| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL068034 | A. BUILDING: _____ B. WING _____ | 03/05/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ADORABLE SENIOR LIVING | 401 WEST QUEEN STREET HILLSBORO, NC 27278 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on March 2, 2018 and March 5, 2018. | D 000 | | |
| D 072 | 10A NCAC 13F .0305(m) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(m) The requirements for outside premises are:<br>(1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition;<br>(2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and<br>(3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.<br><br>This Rule is not met as evidenced by:<br>Based on observations, and interviews the facility failed to assure the outside premises were free from clutter and safe for the residents living within the facility.<br><br>The findings are:<br><br>Observations of the side porch of the facility on 3/2/18 at 8:15 A.M. revealed:<br>-A sign that indicated a yard sale was leaned against the wall of the facility.<br>-An exercise bicycle was placed near the edge of the porch.<br>-A box was underneath the exercise bicycle.<br>-A bottle for antifreeze was under a window.<br>-A dining room chair was near the exercise bicycle.<br>-An ironing board without a cover was on the side of the porch extended and on its side.<br>-A folded cardboard box was sitting in the yard | D 072 | | |

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| D 072 | Continued From page 1 | D 072 | | |

directly in front of the side porch.
-A toilet plunger was lying beside the yard sale sign.
-A cooler was sitting in the yard beside directly in front of the dining room chair.

A second observation of the side porch of the facility on 3/5/18 at 5:51 P.M. revealed:
-The area was clean and without clutter.
-An exercise bicycle was near the end of the porch.
-There were no other items around the exercise bicycle.
-There were two green plastic benches placed neatly under the windows of the facility.

Interview with a resident on 3/5/18 at 12:35 P.M. revealed:
-When the weather was warm, the resident sat on the side porch with staff.
-The "things" on the porch have been there for a long time.
-The resident did not know how long the "things" had been on the porch.

Interview with a first shift Medication Aide (MA) on 3/5/18 at 1:00 P.M. revealed:
-She had worked at the facility for 28 years.
-The items on the side porch were there prior to the new owner's arrival.
-She did not know a specific year or month that they were placed.
-Some of the items were donated to the facility.
-A few of the residents used the exercise bicycle.
-She did not know where the ironing board came from.
-There had not been a yard sale at the facility.
-The facility did have people who cared for the yard.
-The Administrator arranged the care of the yard.

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| D 072 | Continued From page 2<br><br>Interview with the Co-Administrator on 3/5/18 at 2:05 P.M. revealed:<br>-She was at the facility 5 days a week.<br>-She was not aware of the items on the side porch.<br>-She asked if she could look at the items after the interview.<br>-The other Co-Administrator checked the outside premises twice a month.<br>-She was not aware of the last time the other Co-Administrator checked the outside premises.<br>-She was familiar with the rule area concerning maintenance of outside premises.<br>-She was told by the Co-Administrator, those item had been there since they took ownership of the facility. | D 072 | | |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure the reach-in refrigerator, reach-in freezer, the dishwashing area and the racks in the pantry were cleaned.<br><br>The findings are:<br><br>Observation of the inside of the reach-in cooler on 3/2/18 at 9:26 A.M. revealed the bottom shelf of the cooler under the white metal rack had | D 282 | | |

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| D 282 | Continued From page 3<br>multiple areas of brown stains.<br><br>Observation of the dishwashing room on 3/2/18 at 9:31 A.M. revealed:<br>-There was a pink bath towel on the floor bundled up across floor on the outside of the reach-in freezer.<br>-There was a pizza box and some napkins on the dishwashing sink.<br>-All six blades on the white ceiling fan had dust.<br><br>Observation of the inside of the reach-in freezer, which was in the dishwashing room, on 3/2/18 at 9:31 A.M. revealed:<br>-The bottom shelf of the freezer had multiple scratches, multiple areas of dark brown rust stains and black stains.<br>-One to one and a half feet of the edge of the bottom shelf was cracked.<br>-One foot of the insulated material of the freezer was exposed.<br>-There was a white paper towel hanging on the top side shelf of the freezer.<br><br>Observation of the pantry on 3/2/18 at 9:31 A.M. revealed 10 of 12 racks had dark brown stains and were sticky.<br><br>Interview with the Cook on 3/2/18 at 9:49 A.M. revealed she had just gotten to work and she did not know why the dishwashing area was not cleaned.<br><br>A second observation of the kitchen on 3/2/18 at 4:58 P.M. revealed the bottom shelf of the cooler under the white metal rack had multiple areas of brown stains.<br><br>A second observation of the dishwashing room on 3/2/18 at 4:58 P.M. revealed: | D 282 | | |

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| D 282 | Continued From page 4<br>-There was a pink bath towel on the floor bundled up across the outside of the reach-in freezer.<br>-The pizza box and napkins had been removed out of the dishwashing area.<br>-All six blades on the white ceiling fan had dust.<br><br>A second observation of the inside of the reach-in freezer on 3/2/18 at 4:58 P.M. revealed:<br>-The bottom shelf of the freezer had multiple scratches, multiple areas of dark brown rust stains and black stains.<br>-One to one and a half feet of the edge of the bottom shelf was cracked. One foot of the insulated material of the freezer was exposed.<br>-The white paper towel had been removed from the freezer.<br><br>A second observation of the pantry on 3/2/18 at 4:58 P.M. revealed 10 of 12 racks had dark brown stains and was sticky.<br><br>A third observation of the kitchen on 3/5/18 at 2:03 P.M. revealed the bottom shelf of the cooler under the white metal rack had been cleaned.<br><br>A third observation of the dishwashing room on 3/5/18 at 2:02 P.M. revealed:<br>-The pink bath towel on the floor bundled up across the bottom of the reach-in freezer had been removed.<br>-There was a brown rusted table on the floor under the sink.<br>-All six blades on the white ceiling fan still had dust.<br><br>Interview with the Cook on 3/2/18 at 4:57 P.M. revealed:<br>-She cleaned the reach-in cooler weekly and as needed.<br>-She cleaned the reach-in cooler today (3/2/18). | D 282 | | |

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| D 282 | Continued From page 5<br><br>-She had not cleaned the ceiling fan in a while, because she could not reach it. She did not know when the fan was last cleaned.<br>-The towel was on the floor in front of the reach-in freezer, because the freezer leaked water sometimes.<br>-The reach-in freezer had been leaking, since 2016.<br>-The freezer had not gotten out of the appropriate temperature range, because of the leak.<br>-The reach-in freezer was last cleaned one month ago.<br>-The "marks" inside of the freezer "won't come up."<br>-The racks inside of the storage area were cleaned "every few months."<br>-The racks inside of the storage area were last cleaned December 2017 or January 2018.<br><br>Interview with a Co-Administrator on 3/5/18 at 2:05 P.M. revealed:<br>-The facility did not have a cleaning schedule.<br>-Dietary staff cleaned the kitchen all of the time.<br>-Her expectation was for staff to clean the kitchen "like it was supposed to be cleaned."<br>-The reach-in freezer was not broken.<br>-Dietary staff informed her on 3/2/18 the reach-in freezer had been leaking and she told them she would check it.<br>-She checked to make sure the reach-in cooler and reach-in freezer was cleaned 5 days a week when she was at the facility.<br>-She checked the cleanliness of the cooler and freezer on today (3/5/18) and on Saturday 3/3/18. | D 282 | | |
| D 296 | 10A NCAC 13F .0904(c)(7) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service | D 296 | | |

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| D 296 | Continued From page 6<br>(c) Menus in Adult Care Homes:<br>(7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to have matching therapeutic diet for 1 of 1 Resident (#1) on the pureed diet.<br><br>The findings are:<br><br>Review of Resident #1's Resident Register revealed she was admitted to the facility on 12/4/17.<br><br>Review of Resident #1's current FL-2 dated 12/5/17 revealed:<br>-There was an order for a pureed "thin" diet.<br>-There was an order for a supplement [named] to be given daily.<br><br>Review of the facility's diet list (not dated) revealed the resident's diet included a pureed diet.<br><br>Interview with a Supervisor on 3/2/18 at 11:28 A.M. revealed:<br>-The facility did not have a pureed diet menu.<br>-The Cook pureed "whatever diet the resident was on."<br><br>Interview with the Administrator on 3/2/18 at 11:32 A.M. revealed:<br>-The facility did not have a pureed diet menu.<br>-Whatever diet the resident was on, the Cook pureed the meal. | D 296 | | |

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| D 296 | Continued From page 7<br><br>Review of the Friday Regular Diet Week 1 Winter Cycle included 1/4 cup (cp) of tuna, 1/2 pita bread, 1 leaf lettuce, tomatoe chopped and 4 ounces (oz) peaches chopped.<br><br>Observation of Resident #1 in her room on 3/2/18 at 11:50 A.M. revealed:<br>-She was served 4 oz pureed mixed vegetables, 4 oz pureed peaches and a bottle of protein supplement [named] on a tray.<br>-The only protein served with the meal was the supplement.<br><br>Observation of Resident #1 on 3/2/18 at 12:00 P.M. revealed she had eaten 100% of the meal.<br><br>Interview with Cook on 3/2/18 at 11:30 A.M. revealed:<br>-She based the diet and plate preparation on the diet list in the kitchen.<br>-The pureed diet items were thinned using broth or milk.<br>-The consistency of pureed food was similar to applesauce.<br>-She utilized the menu for a Regular diet and pureed the foods in a small food processor.<br><br>Interview with the Supervisor on 3/2/18 at 3:42 P.M. revealed:<br>-Resident #1 was on an order for the Regular Pureed diet and had been on the diet since December 2017.<br>-The resident was on the diet, because the resident had a history of choking.<br>-The way the diet was prepared during the lunch on meal on 3/2/18 was usually how dietary prepared the meal.<br>-The resident had not had any coughing or choking, since she had been on the diet. | D 296 | | |

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| D 296 | Continued From page 8<br><br>Interview with Resident #1's family member on 3/2/18 at 10:45 A.M. revealed the resident had been on the pureed diet for the past 5 years.<br><br>Interview with the Cook on 3/2/18 at 5:12 P.M. revealed:<br>-She had never seen a pureed diet menu, since she had been working at the facility.<br>-Whatever was on the regular diet menu, she pureed it for Resident #1.<br>-She had been following the regular diet menu to pureed Resident #1's meal, since the resident had been at the facility ( 2 1/2 years.)<br>-She received training on preparing pureed diets, before she was hired to work at the facility.<br>-She had not bee trained on how to prepare the pureed diet, since she had been working at the facility.<br><br>Interview with the Co-Administrator on 3/5/18 at 11:25 A.M.. revealed she had purchased new menus and the facility would start the new menus on 3/6/18.<br><br>Observation of the new menus on 3/5/18 at 11:25 A.M. revealed the menus included a pureed diet.<br><br>Review of the Monday Regular Diet Week 2 Winter Cycle included 3 oz roast turkey, 4 oz mashed potatoes, 4 oz buttered sliced carrots, and green grapes.<br><br>Observation of Resident #1 during the lunch meal on 3/5/18 at 12:00 p.m. revealed the resident's meal included 4 oz pureed sweet peas with small chunks on top, 4 oz pureed sweet potatoes, 4 oz mashed potatoes, 3 oz pureed turkey, 4 oz apple sauce.<br><br>Observation of Resident #1 on 3/5/18 at 12:18 | D 296 | | |

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| D 296 | Continued From page 9<br>P.M. revealed the resident had eaten all of the meal and did not cough or choke while eating the meal.<br><br>Interview with the Administrator on 3/5/18 at 2:05 P.M. revealed:<br>-Resident #1 was the only resident on the pureed diet.<br>-The pureed diet should be fine and without any chunks.<br>-She was aware that for every diet order there had to be a menu.<br>-She could not provide an excuse for not having a pureed diet menu.<br>-The Administrators were responsible for making sure the facility had menus for every therapeutic diet order. | D 296 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure 1 of 3 sampled Residents (#1) was treated with respect and dignity by staff assisting the resident with changing clothes in a timely manner and staff talking in a respectful manner to the resident.<br><br>The findings are: | D 338 | | |

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| D 338 | Continued From page 10<br><br>Observations of Resident #1 side table on 3/2/18 at 8:35 A.M. revealed a bell that she resident used as the call bell.<br><br>Review of Resident #1's current FL-2 dated 12/5/17 on 3/2/18 revealed diagnoses of history of stroke, pulmonary embolus, Dementia, anxiety, history of depression, bipolar and osteoporosis.<br><br>Observations of Resident #1 on 3/2/18 at 5:00 P.M. revealed:<br>-She was assisted by the second shift Medication Aide (MA) to the restroom.<br>-The MA told the resident that she had to help other residents with their meals and would return.<br>-The resident began to ring her call bell seconds after the MA walked away.<br>-The MA returned and the resident requested to have her pajamas put on by MA.<br>-The MA explained that she needed to assist another resident and would return to assist her.<br>-The MA left the room and soon after the resident began ringing her bell.<br>-Another MA went to address the resident and explained that she would be assisted after meal time.<br>-The resident continued to ring the call bell multiple times intermittently from 5:00 P.M. until 6:00 P.M.<br>-Staff were in other areas of the facility assisting other residents.<br><br>Observation on 3/2/18 at 5:42 P.M. in Resident #1's room revealed:<br>-Staff D, Personal Care Aide (PCA), was heard telling Resident #1 staff was feeding other residents.<br>-"Wait a little while to go to bed."<br>-"Stop yelling."<br>-"Stop calling me." | D 338 | | |

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| D 338 | Continued From page 11<br><br>Observation during second shift on 3/2/18 from 3:00 P.M. to 5:41 P.M. revealed Staff D had not talked rude or disrespectful to Resident #1.<br><br>Interview with Resident #1 on 3/2/18 at 5:53 P.M. revealed:<br>-"Oh boy, I'm in trouble."<br>-The resident did not want to say what that meant.<br><br>Interview with Staff D on 3/2/18 at 6:15 P.M. revealed:<br>-She described Resident #1 as a "needy person".<br>-Resident #1 could be calm and aggressive.<br>-She was the staff member who primarily cared for the resident on second shift.<br>-She had never witnessed anyone speaking to Resident #1 in a rough or negative tone.<br>-She had never witnessed anyone who told the resident "stop yelling".<br>-She denied talking to the resident in a rough or negative manner.<br>-She denied telling the resident to "stop yelling".<br>-She denied treating any of the residents in a disrespectful manner.<br><br>Interview with a resident on 3/2/18 at 8:41 A.M. revealed:<br>-Staff was nice to the resident.<br>-Staff got the resident what she needed.<br><br>Interview with a second resident on 3/5/18 at 12:35 P.M. revealed the resident did not have any problems with the way staff treated the resident at the facility.<br><br>Interview with family member on 3/5/18 at 12:38 P.M. revealed:<br>-He had never witnessed a staff member who | D 338 | | |

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| D 338 | Continued From page 12<br>spoke to a resident in an ugly manner.<br>-When he visited, he had never witnessed any staff member who treated a resident in an unkind manner.<br><br>Interview with Medication Aide (MA) on 3/5/18 at 1:00 P.M. revealed she had not witnessed any staff member who spoke to a resident in unprofessional manner.<br><br>Interview with the Co-Administrator on 3/5/18 at 12:07 P.M. revealed:<br>-Her expectation was for staff to treat residents with respect.<br>-None of the residents had complained of staff mistreatment to them.<br><br>Interview with the Administrator on 3/5/18 at 5:30 P.M. revealed:<br>-The staff needed to answer the call bell when Resident #1 rang.<br>-The staff were to treat Resident #1 like all the other residents were treated.<br>-She did not expect staff to speak to Resident #1 in an ugly manner because she rang the call bell.<br>-The staff were aware that Resident #1 had "memory issues".<br>-The second shift had two staff members and sometimes three staff members.<br>-The third staff member stayed until after dinner about three to four times per week.<br>-The third staff member was the Supervisor or another MA.<br>-In January, there was a staff meeting and treating/talking to the residents with respect was reviewed.<br><br>Observations of Resident #1 on 3/5/18 at 5:05 P.M. revealed she rang the call bell after her meal was eaten and staff responded quickly. | D 338 | | |

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| D 338 | Continued From page 13<br><br>Observation of a staff member on 3/5/18 at 5:06 P.M. revealed she took Resident #1's tray out of the room. | D 338 | | |
| D 378 | 10a NCAC 13F .1006 (b) Medication Storage<br><br>10a NCAC 13F .1006 Medication Storage<br><br>(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure medications for 1 of 3 sampled residents (Resident #2) were stored in a locked container within a refrigerator or a locked area designated for medication storage.<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 8/10/17 revealed:<br>-Diagnoses of Dementia, Osteoporosis, Osteoarthritis, Anemia, Malignant Neoplasm of lung, Gastro-esophageal Reflux disease, Hypertension, and Chronic Back Pain.<br>-No physician orders for the medication contained in the white box.<br><br>Review of Resident #2 facility records on 3/2/18 revealed: | D 378 | | |

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| D 378 | Continued From page 14<br><br>-A medication packing list was placed in the chart.<br>-The packing list had the names of medication and dispensed amounts listed.<br>-The dispensed amount for Lorazepam was 10 tablets.<br>-The packing list indicated liquid Morphine was sent in the box and the quantity dispensed was 15.<br>-A handwritten list of the same medications as the packing list was written on an order form.<br>-The order form was signed by the Hospice nurse and dated 2/7/18.<br>-A medication insert was in the chart with information about each medication listed on the packing list.<br>-A hand written progress note dated 2/7/18 indicated that Morphine 20 mg from the comfort pack was destroyed.<br>-The progress note was signed by the MA and Hospice nurse.<br><br>Observations of the facility kitchen refrigerator on 3/2/18 at 9:30 A. M. revealed:<br>-The refrigerator was not locked.<br>-The refrigerator contained various food items for residents and staff.<br>-Each shelf within the refrigerator had several food items on it.<br>-A white box was placed in the rear of the third shelf with a pharmaceutical company label.<br>-Staff was not present at that time.<br><br>Observations of the white cardboard box in the facility kitchen refrigerator on 3/2/18 at 9:35 A.M. revealed:<br>-There were two labels on the top of the box.<br>-One label indicated resident #2's name, name of pharmaceutical company, drug number and instructions to keep refrigerated.<br>-The other label read "Please use to reseal". | D 378 | | |

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| D 378 | Continued From page 15<br>-This label indicated a reseal date and place for initials.<br>-The box contained various medications.<br>-The medications were in small plastic reseal able bags.<br>-The only controlled medication in the box was Lorazepam.<br>-There were 10 tablets within the plastic bag.<br>-There was no paperwork contained within the box.<br><br>Interview with first shift Medication Aide (MA)/Supervisor on 3/2/18 at 9:32 A.M. revealed:<br>-The white box was delivered to the facility via a delivery company.<br>-The white box in the refrigerator was delivered in February of 2018.<br>-The box was referred to as a comfort care kit.<br>-The Hospice nurse confirmed receipt of the box.<br>-"Only the Hospice nurse touched the box".<br><br>Attempted interview with the Hospice nurse on 3/5/18 at 11:46 A.M. was unsuccessful.<br><br>Interview with the Co-Administrator on 3/2/18 at 11:45 A.M. revealed:<br>-She was not aware of the white box of medications were in the refrigerator.<br>-The medications needed to be locked or in a locked container.<br><br>Observation of the facility hallway near Administrators' office on 3/2/18 at 8:17 A.M. revealed:<br>-There were various bulletin boards displayed.<br>-One bulletin board was located beside the office and displayed the word "STAFFING".<br>-The same bulletin board had two documents displayed and were hung by thumb tacks.<br>-On the thumb tack to the left of the bulletin board | D 378 | | |

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| D 378 | Continued From page 16<br>was a set of keys.<br><br>Observation of MA/Supervisor accessing medication storage location in the facility on 3/2/18 at 4:00 P.M. revealed:<br>-A large medication cart was inside of an area equal to the size of a storage closet.<br>-The cart had a locked drawer to the right of larger drawers.<br>-The keys that unlocked the locked controlled medication drawer were in a small basket at the rear of the cart.<br>-The keys for the medication closet were placed back on a thumb tack on a bulletin board.<br><br>Observation of second shift MA on 3/2/18 at 4:40 P.M. revealed:<br>-She took a set of keys from the bulletin board hung on the wall directly beside the Administrator office.<br>-She used the keys to unlock the medication closet.<br>-She obtained medications for a resident, closed, locked the medication closet, and placed the keys back on the bulletin board.<br><br>Interview with the Cook on 3/2/18 at 4:45 P.M. revealed:<br>-The refrigerator had been used previously as storage area for medications.<br>-She was aware that the comfort care kits contained medications.<br>-Other medications and comfort care kits were placed in the refrigerator in the past.<br>-In the past, there were medications in the refrigerator that were expired.<br>-The staff member told her that they would ask the Hospice nurse about the medications.<br>-She did not make the Administrator aware of this incident. | D 378 | | |

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| D 378 | Continued From page 17<br><br>Observation of first shift MA/Supervisor accessing medication storage area on 3/5/18 at 1:00 P.M. revealed:<br>-She obtained a set of keys from the bulletin board next to the Administrator's office.<br>-She used the keys to unlock the medication closet.<br>-She placed the keys back on a thumb tack on the bulletin board after using them.<br><br>Interview with the MA/Supervisor on 3/2/18 at 3:45 P.M. revealed:<br>-Resident #2's family were providing medications.<br>-Resident #2 utilized the facility pharmacy after admission to Hospice services.<br>-The Hospice nurse discussed orders or pending orders with her.<br>-The medication orders were faxed to the physician and a signed memo was sent back to the facility.<br>-The memo from the physician indicated if orders were approved or changed.<br>-The memo was treated as an order.<br>-The facility pharmacy prepared the medication administration records.<br>-The facility pharmacy would send a controlled sheet when controlled medications were filled.<br>-When controlled medications were sent without a control sheet, one was made for the medication.<br>-All controlled medications were kept in a locked box in the medication cart.<br>-The medication cart was locked in a medication "cabinet".<br>-She was not aware that controlled medication were in the box in the refrigerator.<br>-Residents went into the kitchen sometimes to see who was cooking for the day.<br>-Residents did not go into the refrigerator. | D 378 | | |

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| D 378 | Continued From page 18<br><br>Interview with another first shift MA on 3/5/18 at 1:00 P.M. revealed:<br>-She had worked at the facility for 28 years.<br>-Medications were delivered during the dayshift and on weekends.<br>-The medications were delivered in a green container that was secured with zip ties.<br>-The medications were placed in the office.<br>-If the office is locked, the staff would call the MA/Supervisor to unlock the office.<br>-The Administrator or the MA/Supervisor placed the delivered medications into the medication cart.<br>-The medication closet was accessed by the set of keys that hung on the bulletin board.<br>-The keys were not kept "anywhere else".<br>-The kitchen refrigerator was used to store medications that required refrigeration.<br>-The Hospice comfort care packs were kept in the refrigerator<br>-The MA/Supervisor took care of the medications for Hospice.<br>-The Administrator was going to obtain a small refrigerator to lock up the medications.<br><br>Interview with Cook on 3/5/18 at 1:40 P.M. revealed:<br>-She had worked at the facility for three years.<br>-During that time she was aware of 6 or 7 other residents who received Hospice services.<br>-These residents had comfort care kits and the kits were placed in the refrigerator.<br>-The refrigerator was locked when not in use to prevent it from "popping open".<br><br>Interview with Hospice physician's office nurse on 3/5/18 at 1:40 P.M. revealed:<br>-The physician signed the order for the comfort care kit on 2/15/18. | D 378 | | |

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| D 378 | Continued From page 19<br>-The process used to address orders for Hospice was in flux at this time.<br>-Some items for residents were delivered to their office and picked up by the facility MA/Supervisor.<br>-When items were picked up, a signature was obtained from the person who picked up the item.<br>-The office had a list of the contents of the comfort care kit.<br>-The list indicated two controlled medications were ordered, Morphine and Lorazepam.<br><br>Interview with the Co-Administrator on 3/5/18 at 2:05 P.M. revealed:<br>-Medications were delivered from the pharmacy in a container secured with zip ties.<br>-The MA/Supervisor opened the container and placed the medications on the cart.<br>-The medication cart was located in a locked medication closet.<br>-The keys to the locked medication closet were kept in the office. The keys for the office were kept in the office.<br>-The office was mainly open and the staff had access to the office.<br>-The MA/Supervisor had the keys to the office.<br>-The MA/Supervisor's shift ended at 3:00 P.M.<br>-The MAs keep the keys to medication closet on their person.<br>-The key ring with the key to the medication closet also held the key to the medication cart and the key to the controlled medication portion of the cart.<br>-The keys seen hung on the bulletin board were to the medication closet, and medication cart.<br>-The keys were hung there sometimes, mainly at night.<br>-The keys were supposed to be held in the pockets of the MAs when on duty; the MAs kept the keys with them at all times when they first took ownership. | D 378 | | |

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| D 378 | Continued From page 20<br>-The MAs would have to begin to keep the keys in their pockets again.<br>-She was aware that the unsecured keys could be accessed by anyone within the facility.<br>-She was aware that access to the keys meant access to the controlled medication. | D 378 | | |