. -On 3/13/16 the Controlled Drug Receipt/Record/Disposition form was signed twice for the resident's MS Contin 15mg at 8:00am. -The MA was instructed by Administrator B to mark through the second 8:00am dose for 3/13/16, document administration of the 8:00pm dose for 3/13/16 on the Controlled Drug Receipt/Record/Disposition form and MAR, but not administer the 8:00pm dose on 3/13/16. -When the MA arrived to work on 3/13/16, it was observed that Resident #6 had slept from 3:00pm to 5:30pm. -Resident #6 woke up at 5:30pm, ate dinner, smoked a cigarette and went back to bed. -The resident woke up around 9:30pm and took his other scheduled medications and went back to bed. Interview with Resident #6 on 4/29/16 at 3:30 pm revealed: -He took scheduled MS Contin 15mg for pain	D 392		

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daily at 8:00am and 8:00pm.
-On 3/13/16 a MA told him he could not take the 8:00pm dose of MS Contin because he was administered two doses (30mg total) at 8:00am on 3/13/16.
-He was not aware of receiving two doses at 8:00am because his medications were mixed with applesauce.
-On 3/13/16 he was "tired and just wanted to sleep all day" .
-He thought he was tired due to the time change (daylight savings time).
-He did not discuss the medication error with the first shift MA or management.

Review of the Controlled Drug Receipt/Record/Disposition form dated 2/26/16 revealed:
-MS Contin 15mg had been documented as administered for 60 doses from 3/04/16 at 8:00pm to 4/03/16 at 8:00am.
-An entry on 3/13/16 at 8:00am documenting one tablet was administered by Staff B, MA.
-A second entry that had been marked out, on 3/13/16 at 8:00am documenting another tablet was administered by Staff B, MA.
-An entry on 3/13/16 at 8:00pm documenting one tablet was administered by Staff D, MA.

Interview with Administrator B on 5/9/16 at 3:10pm revealed:
-She was unaware of the medication error on 3/13/16.
-She stated the second entry on 3/13/16 at 8:00am on the Controlled Drug Receipt/Record/Disposition form, dated 2/26/16, was made in error by Staff B, MA and the medication was not administered.

Interview with Resident #6's Primary Care

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Physician (PCP) on 5/09/16 at 12:24pm revealed he was not notified of the medication error on 3/13/16.

Review of Resident #6's MAR for May 2016 revealed:
-An entry for MS Contin 15mg, one tablet by mouth twice daily with scheduled administration times of 8am and 8pm.
-The MS Contin 15mg had been documented as administered at 8am and 8pm daily from 5/01/16 through 5/04/16 at 8:00am.
-The MS Contin 15mg 5/04/16 8pm dose was initialed and circled (meaning it was not given).
-The MS Contin 15mg had been documented as administered at 8am on 5/05/16.
-There was no documentation on the back of the MAR related to MS Contin 15mg.

Observation of Resident #6s medications on hand on 5/5/16 at 2:25pm revealed there was no MS Contin 15mg available to administer.

Review of the Controlled Drug Receipt/Record/Disposition form dated 4/04/16 revealed the MS Contin 15mg had been documented as administered for 60 doses from 4/04/16 at 8:00pm to 5/04/16 at 8:00am.

Interview with the dispensing pharmacist at the pharmacy provider on 5/5/16 at 3:49pm revealed:
-The dispensing pharmacist did not know Resident #6 was completely out of the MS Contin 15mg.
-The last MS Contin 15mg dispensed for Resident #6 was 60 tablets on 4/04/16.
-Resident #6 should have had enough MS Contin 15mg through 5/5/16.
-The medication was on backorder until 5/4/16 and should be in the pharmacy today.

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D 392	Continued From page 53 Observation of Resident #6's medications on hand on 5/06/16 at 12:00pm revealed: -A cassette of MS Contin 15mg in the medication cart with a label noting a total of 60 tablets dispensed on 5/05/16. -The cassette on the medication cart revealed 2 tablets had been administered and 14 tablets remained. -3 additional cassettes of MS Contin 15mg in the storage area that contained a total of 44 tablets that were dispensed on 5/05/16. Subsequent review of Resident's #6's MAR for May 2016 on 5/6/16 at 12:00pm revealed MS Contin 15mg tablets documented as administered on 5/05/16 at 8pm and 5/06/16 at 8am. Review of the Controlled Drug Receipt/Record/Disposition form dated 5/05/16 revealed the MS Contin 15mg had been documented as administered for 2 doses from 5/05/16 at 8:00pm to 5/06/16 at 8:00am. Interview with Resident #6 on 5/06/16 at 3:00pm revealed: -He stated he was "Ok, no problems" after taking the two MS Contin 30mg doses on 5/04/16 at 8pm and 5/06/16 at 8am. -"If I felt weird I would let someone know." -"It must have been an oversight." -"I don't want to get anyone in trouble,...no harm, no foul." Interview with Resident #6's PCP on 5/09/16 at 12:24pm revealed: -"It seems like I told them to do that (administer MS Contin 30mg)." -"I didn't write anything down, but I vaguely remember it."	D 392		

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D 392	Continued From page 54 -Resident #6 was "always asking for increased pain meds." Refer to confidential interview with a MA. Refer to observation of the top drawer of the gray filing cabinet on 5/05/16 at 2:55pm. Refer to interview with Administrator B on 5/9/16 at 3:10pm Refer to review of a Medication Error Report dated 5/5/16. Refer to review of the facility's policy on medication administration and controlled substances. B. Review of Resident #16's current FL2 dated 7/23/15 revealed: -Diagnoses included degenerative joint disorder, rheumatoid arthritis and osteoarthritis. -A medication order for MS Contin 60mg twice daily. -An admission date of 2/10/03. Review of Resident #16's MAR for May 2016 on 5/5/16 at 2:25pm revealed: -An entry for MS Contin 60mg, one tablet by mouth every 12 hours with scheduled administration times of 8am and 8pm. -The MS Contin 60mg had been documented as administered at 8am and 8pm daily from 5/01/16 through 5/04/16 at 8:00pm. -Documentation was absent for the 5/5/16 8:00am dose. Observation of Resident #16's medications on hand on 5/5/16 at 2:25pm revealed: -A cassette labeled "1 of 4" of MS Contin 60mg in	D 392		

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the medication cart with a label noting 60 tablets dispensed on 5/02/16, and 5 tablets used from the cassette.
-2 additional cassettes labeled "2 of 4" and "3 of 4" of MS Contin 60mg in the storage area that contained a total of 32 tablets that were dispensed on 5/02/16.
-1 cassette labeled "4 of 4" with a dispensed quantity of 12 that was missing one MS Contin 60mg tablet that was dispensed on 5/02/16.

Review of the Controlled Drug Receipt/Record/Disposition form dated 5/02/16 revealed:
-MS Contin 60mg had been documented as administered for 5 doses from 5/2/16 at 8:00pm to 5/04/16 at 8:00pm.
-Documentation was absent for the missing MS Contin 60mg tablet from the cassette labeled "4 of 4".

Interview with a MA, Staff A on 5/5/16 at 2:25pm revealed:
-She did not know what had happened to the missing MS Contin 60mg tablet.
-Resident #16 had refused the 5/5/16 8:00am dose of MS Contin 60mg and she had not documented it on the MAR.

Interview with Resident #16 on 5/9/16 at 3:10pm revealed:
-He had ran out of medications in the past, but could not remember which medication.
-He thought he had received medications at the medication room the morning of 5/5/16.

Refer to confidential interview with a MA.

Refer to observation of the top drawer of the gray filing cabinet on 5/05/16 at 2:55pm.

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D 392	Continued From page 56 Refer to interview with Administrator B on 5/9/16 at 3:10pm Refer to review of a Medication Error Report dated 5/5/16. Refer to review of the facility's policy on medication administration and controlled substances. _____ Confidential interview with a MA revealed: -Resident #6 ran out of MS Contin 15mg "last night" (5/4/16). -She was told by Administrator B on 5/4/16 to take one MS Contin 60mg tablet from Resident #16's supply and cut it in half for Resident #6. -The MA told Administrator B that Resident #6 was ordered 15mg twice daily and that half of Resident #16's tablet would be 30mg. -The MA stated that Administrator B told her "he'll be alright." -The MA stated she did not feel comfortable cutting the medication so Administrator B cut the 60mg tablet in half and gave it (30mg) to Resident #6 on 5/04/16 at 8:00pm. -The MA was instructed by Administrator B on 5/04/16 to place the remaining half of the MS Contin 60mg in a medication cup and place it in a sealed plastic bag. -The MA was instructed by Administrator B to put the remaining half tablet of MS Contin 60mg in the gray filing cabinet, located in the medication room, to give to Resident #6 the next morning on 5/05/16. Observation of the top drawer of the gray filing cabinet on 5/05/16 at 2:55pm revealed a sealed plastic bag with an empty paper medication cup.	D 392		

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D 392	Continued From page 57 Interview with Administrator B on 5/9/16 at 3:10pm revealed: -Staff D, MA called her stating Resident #6 was out of his MS Contin 15mg for the 8pm dose on 5/04/16. -She asked Staff D, MA on 5/4/16 if any other residents were on the same medication as Resident #6. -She was told by Staff D, MA on 5/4/16 that Resident #6 took MS Contin 30mg and that Resident #16 had MS Contin 60mg. -She told Staff D, MA to split one of Resident #16's MS Contin 60mg tablets on 5/4/16 and give it to resident #6. -The MA did not want to split the tablet, so Administrator B split the 60mg tablet in half and Staff D, MA gave the half tablet (30mg) to Resident #6 on 5/4/16 at 8:00pm. -"I split the pill, [Staff D, MA] gave the med." -The other half tablet was put in a cup for [Staff A, MA] to give on 5/5/16 at 8:00am. -"I trusted what the MA told me, I should've known better." -"I found out after the fact that [Resident #6] was on 15mg." -She tried to contact the PCP on 5/05/16 after being notified of the error, but was unable to speak to him. -A Medication Error Report was completed and faxed to the PCP on 5/05/16. -She had not spoken to the PCP regarding the error and had not received a response from him. Review of a Medication Error Report dated 5/5/16 revealed: -Resident #6 was administered morphine sulfate extended release 60mg (one half tablet to equal a 30mg dose). -The error was made because the medication	D 392		

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D 392	Continued From page 58 was not received from the pharmacy due to backorder of medication and staff borrowed medications from resident #16 MS Contin 60mg and gave one-half tablet (30mg) to Resident #6. -The error was discovered by the state surveyor on 5/5/16. -The PCP was notified via fax on 5/5/16 at 6:15pm. Review of the facility's policy on medication administration and controlled substances revealed: -Medications including prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioners orders. -Documentation will be provided by staff who administers medications and performs treatments to the residents on the facility MAR. -Documentation of controlled substances will be maintained by the facility and will be available for review. _____ The facility provided the following Plan of Protection: -The Administrator/Manager shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. -The Administrator/Manager will check all controlled substance count sheets for accuracy of reconciliation. -A new policy will be written concerning controlled substances and will be reviewed with all Medication Aides. -Controlled substances will be counted weekly by the Manager and Medication Aides and the amount given will be deducted to have an accurate count.	D 392		

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D 392	Continued From page 59 -The Administrator/Manager will monitor the medication pass and Medication Aides for accuracy and correct count of controlled substances. THE FACILITY PROVIDED A CORRECTION DATE OF MAY 20, 2016 FOR THIS TYPE UNABATED B VIOLATION.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to management of facilities, health care, medication administration, controlled substances and medication aide qualifications. The findings are: A. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility related to health care, nutrition and food service, activities, medication administration, medication storage, controlled substances, resident rights, and medication aide testing and competency. [Refer to Tag D176 10A	D912		

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D912	Continued From page 60 NCAC 13F .0601(a) Management of Facilities, (Type Unabated B Violation)]. B. Based on interviews and record reviews, the facility failed to notify the physician for 2 of 5 sampled residents (#3, #10) for refusing medications Zoloft [A drug used to treat depression], Amantadine [A drug used to treat Parkinson], Risperidone [A drug used to treat mental disorders], Dilantin [A drug used to prevent and manage seizure activity], and Depakote [A drug used to treat both seizures and bipolar disorder] (Resident #10) and (Resident #3) not being administered Lyrica, a medication used to treat diabetic nerve pain. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care, (Type A1 Violation)]. C. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 3 of 5 sampled residents (Resident #3, #5, and #6) regarding MS Contin (an extended release medication used to treat moderate to severe pain), Lyrica (a medication used to treat diabetic nerve pain), and Advair (an inhaled medication used to prevent flare-ups or worsening of chronic obstructive pulmonary disease). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration, (Type Unabated B Violation)]. D. Based on observations, interviews, and record reviews the facility failed to assure a readily retrievable record of controlled substances for 2 of 6 sampled residents (Resident #6 and #16), that were prescribed MS Contin (an extended release medication used to treat moderate to severe pain) by documenting the receipt, administration and disposition of the controlled	D912		

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D912	Continued From page 61 substances. [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances, (Type Unabated B Violation)]. E. Based on observations, interviews, and record reviews the facility failed to assure 1 of 4 sampled Medication Aides (Staff A) had completed the medication written examination within 60 days of hire as a medication aide. [Refer to Tag D935 G.S. 131D-4.5(b) ACH Medication Aides; Training and Competency, (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.	D935		

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D935	Continued From page 62 (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure 1 of 4 sampled Medication Aides (Staff A) had completed the medication written examination within 60 days of hire as a medication aide. The findings are: Review of Staff A's personnel records on 5/6/16 revealed: -An application date of 12/1/08 as a Personal Care Aide (PCA). -A hire date of 6/5/09 as a Medication Aide (MA)/Supervisor. -A MA clinical skills validation completed on 10/2/09. -A 5 hour medication training completed on	D935		

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D935	Continued From page 63	D935		

8/8/15.
-No documentation of the MA exam ever being taken or passed.

Interview with Staff A on 5/6/16 at 5:46pm revealed:
-She took and passed the MA test years ago.
-She believed she took the test about the time of her clinical skills validation in October 2009.

Interview with Staff A on 5/12/16 at 10:42am revealed:
-A few years ago, she had taken Certified Nursing Assistant (CNA) and MA training at a community college.
-She completed the training for both CNA and MA.
-She took the CNA and MA test and passed them both.
-She took the 5 hour Medication Aide state approved training and diabetic training on 8/8/15 and 8/1/15 respectively as fresher courses.
-She was asked by facility management in October 2015 to work as a MA because the facility was "short staffed" with MAs.

A check of the Health Care Personnel Registry on 5/12/16 at 11:40am revealed no record Staff A had ever passed the CNA or MA exam.

Interview with Administrator B on 5/9/16 at 11:02am revealed:
-They cannot find Staff A's certificate of passing the MA exam, but believed Staff A had the original copy.
-Staff A had taken documentation of the results of the MA exam from her staff folder to make a copy and did not put it back.
-The facility tried to verify Staff A had passed the MA exam through the state web site, but could

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not find the verification on the web site either under her married name or maiden name.
-She had called the state today to verify if Staff A had passed the MA exam, but "they (Raleigh) can't find it."
-Staff A worked for years as a PCA, but last fall "she had been filling in as a MA because we were short staffed."

Telephone interview with the Resident Care Coordinator (RCC) and Administrator B on 5/10/16 at 4:12pm revealed:
-They were still unable to find Staff A's certificate of passing the MA exam.
-The MA had applied to other facilities for employment in the past, and was going to check with them to see if they had kept a copy of her exam.

Telephone interview with the RCC on 5/11/16 at 10:07am revealed she had signed Staff A up to take the next available MA exam that was being offered.

Interview with Administrator B on 5/12/16 at 11:30am revealed:
-The manager on duty was responsible for ensuring staff had the proper qualifications.
-Corporate staff kept a list of all employees working in the their facilities to ensure staff are qualified.

Review of the facility's employee schedule from 4/27/16 through 5/10/16 revealed Staff A was scheduled to work as a MA 9 days out of 14.

On 5/10/16, the facility provided the following Plan of Protection:
-The MA whose medication aide testing is

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D935	Continued From page 65 missing from employee file will not pass medications until medication aide testing is located or until MA passes the exam. -The Administrator/Manager shall ensure within 60 days from the date of hire the individual will pass the exam developed and administered by the Division of Health Regulation, effective 5/10/16. -The Administrator/Manager shall ensure facility is in compliance with G.S. 131D 4.5 (b). -MAs will take the exam developed and administered by DHSR within 60 days of hire. -The Administrator/Manager will review employee files to ensure accuracy. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 26, 2016.	D935		