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
	HAL051025	A. BUILDING: _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

(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 Johnston County Department of Social Services conducted an annual survey and complaint investigation on March 14-16, 2017. The complaint investigation was initiated by the Johnston County Department of Social Services on March 8, 2017.	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 assure the disposition of Norco (a controlled drug used to treat pain) was accurately documented on the record of controlled substances for 1 of 5 residents (Resident #6) sampled. The findings are: Review of Resident #6's current FL-2 dated 09/15/2016 revealed diagnoses included pneumonia, altered mental status, elevated c-reactive protein, urinary tract infection, dysphagia, muscle weakness, diabetes mellitus, seizures, history of anxiety, vitamin D deficiency, depression, cerebrovascular accident - left sided weakness, tremors, and hypertension. Review of a physician orders for Resident #6	D 392	See attached POC	

Joyce M Carter, Exec Dir 4/25/17

Reviewed & Accepted 4/26/17 JW

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D 392	Continued From page 1 revealed: -There was a copy of a physician signed prescription dated 07/08/2016 for Hydrocodone-acetaminophen (Norco) 5-325mg one tablet every 4 hours as needed for pain. -There was a copy of a physician signed prescription dated 07/28/2016 for Norco 5-325mg one tablet every 4 hours as needed for pain. -There was a copy of a physician signed prescription dated 11/23/2016 for Hydrocodone-acetaminophen (Norco) 5-325mg one tablet every 6 hours as needed for pain for up to 7 days. -There was a physician's order dated 02/02/2017 to discontinue Norco. Telephone interview with a Provider Pharmacy Representative (PPR) on 03/16/2017 at 12:00pm revealed: -The pharmacy received the first prescription for Norco 5-325mg tablet every 4 hours as needed for pain for Resident #6 on 07/08/2016, quantity of 20 dispensed. -The pharmacy received a prescription for Norco 5-325mg tablet every 4 hours as needed for pain for Resident #6 on 07/28/2016, quantity of 30 dispensed. -The pharmacy received a prescription for Norco 5-325mg tablet for Resident #6 on 07/29/2016, none dispensed because the prescription did not look like a valid hard copy and did not include a quantity. -The pharmacy received a prescription for Norco 5-325mg tablet every 6 hours as needed for pain times 7 days for Resident #6 on 11/23/2016, quantity of 10 dispensed. -There had been an order received to discontinue the Norco. -A controlled substance "count down sheet" for each controlled medication was sent with each	D 392	See attached POC	

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D 392	Continued From page 2 medication to the facility. -The PPR was not sure if there had been any Hydrocodone-Acetaminophen dispensed for Resident #6 returned to the pharmacy. Review of a Controlled Substance Prescription Returned to Pharmacy sheet revealed on 02/02/2017, a Medication Aide (MA) documented return to pharmacy for two prescriptions of Norco 5mg-325mg (one for quantity 10 and one for quantity 25). Review of a controlled substance (CS) log for Norco for Resident #6 revealed: -The facility staff signed the CS log and documented receipt for a quantity of 30 Norco 5mg-325mg tablets on 07/29/2016. -There was a pharmacy printed medication label affixed to the CS log with instructions for Hydrocodone-Acetaminophen 5mg-325mg tablet every 4 hours as needed for pain. -There were entries on 08/14/2016 and 08/15/2016 for one dose given on each date. -There were entries on 09/03/2016 and 09/12/2016 for one dose given on each date when Resident #6 was not in the assisted living facility, but was in a rehab facility. -The Resident Care Director (RCD) made an entry to the CS log on 10-06-16 at 8pm, one tablet "borrowed for [named resident], leaving a quantity of 25. -There was an entry to the CS log on 10-12-16 at 6pm, one tablet given, leaving a quantity of 24. This entry had a line drawn through it and noted as "error". -There was a signature for a different staff below the above entry which documented the remaining amount as 24. This entry also had a line drawn through it. -Documented on the second line below the above	D 392	See attached POC	

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D 392	Continued From page 3 entry was an entry of 25 in the column for amount remaining. There was no date, time, dose given, or staff signature for this entry. Review of Resident #6's Progress Notes revealed: -On 08/24/2016, Resident #6 "was confused and sent to ER [emergency room] at 4pm". -On 09/19/2016, Resident #6 returned to the facility from rehab. Interview with the Business Office Manager (BOM) on 03/16/2017 at 11:15am revealed Resident #6 was out of the facility from 08/24/2016 to 09/19/2016. Review of a Face Sheet provided by the facility on 03/16/2017 revealed: -Resident #6 had a hospital stay from 08/24/2016 through 08/29/2016. -Resident #6 was admitted to a rehab facility on 08/29/2016. -Resident #6 was discharged from the rehab facility on 09/19/2016. Review of August 2016 Medication Administration Records (MARs) for Resident #6 revealed: -There were printed instructions on the MAR for Hydrocodone-Acetaminophen (Norco) 5mg-325mg one tablet every 4 hours as needed for pain. -There was documentation for administration of Hydrocodone-Acetaminophen 5mg-325mg one tablet on 08/01/2016 at 4am, 08/03/2016 at 1:30am, 08/09/2016 - no time documented, and 08/14/2016 - no time documented, which did not match the August 2016 dates and times documented on the CS log. Review of September 2016 Medication	D 392	See attached POC	

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D 392	Continued From page 4 Administration Records (MARs) for Resident #6 revealed: -There were handwritten instructions on the MAR for Hydrocodone-Acetaminophen (Norco) 5mg-325mg one tablet every 4 hours as needed for pain dated 09-19-2016, with a diagonal line drawn across the instructions. In the section for documenting administration, there was a handwritten note of "hold for clarification". -There was no documentation for administration of the Hydrocodone-Acetaminophen 5-325mg tablets for September 2016, which did not match the September 2016 dates documented on the CS log. Review of controlled substance medications on hand for Resident #6 revealed there was no Hydrocodone-Acetaminophen on hand. Telephone interview with a Medication Aide (MA) on 03/16/2017 at 12:40pm revealed: -The MA thought Resident #6 was prescribed Norco as needed. -The MA did not recall administering Norco to Resident #6. -The MA "probably" had administered the Norco to Resident #6 but would not be able to recall it. -The MA did not remember if Resident #6 was in the hospital in September 2016. -The MA might have signed out Norco for Resident #6 in September 2016 but did not remember right now. -If the MA had documented administration for the Norco, then the MA probably had administered the Norco. -When the MA administered a controlled substance, the MA would pop it out of the card, sign it off in the controlled substance book, give it to the resident, and make sure the resident swallowed. After the medication was	D 392	See attached POC	

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D 392	Continued From page 5 administered, the MA would initial the MAR documenting the administration of medications. -When a resident's medication was not in the facility, the MA did not borrow medication from another resident, but would circle initials and document on the reverse of the MAR the reason the medication was not administered. The MA would also call the pharmacy to check on the status of the medication to see if the medication had been ordered and was being delivered to the facility. Interview with a second Medication Aide on 03/16/2017 at 1:05pm revealed: -The MA did not remember Resident #6 being prescribed Norco. -When the MA administered a controlled substance to a resident, the MA would unlock the narcotic section of the med cart, make sure she had the right residents' medication, pop the pill from the medication package, and look at the remaining count. Once the medication was administered to the resident, the MA would check the medication count to ensure it was correct, sign the controlled substance log, and then sign the MAR. If the MA was administering the last controlled substance, the MA would have a second MA witness it was the last pill being administered. -Controlled substances were counted by the oncoming MAs and off-going MAs for each shift. -If the controlled substance count was not correct, the Mas would stop and contact the RCD for intervention. Interview with the Resident Care Director (RCD) on 03/16/2017 at 2:00pm revealed: -She was responsible for reviewing controlled substances when a discrepancy had been identified.	D 392	See attached POC	

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D 392	Continued From page 6 -She was responsible for reviewing MARs. -She performed "random counts" on controlled substances; and she did not count them daily but "maybe once a week". -She had "probably" reviewed Resident #6's controlled substance logs every three weeks "around about". -She did not always look at the dates of administration documented on the CS logs, but looked at the remaining count of pills and compared that number with the number of pills that were on hand. -She did not know how she had not seen that "something was different" with the CS log for Resident #6's Hydrocodone-Acetaminophen. -She did not know how to account for documentation of administration for Hydrocodone-Acetaminophen to Resident #6 on dates when Resident #6 was not in the facility. -She had not been contacted by any facility staff about borrowing any medication. -Medications were only borrowed in an "emergency situation". -She considered a resident being out of a critical medication an emergency. -She was only aware of the one time she had borrowed Norco from Resident #6 for another resident which she documented on Resident #6's CS log. Interview with the Executive Director (ED) on 03/16/2017 at 2:40pm revealed: -She was not aware CS logs and MARs for Resident #6 did not match. -She could not explain why Hydrocodone-Acetaminophen was documented as given to Resident #6 on days when the resident was not in the facility. -She was not the Executive Director at the facility in August 2016 and September 2016 and was not	D 392	See attached POC	

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D 392	Continued From page 7 sure of processes used at the facility during that timeframe.	D 392		

Joyce M Carter, Exec Dir 4/25/17

10A NCAC 13F .1008(a) Controlled Substances

Meadowview Assisted Living 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 information.

1. Education provided to the RCD and Executive Director on ordering medications, returning medications, reviewing reports showing deliveries and returns received. Completed 4/13/2107

2. Education provided to Med Techs regarding procedure for medications being ordered and returned to the pharmacy.

3. Education provided to the Med Techs regarding procedure for medications not available for administration.

4. Education provided to Med Techs regarding procedure for accurate documentation of the counting of narcotics and counting of controlled substance sheets.

5. RCD/ED will ensure that accurate documentation of the counting of narcotics and counting of controlled substance sheets by utilizing the "Controlled Substance Record Accountability Sheet" Daily for 2 weeks then weekly thereafter.

6. RCD/ED will review the narcotic delivery report to ensure proper documentation of declining count sheets daily for 2 weeks then weekly thereafter.

Date of completion will be April 30, 2017.

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Joyce M. Carter, Executive Director

Meadowview Assisted Living