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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	R-C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey and complaint investigation on October 5-6, 2016. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on September 27, 2016.	{D 000}		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to accurately document the receipt, administration, and disposition of controlled substances for 2 of 5 sampled residents (Residents #4, and #5) with orders for hydrocodone-acetaminophen 5/325 (Resident #4) and alprazolam 0.5 mg (Resident #5). The findings are: A. Review of Resident #4's current FL2 dated 02/15/16 revealed diagnoses included Parkinson's Disease, hyperthyroidism, colon polyps, and metabolic syndrome. Review of Resident #4's record revealed a physician's order dated 09/07/16 prescribing hydrocodone-acetaminophen 5/325 mg (Hydro-APAP 5/325) one tablet every 4 hours as	D 392	(See Attached)	10/18/16

Reviewed and accepted
11-21-2016
HRP

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D 392	Continued From page 1 needed for pain. (Hydro-APAP 5/325 is a narcotic pain reliever used to control moderate to severe pain. Hydro-APAP 5/325 is a controlled substance). Continued review of Resident #4's record revealed a facility "Medication Clarification" sheet dated 09/08/16 ordering Hydro-APAP 5/325 one tablet every 4 hours as needed for pain. Review of the facility's pharmacy provider drug delivery sheets revealed documentation for delivery of 50 Hydro-APAP 5/325 for Resident #4 on 09/07/16 at 2:37 pm. Observation on 10/05/16 at 2:45 pm revealed: -There were two medication carts for the Assisted Living (AL) side of the building. -Both medication carts were locked. -The medication carts contained a separate locked drawer for controlled medications. Observation on 10/05/16 at 2:45 pm of medication on hand for Resident #4 revealed: -No Hydro-APAP 5/325 was available for administration for Resident #4. -All other medications were available for administration as ordered by the physician. -No narcotic count sheet log was available for the Hydro-APAP 5/325 one tablet every 4 hours as needed for pain for Resident #5. Interview on 10/05/16 at 2:45 pm with a dayshift Medication Aide (MA) revealed: -The contract pharmacy routinely sent controlled substances to the facility packed in bubble cards and accompanied with a controlled substance inventory log (CS) for documenting administration of the controlled substances. -MAs were responsible to document	D 392	(See Attached)	10/18/16

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D 392	Continued From page 2 administration of a controlled substance on the resident's Medication Administration Record (MAR) and log the administration on the CS log. -Controlled substances were routinely stored locked in the narcotic drawer of the medication cart. -There was no Hydro-APAP 5/325 on hand and available administration for Resident #4. -There was no CS available for Hydro-APAP 5/325 for Resident #5. -Resident #5 had not requested the Hydro-APAP 5/325 on his shift in several weeks. -There was no documentation to reflect the medication had been returned to the pharmacy. Review of Resident #4's September and October 2016 MARs revealed documentation of administration of 6 doses of Hydro-APAP 5/325 as follows: -On 09/07/16, one tablet administered at 3:40 pm, and at 8:00 pm. -On 09/08/16, one tablet administered at 7:00 am, at 1:00 pm, and at 8:00 pm. -On 09/10/16, one tablet administered at 8:00 am. Interview with a pharmacy representative on 10/05/16 at 4:00 pm and 4:55 pm revealed: -The prescription order for Resident #4's Hydro-APAP 5/325 was dispensed on 09/07/16 for 50 tablets. -The pharmacy routinely dispensed controlled substances in bingo cards of up to 30 tablets, along with a CS log for tracking administration. Resident #4's Hydro-APAP 5/325 would most likely have been dispensed as one bingo card of 30 tablets plus one bingo card of 20 tablets. -The pharmacy had no documentation for the return of 44 tablets of Hydro-APAP 5/325 for Resident #4. -The pharmacy representative stated the	D 392	(See Attached)	10/18/16

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D 392	Continued From page 3 pharmacy had several boxes of medication already sealed up for return to DHHS for destruction, and she was unable to open or search those boxes. Interview on 10/05/16 at 4:45 pm with the Regional Director of Operations (DO) revealed: -The Resident Care Coordinator (RCC) for the assisted living unit would be responsible to assure proper records were maintained for the administration, or disposition of controlled substances. -The DO was unable to locate the CS for Resident #4's Hydro-APAP 5/325, the medication, or record of the return of the medication to the pharmacy provider. Interview on 10/06/16 at 10:15 am and 11:35 am with the assisted living RCC revealed: -She had been in the RCC position since June 2016. -She would be responsible for the accurate documentation of administration of residents' controlled substances and/or the disposition of the medications. -The facility policy was to retain all CS logs for controlled medications administered or returned. -She was not aware Resident #4 did not have Hydro-APAP 5/325 tablets or the CS log for reconciliation of the medication until the survey team questioned the whereabouts of the medication on 10/05/16. -The pharmacy provider conducted an audit of the medications ordered for Resident #4 compared to the MAR and the medications on hand on 09/12/16 with no discrepancy noted. -No staff had reported that Resident #4's Hydro-APAP 5/325 was not available for administration, if needed.	D 392	See Attached	10/18/16

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D 392	Continued From page 4 Observation of documentation provided by the facility of a pharmacy conducted "triple check" revealed: -The pharmacy conducted an audit on 09/12/16. -The audit included comparing (1) MARs to (2) the resident chart to (3) the medication in the medication cart (thus the name "triple check"). -Resident #4's MARS, chart and medication on hand was audited on 09/12/16 and all medication was accounted for. Interview with another MA on 10/06/16 at 11:35 am revealed: -He was aware Resident #4 had Hydro-APAP 5/325 ordered as needed for pain. -Resident #4 had a surgical procedure performed on 09/07/16 but had not requested pain medication except for the first 3 to 4 days after the surgery. -The MA recalled Resident #4 had requested pain medication on 09/10/16 at 8:00 am because he had some physical therapy and needed the pain medication. The MA had administered one Hydro-APAP 5/325. -Resident #4 had not requested another dose of Hydro-APAP 5/325 on his shift since the dose on 09/10/16. Interview on 10/06/16 at 11:20 am with Resident #4 revealed: -He was aware he had an order for pain medication (Hydro-APAP 5/325) he could request if he needed something strong for pain. -He did not like taking strong pain medication because it affected his ability to "get around" because of his Parkinson's. -He needed the pain medication a couple days after he surgery on his pacemaker but had not needed or requested the medication since then.	D 392	See Attached	10/18/16

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D 392	Continued From page 5 Interview on 10/06/16 at 11:55 am with the Administrator revealed: -The RCC is responsible for tracking and accounting for the controlled substance medications for the residents. -She was unaware Resident #4's Hydro-APAP 5/325 was unaccounted for prior to 10/05/16. B. Review of Resident #5's current FL2 dated 01/04/16 revealed: -Diagnoses included right hip fracture, diabetes mellitus, dementia, hypothyroidism, gastro-esophageal reflux disease and depression. -A physician's order for alprazolam (used to treat anxiety) 0.5 mg three times daily as needed. Observation on 10/05/16 at 4:15 pm revealed: -There were two medication carts for the Assisted Living (AL) side of the building. -Both medication carts were locked. -The medication carts contained a separate locked drawer for controlled medications. Observation on 10/05/16 at 4:15 pm of medication on hand for Resident #5 revealed: -No alprazolam 0.5 was available for administration for Resident #5. -All other medications were available for administration as ordered by the physician. -No controlled substance (CS) inventory log was available for the alprazolam 0.5 mg for Resident #5. Interview on 10/05/16 4:20 pm with a Medication Aide (MA) revealed: -The alprazolam 0.5 mg arrived with Resident #3 in January 2016. -The Resident #5's alprazolam 0.5 mg had been returned to the pharmacy "last week or the week	D 392	See Attached	10/18/16

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D 392	Continued From page 6 before" because it had expired. -There was no alprazolam 0.5 mg available for Resident #5. -There was no CS log for the alprazolam 0.5 mg for Resident #5 because it had been returned to the pharmacy. -Resident #5 had not needed to requested the medication for the past 3 months. -There was no documentation to reflect the medication had been returned to the pharmacy. Review of Resident #5's August, September and October 2016 Medication Administration Records (MAR) revealed no documentation of administration of alprazolam 0.5 mg. Interview with a pharmacy representative on 10/06/16 at 9:25 am revealed: -The prescription for alprazolam 0.5 mg was not filled by this pharmacy, it was filled by another pharmacy prior to Resident #5's admission to the facility. -The pharmacy representative stated the pharmacy had several boxes of medication already sealed up for return to DHHS, and she was unable to open or search those boxes. -She was unable to confirm or deny the alprazolam 0.5 mg had been received by the pharmacy, due to the sealed boxes that she could not search. -She was unable to locate the documentation of the alprazolam 0.5 mg being returned to the pharmacy. Interview with another MA on 10/06/16 at 10:45 am revealed: -The alprazolam 0.5 mg for Resident #5 had arrived at the facility with the resident when she was admitted in January 2016. -Resident #5 did have alprazolam 0.5 mg	D 392	See Attached	10/18/16

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D 392	Continued From page 7 available for administration until "a couple of weeks ago". -The medication had been returned to the pharmacy because it was expired. Observation on 10/06/16 at 8:00 am of a CS log for Resident #5 revealed: - 89 alprazolam 0.5 mg had been received by the facility on 01/05/16. -The top of the page was marked "1 of 2". -Only one page was available, the page was dated with administration dates from 01/30/16 through 03/15/16. -The end count documented on the page was 59. -The second page of the CS log for Resident #5's alprazolam 0.5 mg was not available. Interview on 10/06/16 at 9:10 am with the Resident Care Coordinator (RCC) revealed: -Resident #5 had arrived with 89 alprazolam 0.5 mg in January 2016. -The medication had expired and had been returned to the pharmacy, last week or maybe the week before. -The order had been discontinued for non use of the medication. - She was unable to locate the documentation the alprazolam had been returned to the pharmacy, but she remembered that it had happened. Observation of documentation provided by the facility of a pharmacy conducted "triple check" revealed: -The pharmacy conducted an audit on 09/12/16. -The audit included comparing 1) MARs to 2) the resident chart to 3) the medication in the medication cart, thus the name "triple check". -Resident #5's MARS, chart and medication on hand was audited on 09/12/16 and all medication was accounted for.	D 392	See Attached	10/18/16

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D 392	Continued From page 8 Interview on 10/06/16 at 11:50 am with the Administrator revealed: -The RCC is responsible for tracking and accounting for the controlled substance medications for the residents. -She was unaware the Alprazolam 0.5 mg was unaccounted for prior the initiation of the follow-up survey.	D 392	See Attached	10/18/16

1. Education provided to RCD/ RCC on use of [redacted] for ordering medications, returning medications, pulling reports showing deliveries and returns received.
2. Education provided to Med Techs regarding medications being ordered and returned by the RCD/ RCC using the [redacted] stem.
3. Education provided to Med Techs regarding need to accurately sign off and count narcotic sheets at the end of the shift and sign on the Controlled Substance Record indicating the correct number of controlled sheets.
4. RCD/ RCC to use "Controlled Substance Record Accountability Sheet" twice weekly to ensure that narcotics and the declining count sheet are accounted for.
5. RCD/ RCC to pull [redacted] eports twice weekly to review narcotic deliveries and ensure proper documentation of declining count sheets.