STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023008	A. BUILDING: _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY MANOR	1176 WYKE ROAD SHELBY, NC 28150

(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	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
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: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 5 sampled residents (Resident #1) physician was notified when the resident refused to take a weekly scheduled dose of alendronate on multiple occasions. The findings are: Review of Resident #1's current FL2 dated 6/5/17 revealed: -Diagnoses included osteoporosis, hypertension, and history of stroke. -A physician's order for alendronate sodium (used to treat osteoporosis) 70mg 1 tablet every week. Review of Resident #1's June 2017 Medication Administration Record (MAR) revealed: -An entry for alendronate sodium 70mg 1 tablet every week. -The alendronate was documented administered 3 occurrences out of 4 opportunities. The missed dose was indicated by the circling of the medication aide's initials on the front of the MAR. -On 6/26/17, the reason documented the	D 273	Review training of medication administration and refusals was completed on 10/4/17. **All med aides will notify the MD of three consecutive refusals of medications and document. **All med aides will also notify the MD immediately of any medication refusal for anticoagulant, insulin, seizure or hormone therapy and document. **The RCM will monitor daily for one month for any missed meds and assure follow upo and then monitor randomly ongoing.	10/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vergia Strange

TITLE: Administrator

(X6) DATE: 10/19/17

Reviewed and Accepted
Date: 10/31/17 cs

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D 273	Continued From page 1 medication was not administered was "refused." Review of Resident #1's July 2017 MAR revealed: -An entry for alendronate sodium 70mg 1 tablet every week. -The alendronate was documented administered 0 occurrences out of 5 opportunities. Missed doses were indicated by the circling of the medication aides initials on the front of the MAR. -On 7/3/17, the reason documented for the medication not being administered was "refused." -On 7/10/17, the reason documented for the medication not being administered was "refused." -The doses on 7/17/17, 7/24/17, and 7/31/17 were not documented on the back of the MAR as to the reason they were not administered. Review of Resident #1's August 2017 MAR revealed: -An entry for alendronate sodium 70mg 1 tablet every week. -The alendronate was documented administered 4 occurrences out of 4 opportunities. Review of Resident #1's September 2017 MAR revealed: -An entry for alendronate sodium 70mg 1 tablet every week. -The alendronate was documented administered 0 occurrences out of 4 opportunities. -On 9/4/17, the reason documented for the medication not being administered was "refused." -On 9/1/17, the reason documented for the medication not being administered was "refused." -The doses on 9/11/17 and 9/25/17 were not documented on the back of the MAR as to the reason they were not administered. Review of Resident #1's October 2017 MAR revealed:	D 273		

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D 273	Continued From page 2 -An entry for alendronate sodium 70mg 1 tablet every week. -The alendronate was documented administered 0 occurrences out of 1 opportunities. -On 10/2/17, the reason documented for the medication not being administered was "refused." Review of Resident #1's record revealed no documentation her physician had been notified the resident had refused 11 weekly doses of the alendronate sodium from 6/26/17 to 10/2/17. Observation of Resident #1's medications on hand in the facility on 10/4/17 at 9:55am revealed there were 9 tablets of alendronate sodium 70mg available for resident use. Interview with Resident #1 on 10/4/17 at 10:15am revealed: -"I just decided, I didn't want it." -"The doctor won't give me a shot." -"I didn't think it was doing me any good." -The Medication Aide on duty was going to contact the physician that had ordered the alendronate sodium to get it discontinued. -"But he might tell me to take it anyway." Review of Resident #1's physician faxed notification dated 10/4/17 at 3:02pm revealed: -"Resident has been refusing her alendronate sodium weekly." -"Resident stated that she just don't want it." -"May I have an signed order to [discontinue] due to non-use." -The physician responded "Patient may refuse alendronate. Canceling medication will require an appointment." Interview with a medication aide on 10/4/17 at 9:55am revealed:	D 273		

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D 273	Continued From page 3 -She would take the alendronate into Resident #1's room and the resident would say 'I don't want that.' -"She takes it sometimes and sometimes she don't." -She documented medication refusals on the back of the MAR. -Resident #1's physician had not been notified the resident had been refusing the alendronate sodium that was scheduled weekly. -She was going to contact Resident #1's physician to notify him of the resident's refusals. Interview with a second medication aide on 10/4/17 at 2:36pm revealed: -She documented medication refusals "on the back of the MAR." -She would notify the physician "after 2 or 3 doses are refused." -She would document any contact made to the physician in the resident record under the "narrative notes" section of the resident's chart. Interview with the Resident Care Coordinator (RCC) on 10/4/17 at 2:50pm revealed: -"Staff are supposed to document on the back of the MAR every time a medication is refused." -Policy had been for the medication aides to fax the physician "every time a medication was refused." -"They haven't been doing it though." -The Administrator had "put up a policy today to notify the physician after the third medication refusal." Interview with the Administrator on 10/4/17 at 10:40am revealed: -The facility's policy was for the medication aides to notify the physician of refused medications. -Staff were supposed to notify the physician after	D 273		

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D 273	Continued From page 4 3 refusals. Attempted telephone interview with Resident #1's physician on 10/4/17 at 10:19am was unsuccessful by exit.	D 273		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that snacks were offered or made available to all residents between each meal, for a total of three snacks per day, and shown on the menu as snacks. The findings are: Interview with the Administrator on 10/3/17 at 8:45am revealed the facility census was 68. Interviews with eight residents on 10/3/17 during the initial facility tour from 9:00am to 10:30am revealed: -In the morning, snacks were available from 10am to 11am in the Shelby room. -"They bring snack around in the afternoon when they bring water and ice." -"I've never heard anything about a night time snack. The afternoon snack is the only one I	D 298	Management has reviewed with dietary and all care staffg the requirements for snacks three times per day. **Management reviewed with all dietary and care staff provision of snacks three times daily. **Residents have been notified through resident council of a new procedure for provinding snacks -Evening snacks will be provided in the Shelby Room at 8pm. -Notices are posted for residents regarding the the 8pm snack -Care aide will be on duty at 8pm to offer snacks for all residents. -For those residents unable to come to the Shelby Room the aide will pass snacks individually as needed -The ED will monitor this processd weekly for thirty days and randomly thereafter. **The RCM will monitor this process ongoing.	10/31/17

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D 298	Continued From page 5 know of." -"We get a snack at 2 o'clock in the afternoon. I don't know if there's snack in the morning." -Snack is offered "between lunchtime and supper. Must be 3 o'clock." -"I only get snack one time a day from 2-3 o'clock, when they change shifts. If you are not in your room, they don't leave a snack." -"We don't get 3 snacks a day. We get one in the afternoon. In the morning they have snack in the canteen area." The resident was unaware if a bedtime snack was routinely offered "Not that I know of." -"Snacks are given twice per day in the morning and afternoon." -"Snacks are given twice per day." -Another resident stated they received snacks twice per day, but they could ask anytime if they wanted anything else to eat. Review of the posted facility menu on 10/4/17 revealed: -There was a dietician approved snack menu available to the kitchen staff. -There were three snacks listed on the menu, morning, afternoon and evening. Observation on 10/4/17 at 3:15pm revealed snack items listed on the menu were observed in the kitchen, including snacks for residents on a special diet. Observation on 10/3/17 at 2:35pm revealed a personal care aide (PCA) was going door to door throughout the facility with the snack cart, delivering snacks and beverages to the residents. Observation on 10/4/17 at 3:25pm revealed a PCA going door to door throughout the facility with the snack cart, delivering snacks and	D 298		

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D 298	Continued From page 6 beverages to the residents Interview with one personal care aide on 10/4/17 at 3:05pm revealed: -"Snacks are given out in the morning and at 2:30 pm in the afternoon." -"Evening snacks are not given out." -"Some residents go to the vending machines at night or eat snacks they have in their rooms." Interview with a second personal care aide on 10/4/17 at 3:23pm revealed: -"Snacks are given out three times per day." -"The evening snack is given out between 8:00 and 9:00 pm." -"Kitchen staff puts out snacks in a bowl for the staff to pass out for the evening snack." -"Some residents are already asleep when they begin passing out snacks, so those residents are not disturbed." Interview with the Kitchen Manager on 10/4/17 at 10:45am and at 3:10pm revealed: -Snacks were provided to the residents 3 times per day, at 10:00am, 2:00pm and 8:00pm. -The 10:00am snack was served by the kitchen staff in the Shelby Room. -The kitchen staff would either announce the snack over the phone (facility's intercom system) or go to resident rooms and make them aware it was time for snack. -For the 2:00pm and 8:00pm snack, the kitchen staff prepped the snack carts with the snack and beverages and the personal care aides (PCA's) delivered to the residents in their rooms. -Snacks provided included items for residents on a special diet. -Staff followed the snack menu. -The 2:00pm snack today was a moon pie, juice or water.	D 298		

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D 298	Continued From page 7 -The 8:00pm snack today would be peanut butter crackers, juice or water. -Puddings, yogurt and fruits tend to be served at the 10:00am snack time to avoid residents having food products in their rooms that could spoil. -The 2:00pm snack today was being delivered late due to a kitchen department meeting that started at 2:00pm. Interview with the Administrator on 10/4/17 at 3:30pm revealed: -Snacks were to be served at the facility 3 times per day, at 10:00am, 2:00pm and 8:00pm. -The kitchen staff announced the 10:00am snack over the intercom and served the snack in the Shelby Room. -For the 2:00pm and 8:00pm snack, the kitchen staff prepped the snack carts with the snack and beverages and the PCA's delivered to the residents in their rooms.	D 298		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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D 344	Continued From page 8 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure clarification of physician orders for 1 of 5 sampled residents (Resident #4) related to calcitriol and carbamazepine. The findings are: Review of Resident #4's current FL2 dated 8/28/17 revealed diagnoses included status post fall, subdural hematoma, rib fractures, chronic kidney disease, coronary artery disease, diabetes, status post pacemaker, and hypertension. Review of Resident #4's discharge summary dated 8/28/17 revealed: -An order for calcitriol (used to prevent low levels of calcium) 0.25mcg 1 capsule daily in the morning. -An order for carbamazepine (used to treat diabetic neuropathy) 200mg 1 tablet daily at bedtime. 1. Review of Resident #4's September 2017 to October 2017 Medication Administration Record (MAR) revealed: -An entry for calcitriol 0.25mcg 1 capsule on Monday and Friday at 8am. -The calcitriol 0.25mcg 1 capsule was documented administered every Monday and Friday from 9/1/17 to 10/2/17. Observation of Resident #4's medications available on hand in the facility on 10/3/17 at 1:58pm revealed: -There was one bubble pack of calcitriol 0.25mcg capsules with 8 capsules.	D 344	Management completed training with all aides regarding clarification of orders **All med aides will review all documentation for orders when residents return to the community from the Emergency Department and or skilled nursing for rehabilitation. **The documentation will be placed in the RCM's notification folder for final review with signature and date. **The ED will randomly monitor this process for 30 days and then monitor ongoing.	10/13/17

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D 344	Continued From page 9 -The label directions indicated one capsule by mouth on Monday and Friday. Telephone interview with the facility pharmacy on 10/3/17 at 2:27pm revealed: -The current order for Resident #9's calcitriol 0.25mcg 1 capsule every Monday and Friday from a script dated 5/22/17. -The calcitriol was last filled 10/1/17. Interview with Resident #4 on 10/4/17 at 1:49pm revealed: -"I just get calcitriol on Mondays and Friday's." -"It's an orange pill." Interview with the Administrator on 10/4/17 at 3:10pm revealed: -Resident #4 was supposed to receive calcitriol 0.25mcg every Monday and Friday. -The calcitriol order should have been clarified with Resident #4's physician within 24 hours of readmission. Review of Resident #4's signed physician order dated 10/4/17 revealed calcitriol 0.25mcg 1 capsule every Monday and Friday. Refer to the interview with one medication aide on 10/4/17 at 2:36pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/4/17 at 2:50pm. 2. Review of Resident #4's September 2017 to October 2017 Medication Administration Record (MAR) revealed: -An entry for carbamazepine 200mg 2 tablets daily at 8pm. -The carbamazepine 200mg 2 tablets was documented administered daily at 8pm from	D 344		

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D 344	Continued From page 10 9/1/17 to 10/3/17. Observation of Resident #4's medications available on hand in the facility on 10/3/17 at 1:58pm revealed: -There was one bubble pack of carbamazepine 200mg tablets with 29 doses available with 2 tablets inside each bubble. -The label directions indicated two tablets (400mg) daily at bedtime. Telephone interview with the facility pharmacy on 10/3/17 at 2:27pm revealed: -The current order for Resident #4's carbamazepine was 200mg 2 capsules daily at bedtime dated 8/9/17. -A 30 day supply was last dispensed on 10/1/17. -A 30 day supply was also dispensed on 8/9/17. Interview with Resident #4 on 10/4/17 at 1:49pm revealed: -"I get Tegretol (carbamazepine) at night." -"I have no idea what strength it is." -"I get 5 pills every night." Interview with the Administrator on 10/4/17 at 3:10pm: -She had contacted Resident's #4's physician's office and the physician had said "she should get carbamazepine 200mg 2 tablets every night at bedtime." -She had requested a clarification of the order be faxed to the facility as soon as possible. Review of Resident #4's signed physician order dated 10/4/17 revealed carbamazepine 200mg 2 capsules daily at bedtime. Refer to the interview with one medication aide on 10/4/17 at 2:36pm.	D 344		

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D 344	Continued From page 11 Refer to the interview with the Resident Care Coordinator (RCC) on 10/4/17 at 2:50pm. Interview with one medication aide on 10/4/17 at 2:36pm revealed: -When a resident had returned from being discharged from the hospital "we match the discharge paperwork with the previous MARs." -If there were any discrepancies in the medications the hospital had listed for the resident to take versus what the resident was taking prior to the hospitalization "We notify the physician and see if he wants to leave the meds as the previous orders." -Reviewing a resident's MAR was completed as soon as the resident returned to the facility. -Any discrepancies were immediately faxed to the physician's office for clarification. Interview with the Resident Care Coordinator (RCC) on 10/4/17 at 2:50pm revealed: -"The receiving medication aide will check orders on discharge summary" when a resident returned to the facility. -If a resident had returned from the hospital after normal physician office hours, the medication aide would follow the most recent orders from the hospital until the orders could be clarified with the resident's physician the following day. -The RCC also checked the orders "when I come back in." -They did not accept residents being discharged from the hospital "over the weekends." -She was unsure what happened that Resident #4's orders were not clarified.	D 344		

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D 367	Continued From page 12	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (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 observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 2 of 5 sampled residents (#2, #5) for hydrocodone/APAP for Resident #2 and Belsomra for Resident #5. The findings are: A. Review of Resident #5's current FL2 dated 2/8/17 revealed diagnoses included diabetes mellitus type 2, hyperlipidemia, hypertension, cerebrovascular accident, osteoarthritis and atrial	D 367	Review of processd for Medication Administration of Narcotics completed on 10/4/17. **Med Aides will initial each dose administered on theMAR **Med Aides will initial each dose on the bubble pack if so packaged **Med Aides will initial the narcotic control sheet for each administration **The RCM will review narcotic sheets against MAR daily for reconcliation **The ED will monitor this process weekly for thirty days and randomly thereafter.	10/31/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY MANOR	1176 WYKE ROAD SHELBY, NC 28150

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D 367	Continued From page 13 fibrillation. Review of physician orders dated 7/28/17 and 8/28/17 revealed an order for Belsomra 10mg, take 1 tablet by mouth at bedtime as needed. Review of the August 2017 and September 2017 Medication Administration Record (MAR) for Resident #5 revealed a hand-written entry for Belsomra (used to treat insomnia), 10mg at bedtime, as needed. Review of three Controlled Count Sheets revealed: -The medication was Belsomra 10mg tablet. -Instructions printed on the label to take 1 tablet by mouth at bedtime as needed. -The dispense dates were 7/28/17 for 30 pills and 8/29/17 for 15 pills. Review of the August 2017 MAR revealed there was no documentation for the 8:00pm administrations on the front or back of the MAR for the 8/21/17, 8/23/17 and 8/28-30/17 entries documented on the controlled count sheet dated 7/28/17. Review of the September 2017 MAR revealed there was no documentation for the 8:00pm administrations on the front or back of the MAR for the 9/7/17, 9/16-18/17 and 9/20-30/17 entries documented on the controlled count sheet dated 7/28/17 and 8/29/17. Interview with a medication aide on 10/4/17 at 2:20pm revealed: -She had "failed to document properly" on the MAR for Resident #5's Belsomra. -She was a Supervisor-in-Charge (SIC) and can get "distracted" when working on the medication	D 367		

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D 367	Continued From page 14	D 367		

cart by staff asking her questions or taking care of resident care needs.
-When administering Resident #5's Belsomra in her room, she frequently would assist Resident #5 with personal care requests and fail to remember to go back and document on the MAR.

Interview with Resident #5 on 10/4/17 at 3:50pm revealed:
-She knew what medications she took at night.
-She was administered "10 pills" in the evening.
-She knew the Belsomra was to "help her sleep".
-She took the Belsomra "every night" and would "tell them (the staff) if they were not giving me my medications".
-Resident #5 had not missed a dose of Belsomra.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/4/17 at 2:25pm.

Refer to the interview with the Administrator on 10/4/17 at 3:40pm.

B. Review of Resident # 2's current FL2 dated 6/6/17 revealed:
-Diagnoses included atrial fibrillation, hypertension, cardiomyopathy, dyslipidemia, hypothyroidism, osteoarthritis, gastroesophageal reflux and diabetes mellitus.
-Medications included hydrocodone/APAP 5-325 (used to treat pain) 1 tablet every 4 hours as needed for pain.

Review of the May 2017 to October 2017 Medication Administration Records (MARs) revealed an entry for hydrocodone/APAP 5-325 1 tablet every 4 hours as needed for pain.

Review of the medication on hand for Resident #2 on 10/4/17 at 10:00am revealed 80 tablets of

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D 367	Continued From page 15 hydrocodone/APAP 5-325 were available. Review of a Controlled Count Sheet revealed: -The medication was hydrocodone/APAP 5-325 1 tablet every 4 hours as needed for pain. -The dispense date was 5/12/17 for 180 pills. -Instructions printed on the label to take 1 tablet (5-325 mg) every four hours as needed for pain. -The documentation on the controlled count sheet showed 100 (5-325 mg tablets) administered from 5/13/17 through 10/3/17. Review of the May 2017 MAR revealed: -There was no documentation for the 8pm administrations documented on the front or back of the MAR for the 5/13/17, 5/14/17, 5/15/17, 5/27/17, and 5/31/17 entries documented on the controlled count sheet. -There was no documentation for the 4:30am administration on the front or back MAR for the 5/20/17 entry documented on the controlled count sheet. -There was no documentation for the 8:00am administration on the front or back of the MAR for the 5/27/17 entry documented on the controlled count sheet. -There was no documentation for the 11:00pm administration on the front or back of the for the 5/31/17 entry documented on the controlled count sheet. Review of the June 2017 MAR revealed: -There was no documentation for the 8pm administrations on the front or back of the MAR for the 6/3/17, 6/4/17, 6/9/17, and 6/22/17 for the entries documented on the controlled count sheet. -There was no documentation for the 3:00pm administration on the front or back of the MAR for the 6/24/17 and 6/28/17 entries documented on	D 367		

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D 367	Continued From page 16 the controlled count sheet. Review of the July 2017 MAR revealed there was no documentation for the 8pm administrations on the front or back of the MAR for the 7/3/17, 7/22/17, 7/23/17, and 7/25/17 entries documented on the controlled count sheet. Review of the August 2017 MAR revealed there was no documentation for the 8pm administrations on the front or back of the MAR for the 8/30/17 and 8/31/17 entries documented on the controlled count sheet. Review of the September 2017 MAR revealed there was no documentation for the 8pm administrations on the front or back of the MAR for the 9/15/17 and 9/27/17 entries documented on the controlled count sheet. Interview with one medication aide on 10/4/17 at 11:30am revealed: -Prior to giving a controlled medication she checks the MAR to see if resident is within their timeframe to receive a dose. -She administered controlled medications. -She initialed on the front of the MAR, filled out the back of the MAR and then recorded on the controlled count sheet. -The pharmacy audits the controlled log and cart for errors. Interview with a second medication aide on 10/4/17 at 11:50am revealed: -She gave controlled medication when they were requested by the resident. -After administration, she initialed the front side of the MAR and documented on the back and then on the controlled count log.	D 367		

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D 367	Continued From page 17 Interview with third medication aide on 10/4/17 2:38pm revealed: -When a resident asked for an as needed medication, she checked the count to see when the last one was given. -She administered the medication. -She documented her initials on the front of the MAR and documented on the back why the resident wanted the medication. -She recorded the administration on the "narc" (controlled count log) book. Interview with RCC on 10/4/17 at 11:38pm revealed: -She did not do controlled count audits. -She has never been instructed that controlled count audits were a part of her job duties. -She would speak to the Administrator to determine if there was a policy on controlled audits. Interview with Administrator on 10/4/17 at 12:15pm revealed: -She was not aware of a policy on controlled count chart audits or assuring the counts and MAR were reconciled. -She would develop and implement a policy to audit controlled medications, controlled count log and accuracy of MAR's Interview with Resident # 2 on 10/4/17 at 10:45am revealed: -She had taken her hydrocodone/APAP just about every night because she had leg pain. -She requested the medication or the medication aide would ask if she needed the medication before bedtime. Refer to the interview with the RCC on 10/4/17 at 2:25pm.	D 367		

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D 367	Continued From page 18 Refer to the interview with the Administrator on 10/4/17 at 3:40pm. Interview with the RCC on 10/4/17 at 2:25pm revealed she expected the MA's to correctly document on the MAR and all other medication administration documents. Interview with the Administrator on 10/4/17 at 3:40pm revealed: -The RCC was responsible for assuring all medications were correct and accurately documented on the MAR. -She would have the RCC audit all narcotic medication records (control sheets and MAR's) for accuracy. -All resident MAR's were reviewed monthly by the RCC. -After the RCC completed her review, she reviewed the MARs. -"We do this because of having paper MAR's." -Up until today, she had not "cross-referenced" the as-needed narcotic medication MARs with the control sheets. -If there was no documentation on the MAR about an as-needed medication, she took it to mean the resident had not requested the medication. -"Going forward" the MAR will be cross-referenced with the control sheet.	D 367		