

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/28/2018
NAME OF PROVIDER OR SUPPLIER TARA PLANTATION OF CARTHAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 820 S. MCNEILL STREET CARTHAGE, NC 28327		
(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 Moore County Department of Social Services conducted an annual and follow up survey and complaint investigation on February 20-23 and 26-28, 2018 with an exit conference via telephone on February 28, 2018. The Moore County Department of Social Services initiated complaint investigations on February 13 and 14, 2018.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the facility was free of obstructions and hazards as evidenced by medicated creams and liquids not being stored securely and being accessible to residents in the Special Care Unit (SCU); free-standing, unsecured oxygen canisters; carpeting with gaps, wrinkles, buckling, and raised areas in the common areas of the SCU and 3 resident rooms in the Assisted Living (AL) section; and three showers with exposed, rough edges in 3 resident bathrooms in the AL section. The findings are:	D 079		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 079	Continued From page 1 1. Observations upon entry of the facility on 02/20/18 at 10:45am revealed: -There was a resident with a walker who was wearing oxygen by nasal cannula in the Assisted Living (AL) section of the facility located in front of the main entrance door. -The oxygen canister was free-standing and was not secured to the walker or in a oxygen canister holder; creating a hazard. -The area was a high traffic location, adjacent to the common living room area of the AL section; there were multiple staff members and residents in the area, including residents with walkers and wheelchairs that could accidentally hit the unsecured oxygen canister. Observation of the AL section of the facility near the main entrance on 02/20/18 at 11:30am revealed the free-standing oxygen canister had been secured in an oxygen canister holder. Observation of resident room A109 on the special care unit (SCU) on 02/20/18 at 1:03pm revealed: -There was an unsecured oxygen canister standing upright on the floor beside of a floor lamp, behind a recliner. -There was no resident or staff in the room. Interview with the resident who resided in room 109A on 02/20/2018 at 1:10pm revealed: -She had the current oxygen canister and 2 larger oxygen canisters in her room for months. -A few weeks ago they removed the 2 larger oxygen canisters. -The oxygen canisters were always sitting directly on the floor and not in any type of holder. -She does not remember ever using the oxygen. Interview with the Special Care Unit Care	D 079		

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D 079	Continued From page 2 Coordinator (SCUCC) on 02/20/18 at 1:11pm revealed: -She did not know how long the unsecured oxygen canister had been in room A109. -She was "unsure" how the oxygen was supposed to be stored or the process for securing oxygen. -She thought the normal process to use when oxygen was in use was to put the canister in a "portable rolling rack." -There was a room on the Assisted Living (AL) side of the facility to store oxygen that was not in use. -There was not a place to store oxygen on the SCU. Observation on 02/20/18 at 1:14pm revealed the SCUCC removed the unsecured, free-standing oxygen canister from room A109. Interview with a family member of the resident who resided in room A109 on 02/23/18 at 9:30am revealed: -She had seen several oxygen tanks in the resident's room sitting on the floor behind her chair "for a long time". -The staff recently removed 2 larger oxygen tanks. Interview with the Administrator and Administrator's Assistant on 02/20/18 at 1:09pm revealed oxygen was usually stored on a rolling oxygen holder when in use by a resident. Interview with the Administrator on 02/22/18 at 5:40pm revealed: -She expected oxygen to be stored properly at all times. -When in use, oxygen was supposed to be secured in a metal holder.	D 079		

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D 079	Continued From page 3 A second interview with the Administrator and Administrator's Assistant on 02/22/18 at 7:00pm revealed: -The Administrator's Assistant had contacted the facility's durable medical equipment (DME) provider regarding options to secure the oxygen canisters when in use. -The DME provider had brought five oxygen holders that day (02/22/18) to use to secure oxygen when it was in use. -The holders attached to wheelchairs and walkers to secure the oxygen canisters. -Staff would be informed to assure oxygen was secured at all times. 2. Observation of the special care unit (SCU) during the initial tour on 02/20/18 at 11:15am revealed: -The carpeting in the common living room areas and common hallways had wrinkles of various lengths and heights in multiple areas, creating an uneven walking surface which was a fall hazard. -There was an area near two double doors that was greater than two feet long where the carpet seams met that was not adhered to the floor, causing the seams to raise off of the floor creating a fall hazard. Observation of the SCU living areas on 02/20/18 at 1:51pm revealed: -A resident with a walker was walking in the common living area where the carpeting was wrinkled. -A second resident with a rollator walker was walking on another area of the common living room area where the carpet was wrinkled. Observation on 02/20/18 at 1:51pm revealed the carpet in the left common hallway had a wrinkle	D 079		

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D 079	Continued From page 4 that extended the length of the area between two different resident rooms. Interview with a family member of a resident who resided in the SCU on 02/20/18 at 12:00pm revealed the carpet had been like that "awhile." Interview with a family member of another resident who resided in the SCU on 02/20/18 at 12:08pm revealed: -The wrinkles had been present in the carpet for at least a year. -The family member recalled the resident had almost fallen over the wrinkles in the carpet "last year." -The family had reported concerns with the carpeting to a former (named) staff and also to the Administrator in Charge (AIC) during the first part of 2017. -The family was told it was not in the budget to replace the carpet. Interview with the Special Care Unit Care Coordinator (SCUCC) on 02/20/18 at 11:30am revealed: -She was unsure how long the carpet had been in the current condition. -She was not aware of any residents having any falls due to the carpeting. Observation of the SCU living areas on 02/23/18 at 10:35am revealed: -The carpet had been partially replaced on the front sections of each the left and right common hallways. -The old carpet still remained on the back sections of each left and right common hallways. -On the right common hallways was a 3 inch gap where there was no carpet between the new and old carpet, creating a fall hazard.	D 079		

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D 079	Continued From page 5 Observation of resident room #122 in the AL section on 02/20/18 at 11:20 a.m. revealed: -There were two raised areas of carpet near the kitchenette in the resident's room. -One area was one foot in length and 1/2 to 1 inch in height. -The second area was 3 inches in length and 1/2 to 1 inch in height. Observation of resident room #122 on 2/23/18 at 1:15 p.m. revealed the two raised areas on the carpet were the same. Based on observations and interviews the resident, who lived in resident room #122, was not available for interview. Observation of resident room 139 in the AL section on 02/20/18 at 11:45 a.m. revealed the carpet had buckled in several areas at the entrance area into the room. Attempted interviews with the residents of room 139 on 02/20/18 and 02/23/18 were unsuccessful. Observation of resident room 137 in the AL section on 02/20/18 at 11:48 a.m. revealed the carpet had buckled in several areas at the entrance into the room. Interview with the Maintenance Director on 02/21/18 at 3:47 p.m. revealed he did not know about the carpet buckling in the resident rooms, but knew they were going to be replacing carpet everywhere. Interview with the residents of room 137 on	D 079		

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D 079	Continued From page 6 02/22/18 at 4:48 p.m. revealed the carpet had been like that since they moved in. Interview with the Assisted Living Unit Care Coordinator (ALUCC) on 02/23/18 at 11:02 a.m. revealed she had not noticed buckling carpet in any of the resident rooms. Interview with the Assistant Administrator on 02/23/18 at 12:58 p.m. revealed she was not aware of the carpet buckling in any resident rooms. Interview with the Administrator on 02/20/18 at 2:25pm revealed: -She was aware of the wrinkles in the carpeting. -The carpeting had previously been cited by the Division of Health Service Regulation (DHSR) Construction Department (dates not provided). -The facility received notification from DHSR Construction that their plan of correction for the carpet was accepted for correction the deficiency cited for the carpet (dates not provided). -The facility was in the process of replacing the carpeting in the entire building; the process should be completed by the end of the week. -The facility had to obtain funds and schedule the carpet installation, which had taken a little bit of time to coordinate. 3. Observations in room 116A of the Special Care Unit (SCU) on 02/20/2018 at 12:25pm revealed: -There were two 10 ounce containers of shaving cream, one bottle of aftershave liquid with approximately two ounces of liquid in the bottle, and one bottle of cologne in an unlocked bathroom cabinet over the bathroom sink. -Resident #7 was lying in bed with the bed covers	D 079			

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D 079	Continued From page 7 pulled up over his head. -There was no staff in the resident's room. Observation of the label on the bottle of aftershave liquid revealed: -The ingredients in the aftershave included SD alcohol 40-B (a specially denatured alcohol; all SD alcohols are named such due to the denaturant used in them which is intended to make the alcohol undrinkable as it will make a person ill intentionally), menthol, and BHT (butylated hydroxytoluene which is a fat soluble compound used to preserve foods). -The warning label instructions included "For external use only. Flammable. Keep from heat or flame. Do not use while smoking". Observation of the label on the bottle of shaving cream revealed: -The ingredients in the shaving cream included stearic acid (a fatty acid), triethanolamine (a reactionary by-product of two toxic substances - ethylene oxide and ammonia), and isobutane (a liquefied gas used as aerosol propellants). -The warning label instructions included "content under pressure; do not puncture or incinerate". Interview with the Administrator-in-Charge (AIC) on 02/20/2018 at 1:50pm revealed: -All residents had their own bins set up in the utility room where their personal care items were to be stored. -Resident #7 liked to perform some of his own personal care but staff were still supposed to supervise the resident. -The Special Care Unit Care Coordinator (SCUCC) was responsible for ensuring there were no medicated or chemical containing items in the resident rooms.	D 079			

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D 079	Continued From page 8 Observation on 02/20/18 at 1:57pm revealed the SCUCC was walking in the common hall carrying multiple items to include three unlabeled disposable blue cups filled with a thick white creamy substance, a tube of denture adhesive, and a bottle of body wash. Interview with the SCUCC on 02/20/18 at 1:57pm revealed: -The items she had in her hands had been removed from the residents' rooms (room numbers not provided). -The items should not be stored in the residents' rooms on the SCU. -The "creams" in the blue cups was a (named) skin protectant. -The Personal Care Aides (PCAs) used the "cream" as needed when changing or toileting residents. -She had seen the skin protectant in the bathrooms cabinets of the residents' rooms "a lot of times." -Staff were in the process of checking all of the rooms on the SCU at that time to remove anything that was not supposed to be in the rooms. Observations in the bathroom of room 123 of the SCU on 02/20/2018 at 2:00pm revealed: -There was a tube of toothpaste with a warning on the label which read " ...if more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away." -There was no resident or staff in the room at that time. -There was a blue plastic cup filled with an unidentified creamy yellowish-white substance in the unlocked cabinet over the bathroom sink.	D 079		

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D 079	Continued From page 9 Interview with the AIC on 02/20/2018 at 2:00pm revealed: -She did not know what the unidentified creamy yellowish-white substance was. -She thought it might be a skin protectant cream [named] or a skin moisturizing lotion [named]. -She had been in the facility during the past weekend and checked rooms, closets, and drawers, but had not checked room 123. -She had checked empty rooms because she wanted to make sure those rooms were cleaned out. -She would have to look at the resident's medication list to help determine what was in the blue plastic cup. -She had two staff going through rooms on the SCU now "cleaning them out". 4. Observation in room A109 of the Special Care Unit (SCU) on 02/20/2018 at 11:42am revealed: -The resident was sitting in the recliner watching TV. -There was a 6 ounce bottle of [named] sore throat spray sitting on the bedside table. -There was a 16 ounce container of [named] medicated skin cream sitting on the bedside table. -There was a hand bell sitting on the bedside table. -There was a bell hanging on the door to the resident's room. -There was no staff in the resident's room. Observation of the label on the bottle of sore throat spray revealed: -The ingredients included Phenol 1.4% (an oral anesthetic/analgesic), and other inactive ingredients. -The warning included if overdose or accidental poisoning, get medical help or contact the Poison	D 079			

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D 079	Continued From page 10 Control Center right away. Observation of the label on the container of medicated skin cream revealed: -The ingredients included petrolatum, mineral oil, ceresin, lanolin alcohol, phenoxyethanol and piroctone olamine. -The warnings included do not use near high heat, avoid getting it in eyes/nose/mouth, and if overdose, seek emergency medical attention or call the Poison Control Center right away. Observation in bathroom of room A109 of the SCU on 02/20/2018 at 11:42am revealed: -There was no staff or resident in the bathroom. -There were multiple bottles of over-the-counter toiletries to include: (1) hairspray, (1) mouthwash, (3) liquid body soaps, (2) shampoos, (3) spray perfumes, (2) liquid foundation make-ups, (2) skin lotions, (1) stick deodorant, (1) powder, (1) liquid hand soap, (1) toothpaste and (1) box of denture cleanser tablets. Interview with the resident who resided in room A109 on 02/20/2018 at 11:42am revealed: -The doctor allowed her to keep the medicated skin cream and sore throat spray at her bedside so she could use them when she needed. -She had always had her toiletries in the bathroom so she could get to them each day. -The Activity Director hung the bell on her room door so she would know when another SCU resident walked in her room. -She rang the hand bell at her bedside whenever the other SCU residents would wander in her room at night and "mess with" her things or "bother" her. Interview with the Administrator on 02/20/2018 at 1:25pm revealed:	D 079		

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D 079	Continued From page 11 -She was not aware that the resident in room A109 had self-medications at her bedside or the toiletries in her bathroom. -"There was no one on the SCU that self-administered medications and none of them should have any chemicals or hazards in their room." -She would immediately instruct staff to go through all SCU rooms and bathrooms to remove anything that could be hazardous. Interview with A109 resident's family member on 2/23/18 at 9:30am revealed: -The resident had "occasional confusion". -She was aware that the resident had medicated skin cream at her bedside, but did not know she had the sore throat spray. -She was aware that the staff had removed medications and toiletries from her room in the past. Observation on 02/21/18 at 7:25am revealed the beside medicated skin cream, sore throat spray and the bathroom toiletries had been removed from room A109. 5. Observation of resident room 139 on 02/20/18 at 11:45 a.m. revealed the shower had a rough edge where two pieces of plastic came together and had no caulking on the bottom left that was approximately 2 ½-3 inches in length. Attempted interviews with the residents of room 139 on 02/20/18 and 02/23/18 were unsuccessful. Observation of resident room 137 on 02/20/18 at 11:48 a.m. revealed: -The bathroom commode had a piece of wood that was 3 inches wide and 6 inches long wedged	D 079			

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D 079	Continued From page 12 between the floor and the base of the commode. -There was no caulking around the entire commode. -The shower had a rough edge where two pieces of plastic came together and had no caulking on the bottom left that was approximately 2 ½-3 inches in length. Interview with the residents of room 137 on 02/22/18 at 4:48 p.m. revealed: -They did not know how long they had been in room 137. -The commode had been "like that" for about a month. -The Maintenance Director put the piece of wood under the commode to keep it from moving. -They had not noticed the rough edge in the shower. Observation of resident room 143 on 02/20/18 at 11:17 a.m. revealed the shower had a rough edge where two pieces of plastic came together and had no caulking on the bottom left that was approximately 2 ½-3 inches in length. Interview with a resident in room 143 on 02/20/18 at 11:17 a.m. revealed: -He used the shower but did not know how often. -He had not noticed the rough edging on the shower. -He did not know what had happened to it. Interview with a second Resident in room 143 on 02/20/18 at 11:22 a.m. revealed: -He had noticed the rough edge on the shower. -He did not recall how long it had been that way. -He had not reported the rough edge to anyone. -He did not use the shower and preferred to use the shower room in the hall because it was bigger.	D 079		

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D 079	Continued From page 13 Interview with the Maintenance Director on 02/21/18 at 3:47 p.m. revealed: -He received his work orders from the aides, administrator, "anyone who sees something that needed to be done." -He did walk through 2-3 x's per month. -He told residents if they had maintenance issues to tell the aides, and they would tell him. -He worked 8:00 a.m.-5:00 p.m. Monday-Friday. -He was going to make rounds in all the rooms today (02/21/18). -He was not aware of showers that had rough edges that needed to be caulked. -He was behind on maintenance because he had been helping in other areas, cooking, laundry and transportation. -He had seen resident room 137 this morning and would be repairing it today (02/21/18) and would do a walk through to see what else needed to be caulked and would make repairs on what needed to be done. Interview with a housekeeper on 02/23/18 at 10:00 a.m. revealed: -If she noticed something that needed to be repaired, she would complete a repair sheet and put in the Maintenance Directors box on his office door. -She did not work this area often (Assisted Living) so she was not aware of any problems in resident's rooms. -She did not know when the usual housekeeper would be back she was "just helping out." Interview with the Assisted Living Unit Care Coordinator (ALUCC) on 02/23/18 at 11:02 a.m. revealed: -She made rounds every day in the facility. -If she noted something that needed to be	D 079			

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D 079	Continued From page 14 repaired, she would complete a work order and put in the Maintenance Directors box on his office door. -Sometimes if he was there she would tell him verbally things that needed to be done as well. -She had reported the commodes that needed to be caulked. -She did not recall when she had reported it. -She had noted the rough edges on some showers and had reported them to Maintenance Director, but did not recall how long ago. Interview with the Assistant Administrator on 02/23/18 at 12:58 p.m. revealed: -She made random visits to monitor the resident rooms. -She expected the staff to monitor the resident rooms daily and come to her to report any concerns, and she would handle accordingly. -Whatever needed to be done, she would call the Administrator to discuss. -She was not aware of any current outstanding issues with commodes or showers that needed caulking. Observation of resident room 137 on 02/23/18 at 10:55 a.m. revealed the wood had been removed and the commode had been caulked. _____ The facility failed to ensure oxygen canisters were secured in storage racks, creating a potential for an unsecured canister to fall and/or be knocked over, damaging the valve, and rapidly releasing the high pressure gas from the canister, causing injury. The facility failed to assure prescription and over the counter medications and personal care items with hazardous ingredients were stored securely and out of access of the cognitively impaired residents who resided in the SCU. The facility failed to assure the carpeting	D 079			

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D 079	Continued From page 15 was free of wrinkles, gaps, and buckling, creating a fall hazard. This non-compliance was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility on 02/20/2018 revealed: -Oxygen tanks had been secured. -All ingestion hazards have been removed from resident rooms on secured unit. -Carpet is currently being replaced. -Staff instruction and follow up will be provided by the Administrator-in-Charge and Care Coordinators. The Administrator will inspect and document weekly until 03/20/2018, then monthly until 09/20/2018. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2018.	D 079		
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 the Primary Care Provider (PCP) was notified regarding medication refusals for 2 of 8 sampled residents (#5, #7) to include Gabapentin, Ropinirol, Theravite-M, Blephamide Eye Drops (#5) and Biotene Mouthwash (#7).	D 273		

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D 273	Continued From page 16 The findings are: 1. Review of Resident #5's current FL-2 dated 04/26/17 revealed: -Diagnoses included Alzheimer's disease with behaviors, diabetes, chronic pain, hypertension, history of cerebrovascular disease, edema, neuropathy, iron deficiency anemia, peptic ulcer disease, restless leg syndrome and chronic kidney disease. -There was an order for Neurontin (Gabapentin) 300 milligrams (mg) 1 tablet two times per day (Gabapentin is used to treat nerve pain and anticonvulsant) -There was an order for Neurotin (Gabapentin) 300 mg 2 tablets at bedtime. -There was an order for Ropinirole (Requip) 2 mg 1 tablet three times per day (Ropinirole is used to treat Parkinson's disease and restless legs syndrome). -There was an order for Theravite-M 1 tablet per day (Theravite-M is a multivitamin used to treat or prevent vitamin deficiency). -There was an order for Blephamide 0.2% eye drops place one drop into each eye twice a day (Blephamide Eyes Drops is used to prevent or treat eye infections and to treat swelling in the eye). Review of Resident #5's December 2017 electronic Medication Administration Record (eMAR) revealed: -Blephamide 0.2% eye drops were documented as refused 12 times. -Gabapentin 300 mg was documented as refused 15 times. -Ropinirole 2 mg was documented as refused 15 times. -Theravite-M was documented as refused 2 times.	D 273		

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D 273	Continued From page 17 Review of Resident #5's January 2018 eMAR revealed: -Blephamide 0.2% eye drops were documented as refused 9 times. -Gabapentin 300 mg was documented as refused 17 times. -Ropinirole 2 mg was documented as refused 17 times. Review of Resident #5's February 2018 eMAR revealed: -Blephamide 0.2% eye drops were documented as refused 10 times. -Gabapentin 300 mg was documented as refused 13 times. -Ropinirole 2 mg was documented as refused 13 times. Review of Resident #5's progress notes revealed no documentation that the PCP had been notified of Resident #5's medication refusal. Interview with the Primary Care Provider (PCP) on 02/21/18 at 10:55 a.m. revealed she was not aware Resident #5 had refused her medications. Interview with the hospice nurse on 02/22/18 at 1:59 p.m. revealed: -She had been working with Resident #5 since November 2016. -She was aware that Resident #5 refused her medications at times. -Resident #5 would often refuse her medications when she was in "one of her moods" but when re-approached 5 minutes later would often take the medications. -If Resident #5 had experienced any anxiety or pain and had refused those medications she would have addressed the refusal of medications	D 273		

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D 273	Continued From page 18 at that time. Based on observations, interviews, and record reviews, Resident #5 was not interviewable. Attempted interview with Resident #5's Power of Attorney on 02/22/18 at 12:01 p.m. and 02/23/18 at 11:36 a.m. were unsuccessful. Refer to the interview with the Assisted Living Unit Care Coordinator (ALUCC) on 02/21/18 at 8:05 a.m. Refer to the interview with the Primary Care Provider (PCP) on 02/21/18 at 10:55 a.m. Refer to the interview with the Special Care Unit Care Coordinator on 02/22/18 at 3:41 p.m. Refer to the interview with the Administrator in Charge on 02/22/18 at 4:05 p.m. Refer to the interview with the Administrator on 02/22/18 at 6:59 p.m. 2. Review of Resident #7's current FL-2 dated 04/05/17 revealed: -The resident's diagnoses included dementia with psychosis, high blood pressure, glaucoma, coronary artery disease, chronic pain, mood disorder, gout and anxiety -The resident was intermittently disoriented. -There was a medication order for Biotene mouthwash use as a mouth rinse and spit out twice daily. (Biotene mouthwash is used to treat the symptoms of dry mouth). Review of Resident #7's current assessment and care plan dated 04/19/17 revealed:	D 273		

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D 273	Continued From page 19 -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident's vision was very limited (blind) in the left eye. -The resident had a hard time hearing loud sounds/voices. Confidential interview with a concerned citizen revealed: -Resident #7 had been prescribed mouthwash. -Staff gave it to Resident #7, but he did not take it. -Resident #7's mouthwash had built up in his room. -There had been many cups in Resident #7's cabinet, which included mouthwash that had turned solid because it had been left so long. Interview with Resident #7 on 02/14/18 at 4:41pm revealed: -He was being taken care of. -Most of the time he got his medications. -He got his mouthwash every day and used it. -At times he would forget to use the mouth wash or he refused the mouthwash. -Staff would leave the mouthwash in the bathroom. Observation of the inside of Resident #7's bathroom cabinet on 02/14/18 at 4:41pm revealed: -There was one unlabeled disposable medication administration cup with a clear liquid inside. -There was a second unlabeled disposable medication administration cup with a white colored solid substance inside. -There was a third unlabeled disposable medication administration cup with a semi-solid clear and a white colored substance inside.	D 273		

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D 273	Continued From page 20 Review of a Resident #7's December 2017 electronic Medication Administration Record (eMAR) revealed Biotene mouthwash was documented as given to Resident #7 except on 12/05/17 and 12/27/17. Review of a Resident #7's January 2018 eMAR revealed Biotene mouthwash was documented as given to Resident #7 every day. Review of a Resident #7's February 2018 eMAR revealed: -Biotene mouthwash was documented as given to Resident #7 except on 02/03/18 and 02/07/18. -Biotene mouthwash was documented as discontinued on 02/16/18. Interview with Administrator in Charge on 02/14/18 at 2:36 p.m. revealed: -Staff should watch Resident #7 take his mouth wash. -The mouthwash should not be left in Resident #7's room. -She did not know the mouthwash was sitting out. Interview with Medication Aide (MA) on 02/14/18 at 4:43 p.m. revealed: -Resident #7 got his mouthwash in the morning and evening. -She had never had any issues with Resident #7 not taking his mouthwash. -She did not know anything about Resident #7's mouthwash sitting out or getting hard. Telephone interview with Resident #7's Guardian on 02/22/18 at 1:27 p.m. revealed: -There were no concerns about the facility. -He visited Resident #7 quarterly unless the facility called him to come out more. -The facility had treated Resident #7 well and he	D 273			

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D 273	Continued From page 21 had not known of Resident #7 not getting his medications. -He knew nothing about Resident #7 refusing or not getting his mouthwash. -He knew nothing about the mouthwash being left in his room. Interview with Primary Care Provider (PCP) on 02/21/18 at 12:27 p.m. revealed: -She had not seen the facility's policy/procedures for medication refusals. -The facility usually let her know if medications were missed/refused by a resident. -If a resident went more than 24 hours, she would need to know. -She didn't know anything about Resident #7's mouthwash or him refusing medication. -The mouthwash she wouldn't need to know "it's not a big deal". -If Resident #7 continuously refused she would need to be made aware so she could discontinue it. -It would not have harmed Resident#7 if he had not taken it. Refer to the interview with the Assisted Living Unit Care Coordinator (ALUCC) on 02/21/18 at 8:05 a.m. Refer to the interview with the Primary Care Provider (PCP) on 02/21/18 at 10:55 a.m. Refer to the interview with the Special Care Unit Care Coordinator on 02/22/18 at 3:41 p.m. Refer to the interview with the Administrator in Charge on 02/22/18 at 4:05 p.m. Refer to the interview with the Administrator on 02/22/18 at 6:59 p.m.	D 273		

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D 273	Continued From page 22 Interview with the Assisted Living Unit Care Coordinator (ALUCC) on 02/21/18 at 8:50 a.m. revealed when three or more doses (not three dates) of medication were refused, the Medication Aides (MAs) or UCCs notified the provider. Interview with the Primary Care Provider (PCP) on 02/21/18 at 10:55 a.m. revealed: -She would expect to be notified if a resident refused their medication if had gone more than 24 hours. -If a resident continued to refuse she would look at discontinuing the medication. Interview with the Special Care Unit Care Coordinator (SCUCC) on 02/22/18 at 3:41 p.m. revealed: -When a resident refused a medication, the MA used the drop down menu on the electronic Medication Administration Record (eMAR) to choose the option that the resident refused. -When medications were refused, the MAs or UCCs notified the provider by phone or in person when the provider was in the facility. -The notification was usually made after the resident had refused three doses of the medication, but it depended on what medication was refused. Interview with the Administrator in Charge (AIC) on 02/22/18 at 4:05 p.m. revealed: -The MAs were expected to document the administration of medications on the eMARs at the time the medication was administered. -When a medication was not given or refused, it was to be documented as not given on the eMAR; the reason it was not administered was to be documented on the MAR.	D 273		

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D 273	Continued From page 23 -If medications were refused for three doses or a resident continued to refuse a medication, the MAs were supposed to notify the provider. -All MAs had been trained on the administration and documentation of medications. -The AIC expected the MAs to follow the facility's medication administration policy. Interview with the Administrator on 02/22/18 at 6:59 p.m. revealed: -She was not aware that residents were refusing medications and the PCP had not been notified. -She expected the PCP to be notified when residents had refused their medications.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure orders were implemented for 1 of 5 sampled residents (#1) with an order for a Vitamin D lab to be drawn. The findings are: Review of Resident #1's current FL-2 dated 4/10/17 revealed the diagnoses included high	D 276		

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D 276	Continued From page 24 blood pressure, diabetes mellitus and Vitamin D deficiency. Review of Resident #1's physician's orders revealed there was an order dated 12/20/17 for a Vitamin D level to be drawn "to evaluate the effectiveness." Review of Resident #1's progress notes revealed there was no documentation of any Vitamin D lab results in the resident's record. Interview with the Administrator on 2/22/18 at 2:33 p.m. revealed the Administrator revealed she would try to find the Vitamin D lab results, from the order dated 12/20/17. Interview with the Administrator on 2/23/18 at 10:10 a.m. revealed the facility nor Resident #1's PCP's office could find the results for resident #1's Vitamin D lab ordered on 12/20/17. Interview with the Administrator on 2/23/18 at 11:35 a.m. revealed: -When a resident needed a lab to be drawn, the Nurse Practitioner's (NP) either wrote the order and faxed the orders to the PCP's office or wrote the order and the facility faxed the order to the PCP's office. -She did not know if Resident #1's Vitamin D lab had been drawn when ordered on 12/20/17. Interview with Resident #1 on 2/23/18 at 12:50 p.m. revealed: -Someone came today to draw blood for a Vitamin D lab. -Her blood had been checked several times for labs, but no one said it was for Vitamin D until today (2/23/18).	D 276		

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D 276	Continued From page 25 Telephone interview with Resident #1's NP on 2/27/18 at 12:11 p.m. revealed: -She did not know Resident #1's Vitamin D lab had not been drawn until the facility called the PCP's office. -She did not know when someone from the facility called the PCP's office. -If the order was written at the facility, the facility should have faxed the order to the primary care physician's (PCP's) office. -She wanted the lab to be drawn when ordered on 12/20/17. Telephone interview with the Clinical Manager at the resident's PCP's office on 2/27/18 at 12:43 p.m. revealed: -The NP ordered a Vitamin D lab to be drawn on the resident on 2/23/18. -The Vitamin D lab was drawn on 2/23/18 and the results were 30 nanograms (ng)/milliter (ml). According to the reference range, the normal level for Vitamin D ranged from 30 to 100 ng/ml. -She did not see any other Vitamin D levels in the resident's chart. -When a resident had labs that needed to be drawn, the PCP or the facility called the PCP's office and the Clinical Organizer contacted the local lab company. -Once the PCP had the results of the lab, the Clinical Organizer faxed a copy to the facility. Telephone interview with the Lab Technician from the local lab company on 2/27/18 at 1:35 p.m. revealed the only Vitamin D lab drawn on Resident #1 was drawn on 2/23/18. Telephone interview with the Resident Care Coordinator (RCC) on 2/28/18 at 10:05 a.m. revealed: -If Resident #1 had an order for a lab to be	D 276		

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D 276	Continued From page 26 drawn, she faxed the order to the resident's PCP and the PCP's office contacted the lab company to draw the lab. -She does daily chart audits. -She was not aware Resident #1's lab had not been drawn when ordered on 12/20/18. -She could not remember if she did a chart audit of Resident #1's chart in December 2017. Telephone interview with the Administrator-in-Charge on 2/28/18 at 9:45 a.m. revealed: -When Resident #1 had an order for a lab to be drawn, the PCP's office contacted the local lab company to have the lab drawn. -She did not know why Resident #1's Vitamin D lab had not be drawn when it was ordered on 12/20/17. -The RCC was responsible for making sure orders were implemented. Telephone interview with the Administrator on 2/28/18 at 8:32 a.m. revealed: -The facility periodically audited charts for implementation of orders. -The RCC was responsible for making sure labs were complemented. -The facility assumed the PCP faxed the request for the Vitamin D lab order to the PCP's office when ordered on 12/20/17. -The facility was responsible for making sure the lab was completed.	D 276		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:	D 287		

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D 287	Continued From page 27 (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure table service included only non-disposable beverage containers. The findings are: Observation of the AL dining room on 02/21/18 at 7:40 a.m. revealed: -There were 6 tables with 5-6 place settings per table. -Each place setting had a non-disposable hard plastic cup of water, a coffee cup and a blue plastic cup filled with juice. -Some of the place settings had a non-disposable hard plastic cup of milk. Interview with a Personal Care Aide (PCA) on 02/21/18 at 7:36 a.m. revealed: -She always helped with meals, she helped serve the beverages. -They used the blue disposable plastic cups for juice at breakfast. -They had been using the blue disposable plastic cups for juice for about a year. -No residents had complained about using the blue disposable plastic cups. -Some of the residents asked for refills "but not many."	D 287		

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D 287	Continued From page 28 Observation of the dry stock closet on 02/21/18 at 1:32 p.m. revealed: -There was an open pack of blue disposable plastic cups with approximately 100 cups left in the pack. -There were multiple cartons of juice that were used to fill the cups. Interview with a Cook on 02/21/18 at 1:32 p.m. revealed: -They had been using the blue disposable plastic cups for juice for about 1 month. -Prior to that, the juice had been served in a 4 ounce prefilled disposable cups. -He was not sure how many ounces were in the blue disposable plastic cups. -If residents wanted more juice, they would always give them more. -He was not aware that there was a non-disposable rule related to beverage cups. -They had more beverage glasses in stock that they could use for juice. -He had not heard anyone complain about using the blue disposable plastic cups. Interview with a resident on 02/21/18 at 4:38 p.m. revealed: -She ate breakfast "most of the time." -They had blue disposable plastic cups for their juice. -She did not know how long they had used the blue disposable plastic cups. -She usually did not get refills but could if she wanted to. Interview with a second resident on 02/21/18 at 4:45 p.m. revealed: -They always had blue disposable plastic cups for their juice.	D 287		

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D 287	Continued From page 29 -He did not know how long they had used the blue disposable plastic cups. -He could get refills anytime he wanted to. Interview with a third resident on 02/21/18 at 4:48 p.m. revealed: -She ate breakfast every day. -She drank juice at breakfast. -She had juice in blue disposable plastic cups. -She did not know how long they had been using blue plastic cups. -She did not always drink all of her juice. Interview with the Dietary Manager on 02/21/18 at 5:24 p.m. revealed: -They had been using the blue disposable plastic cups for about 6 months; prior to that they had used pre-filled 4 ounce disposable juice cups. -The blue disposable plastic cups were 5.5 ounces. -She had been ordering the blue disposable plastic cups for the snack carts prior to ordering them for juices. -She had enough non-disposable hard plastic juice cups that she could use and would start using those effective 02/22/18. Observation of the AL Dining room on 02/22/18 at 8:20 a.m. revealed no blue disposable plastic cups setting on any of the tables. Interview with a Dietary Aide on 02/22/18 at 2:19 p.m. revealed: -She was responsible for setting the cups out for juices at breakfast. -She did not know how many ounces the juice cups were. -She had sat out the blue disposable plastic cups for juice up until today (02/22/18) when she used non-disposable hard plastic cups.	D 287		

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D 287	Continued From page 30 -The Personal Care Aides (PCAs) were responsible for putting the juice in the cups. -The PCAs refilled the juice when residents asked for more. Interview with the Administrator in Charge on 02/22/18 at 6:15 p.m. revealed: -She had not paid attention to the blue disposable plastic cups in the dining room. -She thought they were using hard plastic cups. -She tried to stop in at least one meal daily to speak to the residents, usually the lunch meal. -She thought the blue cups were about 6 ounces. -She was not aware of the non-disposable rule. -She did not have a procedure to monitor meals, the Dietary Manager and the cooks were responsible for that. Interview with the Administrator on 02/22/18 at 6:25 p.m. revealed: -She had seen the blue disposable plastic cups in the dining room. -Sometimes the residents would keep their cups after taking medications. -She was not aware they were using the blue disposable plastic cups for juice. -She expected the juice to be served in a 6 ounce non-disposable cup.	D 287			
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights 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. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 338			

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D 338	Continued From page 31 failed to assure staff on the special care unit (SCU) were alert, awake, and available to meet the needs of the residents at all times. The findings are: Confidential interviews with a concerned citizen revealed: -Staff C, a Medication Aide/Supervisor (MA/S), fell asleep behind the desk while on duty. -There was a video of Staff C sleeping posted on (named) social media. -Different people who worked at the facility were aware of Staff C falling asleep behind the desk. -Several staff members have had concerns about Staff C "nodding off." -Staff who worked at the facility "were used to it because she does it all the time." -Staff C had been seen asleep "5 or 6 times." -Staff C had been seen sleeping as recent as 02/12/2018 between 5:00am and 6:00am. -A staff had reported Staff C's sleeping while on duty to the Administrator-in-Charge (AIC) and the AIC told that staff "don't worry about it, I'll take care of it." -There was video evidence of Staff C sleeping on duty while attempting to complete duties such as medication counts and charting. -The medication storage room door was open, leaving the medications accessible to the residents. Confidential interview with a second concerned citizen revealed a video had been viewed that was posted on social media of a facility staff member "passed out." Review of the video recordings referenced by the concerned citizens revealed the information provided during interviews was consistent with	D 338			

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D 338	Continued From page 32 the content of the videos. Confidential staff interview revealed: -For "months" prior to the video, night time staff had been reporting Staff C was sleeping while on duty. -The AIC said "I'll talk to her about it." -This staff had observed Staff C asleep on duty about one month ago. -This staff had reported Staff C to the AIC; the AIC said she would "handle it." Confidential interview with a second staff revealed the staff "respectfully declined" interview regarding the video of Staff C. Confidential interview with a third staff revealed the staff was not working when the video of Staff C was record and did not "know nothing else about it." Telephone interview with Staff C on 02/23/18 at 11:41am revealed: -She was previously employed in the facility as a Medication Aide (MA) in the SCU on the night shift. -She had worked at the facility for about four years before she "quit" about one week ago. -The night shift MAs acted as the Supervisor on night shift after the Administrator in Charge (AIC) and Unit Care Coordinator (UCC) left for the day. -She acknowledged she was in the video recording posted on social media. -She "hates the video was posted. I know it looks bad." -She had "been accused of all kinds of stuff. I didn't take anybody's pills and I was not on any kind of drugs." -She was "just sleepy" and was "falling asleep." -She had not had a lot of sleep the previous	D 338			

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D 338	Continued From page 33 weekend (prior to the date the video was recorded on 02/12/18) because her family member had the flu, she had just moved, and had a lot going on at home. -The only time she had ever fallen asleep at work was on 02/12/18. Interview with the AIC on 1/22/18 at 4:06pm revealed: -She found out about the recordings of Staff C sleeping while on duty from the Department of Social Services (DSS) on 02/13/18. -Prior to 02/13/18, she was not aware of Staff C sleeping on the job; she had never observed Staff C to sleep on the job and staff had not reported it to her. -Other staff had not reported "any issues" about Staff C to her. -There had been reports of another (named) staff taking naps on the job in the past, but she could not remember who reported it. -Staff C was a MA/Supervisor in the SCU when the Administrator, AIC, or UCC was not at the facility. -She spoke with Staff C on 02/14/18 at about 5:30 or 6:00am about the video and sleeping on the job. -Staff C "did not confirm or deny" she was asleep while on duty. -Staff C did not provide the AIC with an explanation as to why she was like that in the video. -She (the AIC) consulted with the Administrator by telephone about Staff C. -The Administrator said to put Staff C on a 60 day probation period; if there were any other incidents, Staff C would be terminated. -The AIC recalled Staff C came to staff trainings in the past (dates not provided) and failing asleep during the trainings.	D 338		

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D 338	Continued From page 34 -Staff C told the AIC she was tired and did not get much sleep. -This was not a concern for the AIC because the trainings were held during the day and Staff C worked night shift. -Staff C "basically quit" (no date provided). Review of Staff C's personnel record revealed there was no documentation of disciplinary action related to sleeping while on duty. Interview with the Administrator on 02/23/18 at 8:30am revealed: -She identified the staff member in the video as Staff C. -She noted there was no time stamp on the video. -The staff who observed Staff C in that state and recorded the video was responsible for immediately reporting the incident to the AIC, but had not done so. -If the staff "would have immediately contacted me or [AIC's name], we could have nailed this down pretty quickly." - "What hurt us is failure to report." -She did not know about any previous concerns regarding Staff C falling asleep being reported to the AIC. - "The staff members can't say nothing was done. If we get a report from another staff member, we by law can't discuss disciplinary actions." -Staff would not know if the concerns were addressed because "we can't tell staff what we did." -Staff C had been an "excellent" staff member and MA. -Staff C was "obviously in distress" [acting differently from sleeping] in the video; if staff had reported her sleeping, that was different than what was seen in the video. -When questioned, she did not reveal if the AIC	D 338		

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D 338	Continued From page 35 had ever reported any concerns about Staff C to her. -"I will question [AIC's name] about what she did and didn't do."	D 338		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer a controlled medication ordered for anxiety as ordered for 1 of 8 residents sampled (#15). The findings are: Review of Resident #15's current hospital generated FL-2 dated 01/09/17 revealed: -Diagnoses included advanced Alzheimer's dementia, seizures, and toxic metabolic encephalopathy. -The resident was not oriented to person, place, or time and was incontinent of bladder and bowel. -The resident's speech assessment was documented as "impaired." -The resident was "totally dependent" for bathing, dressing, toileting, transfers, ambulation, and	D 358		

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D 358	Continued From page 36 eating. Interview with the Special Care Unit Care Coordinator (SCUCC) on 02/20/18 at 11:30am revealed: -Resident #15 was "total care" and fully dependent upon staff for all activities of daily living (ADLs). -The resident was never oriented. Review of Resident #15's medication orders dated 08/28/17 revealed: -There was an order for Clonazepam 0.5mg take ½ tablet by mouth daily at 4:00pm. (Clonazepam is a long acting controlled substance used to treat anxiety). -The order was signed by Resident #15's mental health (MH) provider. Review of a subsequent medication order for Resident #15 dated 10/16/17 revealed Clonazepam was discontinued. Review of Resident #15's October 2017 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Clonazepam 0.5mg take ½ tablet by mouth once daily at 4:00pm. -Clonazepam 0.5mg (½ tablet) was documented as administered every day at 4:00pm from 10/01/17-10/16/17 by Staff E and Staff G, both Medication Aides (MAs). -There was documentation Clonazepam was discontinued effective 10/17/17. Review of the controlled substance logs for Resident #15's Clonazepam 0.5mg revealed the medication was documented as administered daily at 4:00pm from 08/29/17-10/16/17.	D 358		

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D 358	Continued From page 37 Review of a copy of a laboratory (lab) results report for Resident #15 dated 10/16/18 obtained from the primary care provider's (PCPs) office revealed: -The "collection date" of the lab was documented as 10/11/17. -The "sample type" was documented as "dried blood." -There were lab results for multiple classes of controlled substances, including results for multiple (named) Benzodiazepines (Clonazepam is a Benzodiazepine). -Resident #15's lab result for Clonazepam was documented as "negative." (This negative result indicates the medication was not detected in Resident 15's blood sample collected on 10/11/17). Review of a "Reference Guide" for the lab results for Resident #15 revealed the lab's "detection window" for Clonazepam was documented as a "minimum" of four days to a "maximum" of nine days. Telephone interview on 02/27/18 at 9:28am with Staff E, MA, who documented administering Resident #15's Clonazepam on multiple dates including from 10/08/17-10/11/17 revealed: -She had previously worked in the facility as a MA in the SCU. -The residents in the SCU were "drug tested" a few days after another resident's Oxycodone was lost but she did not know the results of the tests, because she quit. -She thought her last day working in the facility was 10/12/17. -SCU staff had also been drug tested earlier in October 2017 when the Oxycodone was lost; she had refused to take a drug test because the Oxycodone went missing between 7:00am and	D 358			

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D 358	Continued From page 38 1:00pm and she was not at work during that time. -She recalled Resident #15 was ordered Clonazepam every day at 4:00pm for anxiety; the medication did not seem to help him "at times." -She recalled Resident #15's Clonazepam order being changed or discontinued at one point, but he always got it like it was ordered. -The Clonazepam was always in stock and administered at 4:00pm to the resident. -Resident #15 did not refuse medications. -She did not recall any time when she did not administer Resident #15's Clonazepam when it was ordered. Attempted telephone interview on 02/27/18 at 7:48am and 10:07am with the second MA, Staff G, who documented administering Resident #15's Clonazepam in October 2017 was unsuccessful. Observation of Resident #15 on 02/20/18 at 12:00pm revealed: -The resident was in a geri-chair in the dining area of the SCU. -The resident was non-verbal when spoken to. Observation of Resident #15 on 02/21/18 at 5:52am revealed: -The resident was in a geri-chair in the common areas of the SCU. -A MA readjusted Resident #15's linen. -When the MA interacted with the resident, he was non-verbal and did not make eye contact with the MA. Based on observations, interviews, and record reviews, it was determined Resident #15 was not interviewable. Interview with Resident #15's Power of Attorney/family member on 02/20/18 at 12:00pm	D 358		

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D 358	Continued From page 39 revealed: -Resident #15 was never oriented and dependent on staff for all of his ADLs. -As far as she knew, Resident #15 received his medications like he was supposed and did not run out of or refuse medications. Telephone interview with Resident #15's MH provider on 02/27/18 at 9:04am revealed: -The MH provider acknowledged the order dated 08/28/17 for Clonazepam 0.5mg ½ tablet daily at 4:00pm for anxiety. -She was notified by one of the facility's PCPs that Resident #15 was tested for controlled substances after a pain medication for another resident went missing. -Clonazepam was a longer acting Benzodiazepine, if Resident #15 had received Clonazepam 0.5mg ½ tablet daily from 10/01/17-10/10/17, she would expect the resident to have the medication in his system, especially since he had been on the medication daily for a while and the lab was collected 10/11/17. -Resident #15 was "not oriented at all" and would not be able to tell you if he received the medication or not. -Resident #15 was not one to refuse medications; she did not recall any notification of any refusals of Clonazepam. -She expected Resident #15 to receive Clonazepam as ordered. -She did not recall any notification of Resident #15 having any anxiety during that time (October 2017). Telephone interview with Resident #15's PCP on 02/21/18 at 8:23am revealed: -She ordered labs to check for controlled substances for the residents who resided in the SCU after a resident's Oxycodone was	D 358			

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D 358	Continued From page 40 unaccounted for. -She spoke with the Administrator in Charge (AIC) on 10/11/17 to let her know she was "concerned" about drug diversion in the SCU and would be ordering the labs. -The PCP's practice collected the labs on 10/11/17; the labs were resulted on 10/16/17. Telephone interview with Resident #15's PCP on 02/27/18 at 12:27pm revealed: -Resident #15's 10/16/17 lab results were negative for Clonazepam, but the resident was ordered Clonazepam daily. -There was "no way" Resident #15 would have been negative for Clonazepam on 10/11/17 if the medication was administered daily, as ordered from 10/01/17-10/10/17. -Resident #15 was not oriented and would not know if he had received the medication or not. -She expected medications to be administered as ordered. Telephone interview with a Pharmacist at the facility's primary pharmacy on 02/27/18 at 11:0am revealed: -Resident #15 had an order on file at the pharmacy dated 08/28/17 for Clonazepam 0.5mg take ½ tablet daily at 4:00pm for anxiety. -The pharmacy automatically dispensed seven Clonazepam tablets (which was a 14 day supply) for Resident #15 every two weeks from 08/28/17-10/11/17. -The pharmacy halved the tablets prior to dispensing the medication to the facility and placed it in a cassette for storage. -Resident #15's Clonazepam was discontinued per an order dated 10/16/17. -Clonazepam was a long acting Benzodiazepine with a half -life of 30-40 hours. -The Pharmacist acknowledged due to the long	D 358		

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D 358	Continued From page 41 half-life, it would take one to two days to remove half of the medication from the resident's blood and would take at least four to seven days and up to three to four weeks for the medication to be removed from the body if it was administered every day. -If Resident #15 had received Clonazepam daily from 10/01/17-10/10/17, the medication would have been in his bloodstream when the labs were collected on 10/11/17; the lab result should be positive for Clonazepam. Telephone interview with the second Pharmacist at the facility's primary pharmacy on 02/27/18 at 12:15pm revealed: -Clonazepam was a long-acting controlled medication. -If Resident #15 had been administered Clonazepam 0.5mg ½ tablet from 10/01/17-10/10/17, the medication would show positive on his lab results drawn on 10/11/17. Interview with the AIC on 02/22/18 at 4:06pm revealed: -A resident in the SCU had fifteen Oxycodone go missing in October 2017 (unsure of the exact date); she and the staff looked for the medication but they could not find it. -The PCP was "upset" the medication was missing and was "concerned" about one of the (named) MAs (because the MA refused to be drug tested). -The PCP ordered for "two or three" residents on the SCU to have labs drawn to check for controlled substance medications in their system. -Resident #15 had labs drawn. -She acknowledged Resident #15 was ordered Clonazepam at 4:00pm daily for anxiety. -She was informed by the PCP that Resident #15 lab results were negative for Clonazepam (unsure	D 358		

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D 358	Continued From page 42 of the date); she could not remember if the PCP notified her about the lab results by phone or in person. -The PCP discontinued Resident #15's Clonazepam after that (date not provided). -She had talked with the two MAs (Staff E and Staff G) who documented administering Resident #15's Clonazepam and both said the resident had received the medication daily, as ordered. -She could not explain why Resident #15's lab result was negative for Clonazepam. -She had "no answer" as to why Clonazepam was not in Resident #15's system. -Resident #15 was not oriented and "not able to tell if he got the medication." -She expected medications to be administered as ordered; if the resident had an order for a medication to be given daily at 4:00pm, it should have been given daily. Interview with the Administrator on 02/22/18 at 5:40pm revealed: -She was "unsure" and she was "going from memory" but thought the AIC had notified her by phone about the residents in the SCU being tested. -She was not aware of the lab results for Resident #15. -She acknowledged being concerned because Resident #15's Clonazepam was documented as administered from 10/01/17-10/16/17 but the medication was not in his bloodstream when the lab was collected on 10/11/17. -She expected medications to be administered as ordered. _____ The facility failed to assure a controlled medication was administered as ordered to Resident #15, who was constantly disoriented, resided in the SCU, and had diagnoses including	D 358		

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D 358	Continued From page 43 advanced Alzheimer's dementia. Resident #15 was ordered Clonazepam (a controlled substance prescribed for anxiety) daily at 4:00pm. Clonazepam was documented as administered every day from 10/01/17-10/16/17; however, labs drawn on 10/11/17 revealed Resident #15 was negative for Clonazepam in his bloodstream. Clonazepam is a long acting Benzodiazepine with a half-life of 30-40 hours. If Resident #15 had received Clonazepam every day from 10/01/17-10/16/17, the medication would have been positive in his bloodstream when the lab was drawn on 10/11/17 because there had not been enough time for the medication to be cleared from his bloodstream. The facility's failure to assure Resident #15 received Clonazepam as ordered was detrimental to the health, welfare and safety of the resident and constitutes a Type B Violation. Review of the Plan of Protection (POP) submitted by the facility dated 02/28/18 revealed: - "Instruction regarding rule .1008(a) will begin immediately and be completed by 2/27/18." - Instruction would be given by the Administration in Charge and documented in staffs' file. - "Implement monitoring of controlled substances." - "Refer to POP for 10A NCAC 13 F. 1008a." Review of the POP for 10A NCAC 13F.1008 (a) submitted by the facility dated 02/28/18 and referenced in the POP for 10A NCAC 13F.1004 (a) revealed: - Instructions would be given to Care Coordinators and Medication Aides regarding the policy, procedure, and proper documentation and handling of controlled substances would be completed by 02/27/18. - The Administrator would provide the instruction and documentation would be placed in staffs' file.	D 358		

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D 358	Continued From page 44 -Pharmacy will provide an audit of controlled substances on 03/06/18. -Care Coordinators will check controlled substance logs and document monitoring of logs Monday through Friday. -Care Coordinators would "immediately report any issues to Administrator in Charge." (AIC) -AIC will check logs weekly until 05/31/18, then monthly and "will document monitoring and action taken if any issues." THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2018.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure Medication Aides observed Resident #10 ingest her medication at the time of administration resulting in medications, such as Seroquel and Pravachol,	D 366		

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D 366	Continued From page 45 being found in the resident's room during a subsequent medication pass. The findings are: Review of Resident #10's current FL-2 dated 08/24/2017 revealed: -Diagnoses included L TKR [left total knee replacement], renal insufficiency, DVT [deep vein thrombosis] risk, RA [rheumatoid arthritis], anemia, OAB [overactive bladder], GERD [gastro-esophageal reflux disease], anxiety/depression, and "CHR". -There was a physician's order for Pravastatin 20mg tablet at bedtime. (Pravastatin is generic for Pravachol; used to treat high cholesterol). -The resident's vision was listed under the Functional Limitations section as "wears glasses". Review of the diagnoses listed on the February 2018 Medication Administration Records (MARs) for Resident #10 revealed additional diagnoses included hyperlipidemia, atherosclerotic heart disease of native coronary artery, insomnia, blindness and low vision, and glaucoma. Review of a physician's order dated 02/08/2018 revealed an order for Seroquel 25mg tablet at bedtime. (Seroquel is an anti-psychotic used to treat mental health disorders such as anxiety and mood disorders. Observations of Resident #10's nightstand on 02/21/2018 at 6:03am during the 6:00am medication pass revealed: -There was a small round yellow tablet and a smaller round white tablet laying on the resident's nightstand next to the resident's bed. -There were two white paper medication cups sitting inside of a small clear cup on top of the	D 366			

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D 366	Continued From page 46 nightstand. -There were four small blue plastic drinking cups stacked together laying on the nightstand. Interview with Resident #10 on 02/21/2018 at 6:03am revealed: -She did not know the names of the two medication tablets laying on the nightstand. -She did not know how the two medication tablets got on her nightstand and that someone must have picked them up from the floor last night and placed them on the nightstand. Interview with the MA on 02/21/2018 at 6:03am revealed: -She did not know the names of the two medication tablets laying on the resident's nightstand. -She was going to get them from the resident's room and put them in a cup. -She would check the medications against the resident's medication on the medication cart to see if they were day or nighttime medications. -She was going to check to see if the medications were from last night's medications which was the last time the resident would have gotten medication. -She would put the two pills in the medication cart until she returned to the medication room, and would then crush the medications and dispose of them. Observation of the MA and interview on 02/21/2018 at 6:10am revealed: -The small round yellow tablet had printed on it "PRA 20", and the medication tablets in the cassette labeled Pravastatin had PRA 20 printed on them. -The smaller round white tablet had an "R" printed on it, and the medication tablets in the	D 366		

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D 366	Continued From page 47 cassette labeled Seroquel 25mg had an "R" printed on them. -Both the Pravastatin and the Seroquel were scheduled for 9:00pm last night. -There was another staff [named] who worked last night as the MA until 1:00am, which is when she had come on duty. Interview with the named MA on 02/21/2018 at 6:50am revealed: -She had administered 9:00pm medications to Resident #10 on last night (02/20/2018). -She could not remember the names of the medications she had administered to Resident #10 on 02/20/2018, but "gave what was on the MAR". -Resident #10 was "usually up all night, but was asleep last night, had to wake her up to give her medication, she went right back to sleep". -She had not left any medications in Resident #10's room on the evening of 02/20/2018. -She denied ever leaving medications in residents' rooms in cups and had never seen medications in residents' rooms. -All she had seen in the resident's room were cups. -Resident #10's medications had to be crushed. -When she administered medications, she handed the medication cup and water to the resident, and made sure the residents opened their mouth so she could ensure the medications were taken. -She identified her initials on Resident #10's MARs for administration of 9:00pm medications on 02/20/2018 including Pravachol 20mg one tablet and Seroquel 25mg one tablet. Interview with the Administrator on 02/21/2018 at 7:35am revealed: -She had been notified of medications found in	D 366		

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D 366	Continued From page 48 Resident #10's room on the nightstand during the medication pass this morning. -She was not aware of any medications being found in other resident rooms. -She was aware of photos that had come out, "of a picture of something in a cup with pudding." -She expected staff to watch the residents take their medications, but residents could refuse to show you in their mouth. -Resident #10 had a history of "drug seeking" and had been taken to the hospital previously for overdosing and was thought to be "cheeking medications". -The physician had changed the resident's medication to be crushed. Interview with the Assisted Living Unit Care Coordinator (ALUCC) on 02/21/2018 at 8:50am revealed: -MA's had been trained on medication administration. -MA's were supposed to make sure they were standing and watching the residents take their medications, and then remove the medication cup from the residents' room. -Documentation of medication administration was to be done after the resident had taken the medication. -There should never be medications in the resident rooms. -She was aware of a prior occasion (unsure of the date, but it was "maybe one month ago") when Resident #10 was in bed and told a different [named] MA to put the medication on the table and she would take it. The MA "took her [Resident #10's] word for it" and left the medication. The housekeeper was cleaning the room and found the medications. The housekeeper showed the medication in the room to her, and she got the MA, showed the	D 366		

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D 366	Continued From page 49 medication to the MA, explained the process to the MA, and notified the AIC. Interview with the Nurse Practitioner on 02/21/2018 at 11:00am revealed: -When she went in resident rooms, there were cups with medication in them. -She had seen pills in several resident rooms. -She could not provide specific names for residents or dates for when she had seen medication in cups in the rooms, but she had seen them in the assisted living section of the facility. -It seemed staff were "just leaving meds and water" and she did not agree with this as the meds could pile up and "by the next run, someone could be on the floor". -Staff would not know if a resident took their medications if they were just leaving the medications in the room; the residents "could do anything" they wanted to with the medications and staff would not know. -Resident #10 had a history of mental health diagnoses and drug seeking behaviors. -Resident #10 had been sent to a local emergency room (ER) after being found on the floor unconscious about two months ago. -Resident #10 was pocketing Percocet (a controlled substance which combination drug consisting of an opioid and a pain reliever and fever reducer used for the management of moderate to severe pain). -She had written an order for Resident #10's Percocet to be crushed to prevent the resident from pocketing the medication. -It was a "concern" that the Pravachol and Seroquel had been found in Resident #10's room earlier that day (02/21/18). -Seroquel was an anti-psychotic and could cause problems such as drowsiness and	D 366		

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D 366	Continued From page 50 gastro-intestinal problems. -She expected staff to watch the residents take their medication. Review of a local hospital discharge note for Resident #10 dated 01/07/2018 revealed: -Resident #10 was brought to the ER on 01/03/2018 and on arrival was found lethargic, somnolent, and unable to follow commands. -Resident #10 was evaluated for diminished level of responsiveness. -The resident was found seated on the floor in her room. -The resident had received repeated doses of Narcan (used to treat known or suspected opioid drug overdose) with some improvement. -Once in the emergency department (ED), monitor showed bradycardia with heart rate fluctuating between 40 and 60. -The resident was unable to provide any specific details. -Inpatient treatment was requested. Review of a second local hospital emergency department provider note dated 01/09/2018 revealed: -Resident #10 was seen in the ER for altered mental status/fall after being found in her room lying up against her dresser. -The resident had been drowsy and difficult to arouse since being found in her room. -The resident only answered that she felt sleepy and no further history could be obtained. -Narcan was given with little improvement, the pupils did become less than point, however the patient was still drowsy so further investigation was initiated to include labs and head CT. -The emergency department course included lab work which was "benzo positive" which pointed to "a possible benzodiazepine overdose".	D 366		

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D 366	Continued From page 51 -The resident awakened to verbal stimuli, sat up, carried on a normal conversation, and stated she felt better and thought that "it probably was her medication that made her [feel] felt so sleepy". -The visit diagnoses was documented as "Adverse effect of drug, initial encounter". Review of physicians' order provided by the pharmacy revealed: -There was an order dated 12/13/17 for Percocet 10-325mg 1 tablet twice a day. -There was an order dated 1/10/18 for Percocet 5-325 1 tablet twice a day; crush in applesauce or pudding. -There was an order dated 8/3/17 for Xanax 0.125mg ½ tablet at bedtime as needed for anxiety. Review of facility Drug Management Procedure revealed the procedure included: -Once medication has been administered to resident, while medication technician observes, the med tech will immediately document their initials on the MAR. -Staff would not be allowed to walk away from the resident until medication has been taken. _____ The facility failed to assure Medication Aides observed Resident #10, who had a known history of cheeking medications and two previous hospitalizations for possible overdose, ingested her medications at the time of administration resulting in two medication tablets being found in the resident's room on 02/21/18. Resident #10 had previously been found on the floor lethargic and with decreased level of consciousness and responsiveness requiring emergent hospital evaluation and treatment for "a possible benzodiazepine overdose"; and on a second occasion had been found seated on the floor in	D 366		

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(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 366	Continued From page 52 her room lethargic with emergent hospital evaluation and treatment needed for possible opioid overdose requiring multiple doses of the medication Narcan (used to reverse opioid overdose), within a one week time frame in January 2018. The facility's failure resulted in risk for serious harm and neglect which constitutes a Type A2 Violation. Review of the Plan of Protection submitted by the facility on 02/28/2018 revealed: -Medication passes were followed by the Administrator-In-Charge (AIC) on 02/21/2018. -Instruction was provided as needed. -The AIC will monitor medication passes bi-weekly until 05/31/2018, then monthly, and document on a log. -The POP was accepted with the following addendum per telephone conversation with the Administrator on 02/28/2018 at 1:35pm: The facility has contacted a training provider to schedule additional training for staff on medication administration. Dates of training are pending dependent on provider schedule and availability. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D 366		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and	D 371		

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D 371	Continued From page 53 sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 Medication Aides (Staff A, B) observed during the medication passes implemented infection control measures to prevent the development and/or transmission of infection and/or disease and prevent cross contamination as evidenced by failing to use hand hygiene and wearing contaminated disposable gloves when administering medications. The findings are: 1. Observation of the 6:00am medication pass on the Special Care Unit (SCU) on 02/21/18 from 5:41am-5:50am revealed: -There was no hand sanitizer observed on the medication cart. -At 5:41am, Staff A walked out of the bathroom to resident room A123; she had on a pair of disposable gloves and had a disposable cup in her hand. -After leaving room A123, Staff A did not remove her gloves and proceeded to touch the computer, outside and inside surface the medication cart and drawers of the medication cart, medication cassettes, when preparing one oral medication for a second resident in a different room. -At 5:43am, Staff A went in to room A129, adjusted the resident's bed linen, gave the resident the oral medication, and came back to the medication cart, touching the outside and inside surface of the medication cart and drawers, medication cassettes, and computer screen; Staff A was still wearing the same gloves she had on in room A123 while completing this	D 371			

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D 371	Continued From page 54 task. -At 5:45am, Staff A had removed and discarded her gloves, then prepared and administered one oral medication for a third resident, touching the resident's bed pillow with her hands; afterwards, Staff A touched the computer screen, outside and inside surface of the medication cart and drawers, and medication of another resident as she was crushing the medication in preparation for administration. Staff A was not observed to wash her hands, use sanitizer, or put on gloves before or after this task. -At 5:50am, Staff A administered the crushed oral medication to a fourth resident (that she had touched), repositioned the resident's pillow and head on the pillow then preceding to touch the outside of the medication cart and computer screen; Staff A was not observed to wash her hands, use sanitizer, or put on gloves before or after this task. Interview with Staff A on 02/21/18 at 5:55am revealed: -The normal process she used for infection control was to wear gloves. -She changed the gloves between each resident and washed her hands between the two halls. -Hand sanitizer was usually kept on the medication cart, but it was currently on the other medication cart, which was why she had not used it earlier. -She had completed all of the required training and passed the medication exam. -She had last completed infection control training "last month." Observation on 02/21/18 at 5:56am revealed: -Staff A rolled the medication cart to the locked storage room to get a second medication cart. -She started to wash her hands.	D 371			

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D 371	Continued From page 55 -There was hand sanitizer on the second medication cart. Refer to the facility's Medication Administration Policy. Refer to the interview with the Administrator on 02/22/18 at 5:40pm. 2. Observation of the 5:00m medication pass on the SCU on 02/21/18 from 4:35pm-4:47pm revealed: -At 4:35pm, Staff B rolled a medication cart out of the locked storage room; there was a bottle of hand sanitizer on the medication cart. -At 4:44pm, Staff B had prepared one crushed oral medication and a nutrition supplement for a resident, fed the resident the medication in applesauce, and assisted the resident to drink the supplement through a straw, touching the resident's straw when providing assistance with the supplement; after administering the medication and supplement, the MA touched the computer screen, outside and inside surface of the medication cart and drawers, and medication cassettes of another resident; the MA did not wash her hands, wear gloves, or use hand sanitizer before or after completion of the task. -At 4:45pm, the MA prepared and administered one oral medication to a second resident then proceeded to touch the computer screen, outside and inside surface of the medication cart and drawers, and medication cassettes of another resident; the MA did not wash her hands, wear gloves, or use hand sanitizer before or after completion of the task. -At 4:47pm, the MA prepared and administered one oral medication for a third resident then proceeded to touch the computer screen, and outside surface the medication car; the MA did	D 371			

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D 371	Continued From page 56 not wash her hands, wear, gloves, or use hand sanitizer before or after completion of the task. Interview with Staff B on 02/22/18 at 3:41pm revealed -She had been employed for two years and had been the Special Care Unit Care Coordinator for about one month. -She had completed all of the required MA training to include the 15 hour training and being checked off by a nurse prior to administering medication. -She had completed the state infection control training, but she did not recall when. -The process for infection control was as follows: wear gloves when administering drops or creams, wash hands after administering drops or creams, and use sanitizer after every resident. -She was trained on the facility's medication administration policy during her MA training. -She did not reveal why she had failed to use sanitizer or other infection control to deter and prevent spread of infection and disease when she was administering medications on 02/21/18. Refer to the facility's Medication Administration Policy. Refer to the interview with the Administrator on 02/22/18 at 5:40pm. Review of the facility's Medication Administration Policy revealed: -"Wash your hands thoroughly before preparing or administering any medications." -"Antiseptic solutions, i.e. alcohol gel, should be used as an alternative when soap and water are not readily available." Interview with the Administrator on 02/22/18 at	D 371		

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D 371	Continued From page 57 5:40pm revealed: -She expected all staff to use appropriate infection control and wear personal protective equipment (PPE) as needed at all times. -She expected the MAs to follow the medication administration policy and appropriate infection control when administering medication. -The MAs had all been trained on the policy and completed infection control training.	D 371		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 residents sampled (#2) who self-administered medications was assessed as competent and physically able to self-administer medications prior to the resident administering her own medications.	D 375		

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D 375	Continued From page 58 The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -Residents that self-administer medication must obtain a current written order from the attending physician that a resident may self-administer his/her medications. -Residents must keep all medications including over the counter medications in a locked secured area out of reach or view of other residents. -The facility will ensure that the self-administered resident receives medication from the facility pharmacy that is ordered on a timely basis. However it too is the resident's responsibility to ensure that if medications are running low (NOT OUT) to notify the Med Tech that medications are to be reordered. -Residents that appear to misuse self-administer medications, disperse personal medication to other residents or refuse to administer their medication, the following will be conducted: documentation of the resident's current conditions and misappropriation of his/her medication; the physician will be notified of the resident's conditions and circumstances of misuse or refused medications; an incident report will be completed and faxed to the Department of Social Services; a self-administration assessment will be completed on the resident by the Administrator and all findings will be documented with a copy of the assessment being faxed to the physician. Review of Resident #2's current FL2 dated 4/17/17 revealed: -Diagnoses included dementia, diabetes mellitus, atrial fibrillation, neuropathy, hypertension, depression, osteoporosis and osteoarthritis. -Resident #2 was intermittently disoriented.	D 375			

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D 375	Continued From page 59 Review of Resident #2's care plan dated 9/25/17 revealed: -The resident was sometimes disoriented, forgetful and needed reminders. -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with toileting, ambulation, transferring and personal hygiene. -The resident required supervision with eating. -There was no documentation regarding self-administration of medications. Review of Resident #2's record revealed: -There was a physician's order on 1/15/18 for Eucerin Cream to face/neck/chest/back twice a day; may self-administer and keep at bedside. -There was a physician's order on 2/19/18 for Chloraseptic sore throat spray; two sprays every 2 hours as needed for sore throat; may keep at bedside and self-administer. -There was no documentation that the resident was assessed as competent and physically able to self-administer medications. Observation of Resident #2's room on 02/20/2018 at 11:42am revealed: -The resident was sitting in the recliner watching TV. -Sitting on the bedside table was a 6 ounce bottle of labeled Chloraseptic sore throat spray; two sprays every 2 hours as needed for sore throat; may keep at bedside and self-administer. -Sitting on the bedside table was a 16 ounce container of labeled Eucerin Cream; apply to face/neck/chest/back twice a day; may self-administer and keep at bedside. Interview with the Administrator on 02/20/2018 at 1:25pm revealed:	D 375		

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D 375	Continued From page 60 -She was not aware that Resident #2 had medications at her bedside. -"There was no one on the SCU that self-administered medications." Interview with Resident #2 on 02/22/2018 at 11:50am revealed: -The doctor allowed her to keep the medicated skin cream and sore throat spray at her bedside so she could use them when she needed. -She used the throat spray whenever her throat hurt. -She used the cream on her neck and chest twice a day and would apply when she changed her clothes. -The Med Aide (MA) left the cream and spray on her bedside table and told her to use the cream if she itches and the throat spray if her throat hurt. -Resident #2 had told the MA that she knew how to use both and the MA didn't need to show her how. -The Activity Director hung the bell on her room door so she would know when another SCU resident walked in her room. -She rang the hand bell at her bedside whenever the other SCU residents would wander in her room at night and "mess with" her things or "bother" her. Interview with Resident #2's physician on 2/21/18 at 11:30 revealed: -On 1/15/18 she prescribed Resident #2 Eucerin Cream; apply to face/neck/chest/back twice a day; may self-administer and keep at bedside. -The resident told her she needed to self-administer her cream because the staff would not bring it to her immediately when she needed it. Interview with the Special Care Unit Coordinator	D 375		

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D 375	Continued From page 61 (SCUC) on 2/22/18 at 2:40pm revealed: -She was aware that Resident #2 had an order to self-administer her Eucerin Cream and Chloraseptic Sore Throat Spray. -She was not aware that Resident #2 could not have her Eucerin Cream and Chloraseptic Sore Throat Spray at her bed side all the time. -She did not know the self-medications were to be locked up when not in use. -She was not trained on a self-administration of medication policy and was not aware if there was a policy for that in the SCU. Interview with the Administrator-in-Charge on 02/22/2018 at 5:15pm revealed: -She was not aware that Resident #2 had self-medications at her bedside. -When Resident #2 moved from AL to SCU back in 2015, the AIC verified then that all self-administration of medication orders were discontinued. -"There should be no one on the SCU that self-administered medications." -She was not sure if the self-administration of medication policy included that SCU residents could not self-administer, but she would check. Interview with the Administrator on 02/22/2018 at 6:25pm revealed: -She was not aware that Resident #2 had a self-administration order for Eucerin Cream and Chloraseptic Sore Throat Spray. -They did not have an official assessment they used to validate if a resident was competent to self-administer medications. -"We let the nurse use their best judgment and talk with the family and resident to see if they can self-medicate." -She acknowledged that typically the licensed health professional support (LHPS) nurse	D 375		

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D 375	Continued From page 62 assessed the resident and documented the assessment on the LHPS form. -She expected that all staff would follow the process they had outlined in their Self Administering of Medication policy and would make sure all staff are aware. Interview with Resident #2's family member on 2/23/18 at 9:30am revealed: -The resident had "occasional confusion". -She was aware that the resident had medicated skin cream at her bedside, but did not know she had the sore throat spray. -"If her medications were locked up, then she may not remember where they were if she needed them." Interview with Resident #2's physician on 2/27/18 at 12:25pm revealed: -She generally did not write self-administration of medication orders for residents in the SCU. -On 2/19/18 she ordered Resident #2 Chloraseptic sore throat spray; two sprays every 2 hours as needed for sore throat; may keep at bedside and self-administer. -The resident told her she needed to self-administer her Chloraseptic spray because the staff would not bring it to her immediately when she needed it.	D 375			
D 377	10A NCAC 13F .1006(a) Medication Storage 10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.	D 377			

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D 377	Continued From page 63 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that the residents' medications were stored in a safe and secure manner for 1 of 1 residents sampled (#2) who self-administered medications. The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -Residents that self-administer medication must obtain a current written order from the attending physician that a resident may self-administer his/her medications. -Residents must keep all medications including over the counter medications in a locked secured area out of reach or view of other residents. -The facility will ensure self-administered resident that receives medication from the facility pharmacy is ordered on a timely basis. However it too is the resident's responsibility to ensure that if medications are running low (NOT OUT) to notify the Med Tech that medications are to be reordered. -Residents that appear to misuse self-administer medications, disperse personal medication to other residents or refuse to administer their medication, the following will be conducted: documentation of the resident's current conditions and misappropriation of his/her medication; the physician will be notified of the resident's conditions and circumstances of misuse or refused medications; an incident report will be completed and faxed to the Department of Social Services; a self-administration assessment will be completed on the resident by the Administrator	D 377			

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D 377	Continued From page 64 and all findings will be documented with a copy of the assessment being faxed to the physician. Review of Resident #2's current FL2 dated 4/17/17 revealed: -Diagnoses included dementia, diabetes mellitus, atrial fibrillation, neuropathy, hypertension, depression, osteoporosis and osteoarthritis. -Resident #2 was intermittently disoriented. Review of Resident #2's care plan dated 9/25/17 revealed: -The resident was sometimes disoriented, forgetful and needed reminders. -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with toileting, ambulation, transferring and personal hygiene. -The resident required supervision with eating. -There was no documentation regarding self-administration of medications. Review of Resident #2's record revealed: -There was a doctor's order on 1/15/18 for Eucerin Cream to face/neck/chest/back twice a day; may self-administer and keep at bedside. -There was a doctor's order on 2/19/18 for Chloraseptic sore throat spray; two sprays every 2 hours as needed for sore throat; may keep at bedside and self-administer. -There was no documentation that the resident was assessed as competent and physically able to self-administer medications. Observation of Resident #2's room on 02/20/2018 at 11:42am revealed: -The resident was sitting in the recliner watching TV. -Sitting on the bedside table was a 6 ounce bottle	D 377			

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D 377	Continued From page 65 of labeled Chloraseptic sore throat spray; two sprays every 2 hours as needed for sore throat; may keep at bedside and self-administer. -Sitting on the bedside table was a 16 ounce container of labeled Eucerin Cream; apply to face/neck/chest/back twice a day; may self-administer and keep at bedside. -There was a hand bell sitting on the bedside table. -There was a bell hanging on the door to the resident's room. -There was no staff in the resident's room. Observation of the label on the bottle of sore throat spray revealed: -The ingredients included Phenol 1.4% (an oral anesthetic/analgesic), and other inactive ingredients. -The warning included if overdose or accidental poisoning, get medical help or contact the Poison Control Center right away. Observation of the label on the container of medicated skin cream revealed: -The ingredients included petrolatum, mineral oil, ceresin, lanolin alcohol, phenoxyethanol and piroctone olamine. -The warnings included do not use near high heat, avoid getting it in eyes/nose/mouth, and if overdose, seek emergency medical attention or call the Poison Control Center right away. Interview with Resident #2 on 02/20/2018 at 11:42am revealed: -The doctor allowed her to keep the medicated skin cream and sore throat spray at her bedside so she could use them when she needed. -The Activity Director hung the bell on her room door so she would know when another SCU resident walked in her room.	D 377		

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D 377	Continued From page 66 -She rang the hand bell at her bedside whenever the other SCU residents would wander in her room at night and "mess with" her things. Interview with the Administrator on 02/20/2018 at 1:25pm revealed: -She was not aware that Resident #2 had self-medications at her bedside. -"There was no one on the SCU that self-administered medications and none of them should have any chemicals or hazards in their room." -She would immediately instruct staff to go through all SCU rooms and bathrooms to remove anything that could be hazardous. Interview with Resident #2 on 02/22/2018 at 11:50am revealed: -The doctor allowed her to keep the medicated skin cream and sore throat spray at her bedside so she could use them when she needed. -She used the throat spray whenever her throat hurt. -She used the cream on her neck and chest twice a day and would apply when she changed her clothes. -The Med Aide (MA) left the cream and spray on her bedside table and told her to use the cream if she itches and the throat spray if her throat hurt. -The Activity Director hung the bell on her room door so she would know when another SCU resident walked in her room. -She rang the hand bell at her bedside whenever the other SCU residents would wander in her room at night and "mess with" her things. Interview with Resident #2's physician on 2/21/18 at 11:30 revealed: -Resident #2 is fully alert and oriented. -On 1/15/18 she prescribed Resident #2 Eucerin	D 377			

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D 377	Continued From page 67 Cream; apply to face/neck/chest/back twice a day; may self-administer and keep at bedside. -The resident told her she needed to self-administer her cream because the staff would not bring it to her immediately when she needed it. Interview with the Special Care Unit Coordinator (SCUC) on 2/22/18 at 2:40pm revealed: -She was aware that Resident #2 had an order to self-administer her Eucerin Cream and Chloraseptic Sore Throat Spray. -She was not aware that Resident #2 could not have her Eucerin Cream and Chloraseptic Sore Throat Spray at her bed side all the time. -She did not know the self-medications were to be locked up when not in use. -She was not trained on a self-administration of medication policy and was not aware if there was a policy for that in the SCU. Interview with the Administrator-in-Charge on 02/22/2018 at 5:15pm revealed: -She was aware that all self-administered medications should be stored in a safe and secure manner. -She was not aware that Resident #2 had self-medications at her bedside. -When Resident #2 moved from AL to SCU back in 2015, the AIC verified that all self-administration of medication orders were discontinued. -"There should be no one on the SCU that self-administered medications." -She was not sure if the self-administration of medication policy included that SCU residents could not self-administer. Interview with the Administrator on 02/22/2018 at 6:25pm revealed:	D 377		

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D 377	Continued From page 68 -She was not aware that Resident #2 had a self-administration order for Eucerin Cream and Chloraseptic Sore Throat Spray. -Their policy required that residents who self-administer must keep all medications in a locked secured area out of reach of other residents. -They do not have an official assessment they use to validate if a resident is competent to self-administer medications. -"We let the nurse use their best judgment and talk with the family and resident to see if they can self-medicate." -She acknowledged that typically the licensed health professional support (LHPS) nurse assessed the resident and documented the assessment on the LHPS form. -They would look into getting something for Resident to lock her medications in her room. -She expected that all staff would follow the process they had outlined in their Self Administering of Medication policy and would make sure all staff are aware. Interview with Resident #2's family member on 2/23/18 at 9:30am revealed: -The resident had "occasional confusion". -She was aware that the resident had medicated skin cream at her bedside, but did not know she had the sore throat spray. -She was aware that the staff had removed medications and toiletries from her room in the past. -"If her medications were locked up, then she may not remember where they are if she needed them." Interview with a second physician of Resident #2 on 2/27/18 at 12:25pm revealed: -She generally did not write self-administration of	D 377		

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D 377	Continued From page 69 medication orders for residents in the SCU. -On 2/19/18 she ordered Resident #2 Chloraseptic sore throat spray; two sprays every 2 hours as needed for sore throat; may keep at bedside and self-administer. -The resident told her she needed to self-administer her Chloraseptic spray because the staff would not bring it to her immediately when she needed it. -She was aware that the medications were to be secured in the resident's room and they were taken until she could get something to lock them in.	D 377		
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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure records for the administration and return of controlled substances to the pharmacy were maintained, accurate, and reconciled at all times for 2 of 8 residents sampled (#5, #13) for a pain medication (#5) and a medication used to treat insomnia (#13); and controlled substances were documented as administered on the controlled	D 392		

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D 392	Continued From page 70 substance log at the time of administration. The findings are: 1. a. Observation of the 5:00pm medication pass on the Special Care Unit (SCU) on 02/21/18 at 4:41pm revealed: -The Special Care Unit Care Coordinator (SCUCC) crushed a ½ tablet of Lorazepam 1mg and administered the medication to a resident in applesauce. (Lorazepam is a controlled substance used to treat anxiety). -The SCUCC was not observed to verify the count or sign the controlled substance log at the time of administration. -The SCUCC documented the medication as administered on the electronic Medication Administration Record (eMAR). Interview with the SCUCC on 02/21/18 at 5:50pm revealed: -The procedure that was supposed to be used when administering control substances was as follows: count the medication before preparing it, administer the medication to the resident, document the administration in the computer on the eMAR, then sign the controlled substance log and verify the count. -The controlled substance log book was usually kept on the medication cart. -The controlled substance logs were supposed to be signed when the controlled substance was given. Observation on 02/21/18 at 6:06pm revealed the SCUCC signed the controlled substance log for the resident's 1/2 tablet Lorazepam 1mg documenting the medication as administered at 4:00pm prior to the surveyor checking the resident's counts and controlled substances on	D 392			

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D 392	Continued From page 71 hand. (The Lorazepam was observed to be administered by the SCUCC during the medication pass at 4:41pm) Interview with the SCUCC on 02/021/18 at 6:06pm revealed she recalled administering the Lorazepam to the resident at about 4:00pm but she had not signed the controlled substance log when she administered the medication so she was signing the log at that time (02/21/18 at 6:06pm). b. Observation of the 5:00pm medication pass on the SCU on 02/21/18 at 4:45pm revealed: -The SCUCC administered one oral medication to a resident. -The resident told the MA she thought she was supposed to get a "Percocet" at that time. (Percocet is a controlled substance used to treat pain). -The SCUCC responded to the resident Percocet was not scheduled and she needed to ask for the medication when she needed it. Observation on 02/21/18 at 6:05pm revealed the SCUCC signed the controlled substance log for the resident's Percocet prior to the surveyor checking the resident's counts and controlled substances on hand. Interview with the SCUCC on 02/021/18 at 6:06pm revealed: -The resident had asked her for the Percocet sometime after she (the SCUCC) had administered the resident's other medication at about 4:30pm that day (02/21/18). -She administered the Percocet when the resident had requested it and documented it on the eMAR, but had not signed the controlled substance log when she administered the	D 392			

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D 392	Continued From page 72 medication so she was signing the log now (02/21/18 at 6:05pm) to make the count correct. c. Observation on 02/21/18 at 6:06pm revealed the SCUCC signed the controlled substance logs for two additional resident's controlled substances (Morphine and Xanax) as the surveyor was checking the counts and controlled substances on hand for each resident in the SCU. Interview with the SCUCC on 02/021/18 at 6:06pm revealed: -She had administered the Xanax (a controlled substance used to treat anxiety) and Morphine (a controlled substance used to treat pain) earlier that day (02/21/18, no time of administration provided) but had not signed or documented the administration on the controlled substance logs. -She could "remember" the counts of the controlled substances and what she gave earlier that day. -She could look back at the eMAR if needed, to double check if the medications were given. -She usually signed the controlled substance logs at the time she administered the control substance but she was "in a hurry." Interview with the Administrator in Charge (AIC) on 02/21/18 at 4:06pm revealed: -It was facility policy to sign the controlled substance log at the time any controlled substance was administered. -All staff who administered medications had been trained on the administration and documentation of medications during their MA classes and training. -She expected staff to follow the policies for medication administration and documentation. Interview with the Administrator on 02/21/18 at	D 392		

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D 392	Continued From page 73 7:00pm revealed: -The documentation of controlled substances was supposed to be completed at the time of administration. -The procedure was for the staff to document on the eMAR and sign the controlled substance log at the time any controlled substance was administered. -She had "talked to" the SCUCC about the "handling and managing" controlled substances. 2. Review of Resident #5's FL-2 dated 04/26/17 revealed diagnoses included Alzheimer's disease with behaviors, diabetes, chronic pain, hypertension, history of cerebrovascular disease, and chronic kidney disease. Review of Resident #5's physician's orders dated 04/26/17 revealed an order for Norco 5/325mg take one by mouth every four hours as needed for pain. (Norco is a controlled substance with a combination of the drugs Hydrocodone 5mg and Acetaminophen 325mg used to treat pain). Review of a subsequent physician's order for Resident #5 dated 10/16/17 revealed Norco was discontinued. Review of Resident #5's electronic Medication Administration Record (eMAR) for October 2017 revealed: -There was an entry for Norco 5/325mg take one every four hours as needed for pain. -Norco was documented as administered on 10/09/17 at 8:37pm. Review of Resident #5's Norco 5/325mg controlled substance log revealed on 10/09/17 at 8:37pm Norco was documented as "refuse-destroyed."	D 392		

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D 392	Continued From page 74 Telephone interview on 02/23/18 at 11:41am with Staff C, a former Medication Aide (MA), who documented administering Norco on the eMAR and documented destroying it on the controlled substance log revealed: -Resident #5 would "sporadically" say she was hurting. -The resident had a PRN order for "Hydrocodone." -Resident #5 would refuse her eye drops, but not her pain medication. -It took "patience" to give Resident #5 her medications; the medications had to be crushed. -The resident's medications were crushed anyway, so the medication would not have been dropped on the floor or anything. -There had never been any inconsistencies with the counts for Resident #5's Norco. -She had no recollection of documenting Resident #5's Norco as administered on the eMAR and destroyed on the control log. -She had no recollection of ever having to destroy any of Resident #5's PRN Norco. Interview with the Administrator in Charge (AIC) on 02/22/18 at 4:06pm revealed: -She acknowledged Resident #5 had been ordered PRN (as needed) Norco. -She acknowledged Norco was documented on the eMAR as having been administered on 10/09/17 at 8:37pm. -She acknowledged Norco was documented as "destroyed" on the control log. -She acknowledged there was an "inconsistency." 3. Review of Resident #13's most recent FL-2 dated 11/23/2016 revealed diagnoses included	D 392		

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D 392	Continued From page 75 pulmonary fibrosis, dementia, "HPB", and deep vein thrombosis. Review of updated physician's orders dated 03/06/2017 revealed diagnoses included pulmonary fibrosis, dementia, HTN [hypertension], and DVT. Review of physician's orders for Resident #13 revealed: -There was a physician's order dated 11/15/2017 for Ambien (a controlled substance used to treat insomnia) 5mg tablet at bedtime. -There was a subsequent physician's order dated 01/08/2018 to discontinue the Ambien. Review of a prescription from the Primary Care Provider (PCP) for Resident #13 dated 11/22/2017 revealed there were instructions for Ambien 5mg tablet at bedtime, quantity of 30 with six refills. Observation of controlled substance medications on hand on 02/21/2018 revealed there was no Ambien 5mg tablets for Resident #13. Review of completed Return of Drugs forms for the facility dated from 11/20/2017 through 01/30/2018 revealed: -There was documentation for Ambien 5mg quantity 10 handwritten on the form dated 01/10/2018. -There was no other documentation for Ambien 5mg tablets for Resident #13 on any of the Return of Drugs forms. Review of a controlled substance log (CSL) for Ambien 5mg tablet for Resident #13 dated 11/15/2017 revealed: -A facility staff documented 14 Ambien 5mg	D 392			

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D 392	Continued From page 76 tablets were added to the cart on 11/15/2017. -Staff documented on the CSL that one tablet was administered each night from 11/15/2017 through 11/21/2017 with 7 tablets remaining. -There was no documentation on the CSL sheet dated 11/15/2017 for the disposition of the 7 remaining Ambien 5mg tablets dispensed to the facility. Review of a controlled substance log (CSL) for Ambien 5mg tablet for Resident #13 not dated revealed: -A facility staff documented 14 Ambien 5mg tablets were received on 11/26/2017. -Staff documented on the CSL that one tablet of Ambien 5mg tablet was administered each night from 11/26/2017 through 12/03/2017 with 3 tablets remaining. -There was no documentation on the CSL sheet beginning 11/26/2017 for the disposition of the 3 remaining Ambien 5mg tablets dispensed to the facility. Review of the November 2017 electronic Medication Administration Records (eMARs) for Resident #13 revealed: -There was no transcription for Ambien 5mg tablets printed to the eMARs. -There was no documentation for administration of Ambien 5mg on the eMARs. Review of a controlled substance log (CSL) for Ambien 5mg tablet for Resident #13 not dated revealed: -A facility staff documented 14 Ambien 5mg tablets were received on 12/21/2017. -Staff documented on the CSL that one tablet of Ambien 5mg tablet was administered each night on 12/21/2017, 12/26/2017 through 12/29/2017, and 01/02/2018 through 01/03/2018 with 7 tablets	D 392			

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D 392	Continued From page 77 remaining. -There was no documentation on the CSL sheet beginning 12/21/2017 for the disposition of the 7 remaining Ambien 5mg tablets dispensed to the facility. Review of the December 2017 electronic Medication Administration Records (eMARs) for Resident #13 revealed: - Ambien 5mg take one tablet once daily was printed to the eMARs. -There was documentation for administration of Ambien 5mg at 8:00pm nightly on the eMARs for 12/26/2017 through 12/29/2017. -There was documentation for leave of absence on 12/12/2017, 12/13/2017, 12/22/2017 -12/25/2017, and 12/30/2017-12/31/2017. -There was a symbol used for the remaining days in the month of December 2017 which meant missed dose. -There was no additional information on the December 2017 eMARs regarding the Ambien 5mg tablet for Resident #13. Review of a controlled substance log (CSL) for Ambien 5mg tablet for Resident #13 not dated revealed: -A facility staff documented 14 Ambien 5mg tablets were received on 01/04/2018. -Staff documented on the CSL that one tablet of Ambien 5mg tablet was administered each night from 01/04/2018 through 01/07/2018 with 10 tablets remaining. -There was no documentation on the CSL sheet beginning 01/04/2018 for the disposition of the 10 remaining Ambien 5mg tablets dispensed to the facility. Review of the January 2018 electronic Medication Administration Records (eMARs) for Resident	D 392			

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D 392	Continued From page 78 #13 revealed: - Ambien 5mg take one tablet once daily was printed to the eMARs. -There was documentation for administration of Ambien 5mg at 8:00pm nightly on the eMARs for 01/02/2018 through 01/07/2018. -There was documentation for leave of absence on 01/01/2018. -There was documentation the Ambien 5mg was discontinued on 01/08/2018. -There was no additional information on the January 2018 eMARs regarding the Ambien 5mg tablet for Resident #13. Telephone interview with the Pharmacist on 02/21/2018 at 4:45pm revealed: -The original prescription bill date was 11/15/2017 quantity 16. -A quantity of 30 Ambien 5mg tablets was billed on 12/01/2017, and again on 01/01/2018. -The pharmacy dispensed to the facility Ambien 5mg quantity of 14 every two weeks in the facility cycle fill of medications. -There were some missing Ambien and Ambien medication cassette that did not come back to the pharmacy in the return of drugs tote for Resident #13. -Ambien 5mg tablet quantity 10 was documented on the Return of Drugs list dated 01/10/2018, but the cassette of Ambien was not in the pharmacy return tote. -The pharmacy contacted the PCP for Resident #13 last week about the missing Ambien. -The pharmacy did not know where the Ambien 5mg tablets were. -The facility AIC and ALUCC were contacted about the missing Ambien. -The pharmacy did not know the date of when the AIC and ALUCC were contacted.	D 392			

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D 392	Continued From page 79 Interview with a Medication Aide (MA) on 02/21/2018 at 5:20pm revealed: -Medications to be returned to the pharmacy were placed in a tote. -The medications for return were listed on a pharmacy Return of drugs form. -The medications for return to pharmacy were supposed to be picked up everyday. -The 7p-7a shift MAs usually wrote down all the medications for pharmacy return on the return of drugs form. -There were separate totes used in the assisted living section and special care unit section for pharmacy return medications. -The MA who completed the 01/10/2018 Return of Drugs form was on medical leave. Telephone interview with a second MA on 02/23/2018 at 6:30am revealed: -She put medications in the tote to return to the pharmacy. -She did not know anything about Ambien for Resident #13. -She did not send any medications back to the pharmacy. -The first shift staff notified the pharmacy to pick up the tote of medications for return to the pharmacy. Telephone interview with a third MA on 02/26/2018 at 6:45am revealed: -Medications for return to pharmacy were kept in a tote in the medication room. -During the night shift, the MAs wrote a list of the medications on a Return of Drugs form which included the resident's name, drug name, prescription number, quantity being returned, and reason for return. -Sometimes the day shift MAs completed the Return of Drugs forms for the medications in the	D 392			

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D 392	Continued From page 80 drug return tote, but the form was mainly completed by the night shift MA. -She sometimes completed the Return of Drugs form. -The pharmacy picked up the return drugs tote, but not everyday. -She remembered Resident #13 being prescribed Ambien. -She did not remember anything about the Ambien being returned to the pharmacy because she was not at the facility when it went back. -If she wrote up the Return of Drugs form, she would sign it. -She remembered the AIC and UCC asking her about the missing Ambien cassette, but did not remember the date she was asked. -She did not know if the missing Ambien cassette was ever found. -She did not know who last saw the Ambien cassette for Resident #13. -The tote for the medications to be returned to the pharmacy was kept in the locked medication room. Telephone interview with a fourth MA (whose signature was on the Return of Drugs form dated 01/10/2018) on 02/26/2018 at 5:20pm revealed: -She did not know much about Resident #13's Ambien except that the resident was prescribed the Ambien at night time before it was discontinued. -She had never administered the Ambien 5mg tablet to Resident #13. -The MAs put the medication in the tote that needed to be returned to the pharmacy. -When the medications were placed in the return medication tote, the medications were not documented on the drug return sheet at that time. -When the tote got full, a MA was responsible for logging all the medicines in the tote on the Return	D 392			

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D 392	Continued From page 81 of Drugs form. -When the pharmacy came to the facility to pick up the tote, the MA working would sign the Return of Drugs form. -The MA that signed the Return of Drugs form was not always the MA who had inventoried the medications in the return tote. -The facility "really don't have a system". -Sometimes she signed the Return of Drugs form when she logged the medications on the form, and left the form in the tote. -If she did not finish writing all the return medications on the Return of Drugs form, she would tell the next MA, who would write the return medications on the Return of Drugs form and/or pass it on to the next MA to finish. -If her signature was on the Return of Drugs form, then she signed it when it was sent back to the pharmacy, unless it was a day she forgot to send the tote back to the pharmacy. -She did not know if the missing cassette of Ambien 5mg tablets were ever found. -She did not have to do any documentation about the missing Ambien medication cassette. -The ALUCC would usually complete that documentation. -She did not know if the ALUCC had completed any documentation about the missing Ambien medication cassette. Interview with the ALUCC on 02/21/2018 at 5:55pm revealed: -The pharmacy delivered new medication cassettes to the facility every other Wednesday evening to begin administering from the following Thursday. -For medications discontinued and needing return to the pharmacy, they are picked up by a courier about every few days.	D 392			

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D 392	Continued From page 82 Telephone interview with the ALUCC on 02/27/2018 at 9:05am revealed: -She thought she had received a telephone call from the pharmacy on 01/23/2018 who informed her when checking in the medications returned to the pharmacy in the tote, Resident #13's Ambien was not in the tote. -She made the AIC aware and was instructed to check everywhere she knew to check for the medication, which she did. -She had a MA [who signed the Return of Drugs form dated 01/10/2018] check behind her in case she had overlooked something. -The pharmacy was called and notified the medication cassette was not found in the facility. -She reviewed a copy of the Return of Drugs form the pharmacy faxed back to the facility and noted the Ambien for Resident #13 was listed on the return drug form, and the form had been signed by the pharmacy driver which meant the medication was in the return tote. -When the pharmacy driver picked up the return medication tote, she and the MA were supposed to go through the list and make sure everything that was listed on the form was in the tote, then she and the MA were supposed sign the Return of Drugs form. -She did not complete any paperwork regarding the missing Ambien. -The missing medication protocol was to contact the AIC who "took it from there to contact whoever else needed to be contacted". -She was not aware of a written policy on missing medications. -The proper routine if medications were sent back to the pharmacy would be to list those medications on a return sheet which was completed by the night shift MAs. -Control drug counts were performed after every shift.	D 392		

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D 392	Continued From page 83 -If there was a discrepancy found when the controlled drugs were counted, the MA was supposed to let her know or go to the AIC and let the AIC know. -She had not been contacted about any of the discrepancies on the 12/6/2017, 1/3/2018, and 1/7/2018 CSLs for Resident #13. -If she had been contacted she would have asked where the medication was and why the count was off, and involved the AIC. -She was responsible for reviewing CSLs every day and was not sure why she had not picked up that the CSLs for Resident #13's Ambien were inaccurate. Interview with the Administrator on 02/21/2018 at 6:05pm revealed: -Resident #13's discontinued Ambien was listed on the Return of Drugs form dated 01/10/2018 and signed by the pharmacy courier. -If the courier checked the medications for return to pharmacy and signed for them, she did not know what had happened to them once the medications left the facility. -The facility was contacted by the pharmacy "a couple weeks later" about the missing cassette of Ambien from the return medication tote for 01/10/2018. -Facility staff checked the medication carts and in the medication room but did not find the missing cassette of Ambien 5mg tablets. -The missing Ambien was not reported to anyone because once the pharmacy courier picked up the medications and signed for picking them up "it was out of our hands, we can't be responsible for them anymore". Interview with the AIC on 02/22/2018 at 11:25am revealed: -Resident #13 went on a leave of absence (LOA)	D 392		

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D 392	Continued From page 84 on 11/22/2017 and returned on 11/26/2017. -Medication was prepackaged at the pharmacy for the LOA. -The Ambien remaining in the medication cassettes was returned to the pharmacy when the medication cassettes were changed out. -Any medication in the medication cassettes were returned to the pharmacy when the medication cassettes were changed out every 14 days. -The medication dispensing system for controlled medications had recently changed and controlled medications were no longer in the routine medication 14 day cycle fill process. -There was no way to account for controlled medications that were returned to the pharmacy with the medication cassettes change out every 14 days. Interview with the Administrator on 02/22/2018 at 3:15pm revealed: -The facility did not complete drug return sheets on cassette change out days. -The facility used drug return sheets only when medications were discontinued or the resident was discharged. Interview with the provider pharmacy on 02/22/2018 at 3:25pm revealed: -It would be difficult to track the number of pills returned to the pharmacy when cassettes are changed out. -The facility did not traditionally write up returned medications on drug return sheets during change out of cassettes. -The pharmacy could account for the quantity of pills sent to the facility but not the quantity of pills returned to the pharmacy at change out of cassettes. -It was an expectation that the facility would document on their CSL inventory sheets the	D 392			

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D 392	Continued From page 85 quantity of Ambien 5mg pills returned to the pharmacy with each cassette change out. Interview with the Pharmacist at the provider pharmacy on 02/23/2018 at 4:15pm revealed: -The medication cassette with the Ambien 5mg tablets for Resident #13 had not been found. -She thought one of two things could have happened with the medication cassette of Ambien 5mg tablets. -Whoever wrote up the medications on the Return of Drugs form put the cassette in the tote, and either someone took it out of the tote and put it back in the medication cart and forgot to mark the medication off the return of drugs form or it was diverted. -Ambien was not a medication that is normally diverted. -Ambien does not stay in your system very long. -The pharmacy documented contacting the facility about the missing cassette of Ambien 5mg tablets on 01/15/2018, but could have mentioned it to the facility "over time". -The pharmacy had recently changed their system of dispensing controlled substances; all controlled substances were now sent separately from other medications. A second interview with the Pharmacist on 02/27/18 at 11:08am revealed: -The pharmacy provided the controlled substance logs for the facility to use to maintain counts of the controlled substances but did not dictate how the facility kept count. -The facility should have a system in place to maintain accurate counts of controlled substances. -Once a medication was dispense to the facility, it was the facility's responsibility to keep records of what was dispensed/received from the pharmacy,	D 392			

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D 392	Continued From page 86 administered, and returned to the pharmacy. _____ The facility failed to have a system in place to accurately account for Resident #13's Ambien when it was returned to the pharmacy resulting in a cassette of 10 Ambien being unaccountable for. This non-compliance was detrimental to the welfare and safety of the resident which constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility dated 02/28/18 revealed: -Instructions would be given to Care Coordinators and Medication Aides regarding the policy, procedure, and proper documentation and handling of controlled substances would be completed by 02/27/18. -The Administrator would provide the instruction and documentation would be placed in staffs' file. -Pharmacy will provide an audit of controlled substances on 03/06/18. -Care Coordinators will check controlled substance logs and document monitoring of logs Monday through Friday. -Care Coordinators would "immediately report any issues to Administrator in Charge." (AIC) -AIC will check logs weekly until 05/31/18, then monthly and "will document monitoring and action taken if any issues." THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2018.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance	D 399		

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D 399	Continued From page 87 (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversions of controlled substances to the pharmacy for 1 of 2 residents sampled (#15) who was prescribed Clonazepam. The findings are: Review of Resident #15's most current FL-2 dated 01/09/17 revealed: -Diagnoses included advanced Alzheimer's dementia, seizures, and toxic metabolic encephalopathy. -The resident was not oriented to person, place, or time. Interview with the Special Care Unit Care Coordinator (SCUCC) on 02/20/18 at 11:30am revealed Resident #15 was never oriented. Review of Resident #15's medication orders dated 08/28/17 revealed an order for Clonazepam 0.5mg take ½ tablet by mouth daily at 4:00pm. (Clonazepam is a controlled medication used to treat anxiety. Clonazepam is a long acting class of drug called	D 399		

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D 399	Continued From page 88 Benzodiazepine). Review of Resident #15's October 2017 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Clonazepam 0.5mg take ½ tablet by mouth once daily with administration time of 4:00pm. -Clonazepam 0.5mg (½ tablet) was documented as administered by every day at 4:00pm from 10/01/17-10/16/17 by two different Medication Aides (MAs). Review of the controlled substance log for Resident #15's Clonazepam 0.5mg ½ tablet daily revealed the medication was documented as administered daily from 10/01/17-10/16/17 at 4:00pm. Review of a copy of a laboratory (lab) results report for Resident #15 dated 10/16/18 obtained from the primary care provider's (PCPs) office revealed: -The "collection date" of the lab was documented as 10/11/17. -The "sample type" was documented as "dried blood." -Resident #15's lab result for Clonazepam was documented as "negative." (This negative result indicates the medication was not detected in Resident 15's blood (lab) collected on 10/11/17). Review of a "Reference Guide" for the lab results for Resident #15 revealed the lab's "detection window" for Clonazepam was documented as a "minimum" of four days to a "maximum" of nine days. Telephone interview with Resident #15's PCP on 02/21/18 at 8:23am revealed:	D 399		

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D 399	Continued From page 89 -She spoke with the AIC on 10/11/17 to let her know she was "concerned" about drug diversion in the SCU and would be ordering labs to be drawn for the residents who resided in the SCU. -The PCP's lab provider collected the labs on 10/11/17; the labs were resulted on 10/16/17. -Resident #15 was ordered Clonazepam daily, but his lab result dated 10/16/17 was negative for Clonazepam. (The lab was drawn on 10/11/17). -On 10/16/17, she notified the AIC about the lab result and possibility of drug diversion. Telephone interview with Resident #15's mental health (MH) provider on 02/27/18 at 9:04am revealed: -She was notified by one of the PCPs that Resident #15 was tested for controlled substances after a pain medication for another resident went missing. -Clonazepam was a longer acting Benzodiazepine, if Resident #15 had received Clonazepam 0.5mg ½ tablet daily from 10/01/17-10/10/17, she would expect the resident to have the medication in his system, especially since he had been on the medication daily for a while and the lab was collected 10/11/17. -Resident #15 was "not oriented at all" and would not be able to tell you if he received the medication or not. -Resident #15 was not one to refuse medications; she did not recall any notification of any refusals of Clonazepam. A second telephone interview with Resident #15's PCP on 02/27/18 at 12:27pm revealed: -Resident #15's was ordered to receive Clonazepam daily but his lab results dated 10/16/17 (drawn 10/11/17) were negative for Clonazepam; the medication had been documented as given.	D 399			

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D 399	Continued From page 90 -Resident #15 was not oriented and would not know or be able to tell you if he had received the medication or not. -She notified the AIC of Resident #15's lab results on 10/16/17, but did not leave a copy of the result at the facility. -She told the AIC the lab results and that she suspected drug diversion; the AIC should have notified law enforcement. -Later on 10/16/17 (after she had notified the AIC about the lab results), the AIC said it was "taken care of." -The AIC told the PCP she had contacted pharmacy about the lab results. Telephone interview with a Pharmacist at the facility's primary pharmacy on 02/27/18 at 11:0am revealed: -Resident #15 had an order dated 08/28/17 for Clonazepam 0.5mg take ½ table daily at 4:00pm for anxiety. -Resident #15's Clonazepam was discontinued per another order dated 10/16/17. -The facility had not notified the pharmacy about the lab results or reported any suspected drug diversion for Resident #15. -"I did not know that." -The facility may have spoken to the other (named) Pharmacist about Resident #15. -If Resident #15 had received Clonazepam daily from 10/01/17-10/10/17, the medication would have been in his bloodstream when the labs were collected on 10/11/17. Telephone interview with the second Pharmacist at the facility's primary pharmacy on 02/27/18 at 12:15pm revealed: -The Pharmacist recalled the AIC contacting her about lab results for another resident only (unsure of the date); she recalled the incident because	D 399		

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D 399	Continued From page 91 she had a pharmacy student working with her and she had the pharmacy student look up the information. -She was not contacted by anyone at the facility about Resident #15. -If Resident #15 had been administered Clonazepam 0.5mg ½ tablet from 10/01/17-10/10/17, the medication would have shown positive on his lab results drawn on 10/11/17. Interview with the Administrator-in-Charge on 1/22/18 at 4:06 p.m. revealed: -The PCP was "upset" about some missing Oxycodone for another (named) resident and ordered for "two or three" residents on the SCU to have labs drawn to check for controlled substance medications due to suspected drug diversion. -She acknowledged Resident #15 was ordered Clonazepam at 4:00pm for anxiety. -She was informed by the PCP that Resident #15 tested negative for Clonazepam (unsure of the date); she could not remember if the PCP notified her about the lab test results by phone or in person. -The PCP discontinued Resident #15's Clonazepam after that (date not provided). -She had talked with the two MAs (Staff E and Staff G) who documented administering Resident #15's Clonazepam in October 2017; both staff said the resident had received the medication daily, as ordered. -She could not explain why Resident #15's lab result was negative for Clonazepam. -After she was notified by the PCP about the lab results, she called the pharmacy because she suspected the medications were not given; she could not say if she spoke with the pharmacy specifically about Resident #15.	D 399		

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D 399	Continued From page 92 -She had not notified the Administrator of the lab results for Resident #15 and was "unsure" if the Administrator was aware of the result. Interview with the Administrator on 02/22/18 at 5:40pm revealed: -She was "unsure" of the date she was notified and she was "going from memory" but thought the AIC notified her by phone that the residents in the SCU were going to be drug tested. -She was not aware of the lab result for Resident #15. -She acknowledged being concerned because Resident #15's Clonazepam was documented as administered from 10/01/17-10/16/17 but the medication was not in his bloodstream when the lab was collected on 10/11/17. -"I feel if the [named PCP practice] had a suspicion they should have moved forward with it and they should have contacted me. They have my number and if they don't, they could have asked anyone." A second interview with the Administrator on 02/23/18 at 8:30am revealed: -She had questioned the AIC about the labs drawn on the residents in the SCU. -The PCP notified the AIC about Resident #15's lab results being negative for Clonazepam but the AIC was not ever given a copy of the lab result. -"Unless [AIC's name] is standing over the med (medication) pass, there is no way for her to know" (about the suspected drug diversion). -She did not have a "timeline" and did not know when AIC received the lab results from the PCP. -She did not know if the suspected drug diversion (related to the lab results) was reported to pharmacy, law enforcement, Health Care Personnel Registry, or the local Department of Social Services; she would have to ask the AIC	D 399			

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D 399	Continued From page 93 because she did not know what was actually reported. Telephone interview with the AIC and Administrator on 02/27/18 at 2:46pm revealed: -The report of Resident #15's lab results from the PCP was "word of mouth." -The AIC never received an actual copy of Resident #15's lab results from the PCP. -After she received the lab results from the PCP for two other residents, she called the pharmacy to report the findings and ask what the lab results meant. -The AIC was "unsure" if she contacted the pharmacy specifically about Resident #15.	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report allegations of drug diversion and exploitation by Staff E to the North Carolina Health Care Personnel Registry (HCPR) related to Resident #15 who resided in the special care unit. The findings are: Based on record reviews and interviews, fifteen	D 438		

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D 438	Continued From page 94 Oxycodone 5/325mg were unaccounted for on 10/05/17 for a resident who resided in the special care unit (SCU). (Oxycodone is a controlled substance used to treat pain). The facility reported the missing Oxycodone to the pharmacy, law enforcement, and HCPR. The facility's contracted Primary Care Provider's (PCP) ordered controlled substance drug screening labs for the residents in the SCU after being notified about the missing Oxycodone. The lab results from the drug screenings revealed Resident #15 was negative for Clonazepam, which had been ordered and documented as administered daily. (Clonazepam is a controlled substance used to treat anxiety). Telephone interview on 02/21/18 at 8:23am with the PCP who ordered the labs revealed: -The Oxycodone went missing on 10/05/17; the facility notified the PCP about the missing Oxycodone on 10/09/17. -She spoke with the AIC on 10/11/17 to let her know she was "concerned" about drug diversion in the SCU and would be ordering labs drawn for the residents who resided in the SCU. -The PCP's lab provider collected the labs on 10/11/17; the labs were resulted on 10/16/17. -After receiving the lab results, she reviewed each residents' orders, controlled substance logs, and MARs (on 10/16/17 when she was in the facility). -Resident #15 was ordered Clonazepam daily but his lab result was negative for Clonazepam. -On 10/16/17, she notified the Administrator-in Charge (AIC) about Resident #15's lab results and possibility of drug diversion. -The AIC told the PCP everything "was handled" that day (10/16/17). -The PCP assumed the police, DSS, and pharmacy had been notified and the suspected	D 438		

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D 438	Continued From page 95 diversion would be investigated. Interview with the AIC on 02/22/18 at 4:06pm revealed: -The Medication Aides (MAs) and Unit Care Coordinator (UCC) in the SCU were urine drug tested at the facility beginning the day the Oxycodone was first noticed as missing. -She (the AIC) conducted the drug tests for all staff and had someone to witness the drug testing, but she could not remember the staff who witnessed the onsite drug tests. -Two named staff (Staff F and Staff C) were drug tested the same day the Oxycodone was noticed missing, but a third staff, Staff E, (who was on duty that day) refused a drug test. -Staff E left that day, and came back with a payment receipt for a drug test (not lab results). -Staff E was not terminated when she refused to be drug tested; the staff continued to work in the facility until the staff "was a no call no show" and did not return back to work. -Staff E would have been suspended and/or terminated if she would not have provided her drug screen results, but she quit first. -Other staff members were tested on other dates when they reported for their scheduled shifts. -All staff who were drug tested at the facility had negative results. -The PCP was "concerned" about Staff E because Staff E refused to be drug tested and Staff E was still working after refusing a drug test. -The PCP ordered for "two or three" residents on the SCU to have labs drawn to check for controlled substance medications due to suspected drug diversion. Review of Resident #15's current FL-2 dated 01/09/17 revealed: -Diagnoses included advanced Alzheimer's	D 438		

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D 438	Continued From page 96 dementia, seizures, and toxic metabolic encephalopathy. -The resident was not oriented to person, place, or time. Interview with the Special Care Unit Care Coordinator (SCUCC) on 02/20/18 at 11:30am revealed Resident #15 was never oriented. Review of Resident #15's October 2017 electronic Medication Administration Record (eMAR) revealed; -Clonazepam 0.5mg (½ tablet) was documented as administered every day at 4:00pm from 10/01/17-10/16/17. -Staff E and Staff G initialed the eMARs as documentation of administering Resident #15's Clonazepam: Staff E documented administration of the medication on 10/01/17, 10/04/17, 10/05/17, 10/08/17-10/11/17; Staff G documented administration of the medication on 10/02/17-10/03/17, 10/06/17-10/07/17, and 10/12/17-10/16/17. Review of Resident #15's October 2017 control log for Clonazepam revealed Clonazepam 0.5mg (½ tablet) was documented as administered every day at 4:00pm from 10/01/17-10/16/17. Review of a copy of a laboratory (lab) results report for Resident #15 dated 10/16/17 obtained from the PCP's office revealed: -The "collection date" of the lab was documented as 10/11/17. -The "sample type" was documented as "dried blood." -Resident #15's lab result for Clonazepam was documented as "negative." (This negative result indicates the medication was not detected in Resident 15's blood sample collected on	D 438			

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D 438	Continued From page 97 10/11/17). Telephone interview with Staff F, the former Special Care Unit Care Coordinator (SCUCC) on 02/22/18 at 9:12am revealed: -She was the former SCUCC; she quit in October 2017 for health reasons. -Sometime before she quit in October 2017 (she did not know the date), she recalled receiving a bag from the pharmacy with two cassettes of Oxycodone for a resident. -She asked Staff G, a Medication Aide (MA), if the resident needed the medication to be stocked on the medication cart; Staff G said the medication was not needed on the cart. -She (Staff F) locked the Oxycodone in the over-stock box. -Later that same week (date unknown), Staff E, another MA, was looking in an unused file in a drawer in the SCU and found the controlled substance log for the Oxycodone folded up in the file (the log was not in the controlled substance log book where it was supposed to be). -She (Staff F) looked in the over-stock box and noticed one cassette of Oxycodone was missing (it was one of the two cassettes she had placed in the over-stock box earlier that week). -Staff F noticed there was another controlled log sheet for the Oxycodone which had been "handwritten" by Staff C. -She notified the AIC within 15 minutes of finding the Oxycodone missing. -The Oxycodone was never found. -She and the other staff on the SCU were drug tested at the facility beginning the day the Oxycodone went missing. -Staff E, who was on duty when the Oxycodone was noticed missing, refused a drug test that day. -Staff E said she was "insulted" to be drug tested. -The AIC told Staff E to go get a drug test	D 438		

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D 438	Continued From page 98 somewhere else but she did not know if Staff E did. Based on observations, interviews, and record reviews, it was determined Resident #15 was not interviewable. Interview with Resident #15's Power of Attorney/family member on 02/20/18 at 12:00pm revealed: -Resident #15 was never oriented and dependent on staff for all of his activities of daily living. -As far as she knew, Resident #15 he received his medications like he was supposed and did not run out of or refuse medications. A second telephone interview with Resident #15's PCP on 02/27/18 at 12:27pm revealed: -Resident #15's 10/16/17 lab results were negative for Clonazepam, but he had an order for scheduled Clonazepam to be given daily. -She stayed late in the facility on 10/16/17 reviewing the labs orders, eMARs, controlled substance logs, and orders for the residents; the AIC left at 5:00pm that day (10/16/17). -There were only two staff who documented administering Resident #15's Clonazepam in October 2017; Staff E (who refused to be drug tested the previous week) was one of the two staff. -Staff E was allowed to continue to work in the facility after previously refusing an in house drug screen. -Resident #15 was not oriented and would not know if he had received the medication or not. -She notified the AIC of Resident #15's lab results on 10/16/17, but did not leave a copy of the result at the facility. -Later on 10/16/17 (after she had notified the AIC about the lab results), the AIC said it was "taken	D 438			

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D 438	Continued From page 99 care of." -Nobody had ever contacted her regarding the lab results until 02/21/18. -She had told the AIC the reason she ordered the labs; she had no reason to order labs without suspected drug diversion. Telephone interview with a Pharmacist at the facility's primary pharmacy on 02/27/18 at 11:0am revealed: -Resident #15 had an order on file at the pharmacy dated 08/28/17 for Clonazepam 0.5mg take ½ tablet daily at 4:00pm for anxiety. -The pharmacy automatically dispensed seven Clonazepam tablets (which was a 14 day supply) for Resident #15 every two weeks from 08/28/17-10/11/17. -The pharmacy halved the tablets prior to dispensing the medication to the facility and placed it in a cassette for storage. -Resident #15's Clonazepam was discontinued per an order dated 10/16/17. -Clonazepam was a long acting Benzodiazepine with a half -life of 30-40 hours. -The Pharmacist acknowledged due to the long half-life, it would take one to two days to remove half of the medication from the resident's blood and would take at least four to seven days and up to three to four weeks for the medication to be removed from the body if it was administered every day. -If Resident #15 had received Clonazepam daily from 10/01/17-10/10/17, the medication would have been in his bloodstream when the labs were collected on 10/11/17; the lab result should be positive for Clonazepam. Interview with the AIC on 02/22/18 at 4:06 p.m. revealed: -She acknowledged Resident #15 was ordered	D 438		

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D 438	Continued From page 100 Clonazepam at 4:00pm daily for anxiety. -She acknowledged there were only two staff (Staff E and G) who documented administration of Resident 15's Clonazepam. -She was notified by the PCP of the lab results for Resident #15 being negative for Clonazepam (unsure of the date); she could not remember if the PCP notified her about the lab results by phone or in person. -She could not explain why Resident #15's lab result was negative for Clonazepam. -Resident #15 was not oriented and "not able to tell if he got the medication." -She had not notified the Administrator of the lab results for Resident #15 and was "unsure" if the Administrator was aware of the results. -She had talked with the two MAs (Staff E and Staff G) who documented administering Resident #15's Clonazepam and both said the resident had received the medication daily, as ordered. -She acknowledged Staff E documented administering Clonazepam to Resident #15 from 10/08/17-10/11/17. -After the PCP told her the negative lab results, concerns about Staff E, and alleged drug diversion, she called the pharmacy because she suspected the medications were not given. -She had not reported the incident (for Resident #15 being negative for Clonazepam) to HCPR because she had "no proof" of drug diversion. Interview with the Administrator on 02/22/18 at 5:40pm revealed: -She was "unsure" of the date she was notified and she was "going from memory" but thought the AIC notified her by phone that the residents in the SCU were going to be drug tested. -She was not aware of Resident #15's lab results. -She acknowledged being concerned because Resident #15's Clonazepam was documented as	D 438		

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D 438	Continued From page 101 administered from 10/01/17-10/16/17 but the medication was not in his bloodstream when the lab was collected on 10/11/17. -She was aware of the rules requiring reporting of suspected drug diversion to HCPR. -"I feel if the [named PCP practice] had a suspicion they should have moved forward with it and they should have contacted me. They have my number and if they don't, they could have asked anyone." -When asked if she expected the AIC to notify the police and HCPR, she responded "I think at one point she did." -She would have expected the AIC to report this incident to HCPR and "at least investigate internally." A second interview with the Administrator on 02/23/18 at 8:30am revealed: -She had questioned the AIC about the labs drawn on the residents in the SCU. -She acknowledged Resident #15's negative lab result was a new suspicion of drug diversion that should have been reported. -The PCP notified the AIC about Resident #15's lab results being negative for Clonazepam but did not provide a copy of the lab result. -She did not have a "timeline" and did not know when the AIC received the information from the PCP. -She did not know if the suspected drug diversion (related to the lab results) was reported to HCPR she would have to ask the AIC because she did not know what was actually reported. -"Unless [AIC's name] is standing over the med (medication) pass, there is no way for her to know" (about suspected drug diversion). -"I will work with her on documentation." Telephone interview with Staff E on 02/27/18 at	D 438		

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D 438	Continued From page 102 9:28am, who documented administering Resident #15's Clonazepam on multiple dates including from 10/08/17-10/11/17 revealed: -She had previously worked in the facility as a MA in the SCU. -The residents in the SCU were "drug tested" a few days after another resident's Oxycodone was lost but she did not know the results of the tests, because she quit. -SCU staff had also been drug tested earlier in October 2017 when the Oxycodone was lost. -She had refused to take a drug test because the Oxycodone went missing between 7:00am and 1:00pm and she was not at work during that time. -She continued to work at the facility after refusing the drug test; she thought her last day working in the facility was 10/12/17; she quit because she was "tired of all that was going on." -She recalled Resident #15 was ordered Clonazepam every day at 4:00pm for anxiety; the medication did not seem to help him "at times." -She recalled Resident #15's Clonazepam order being changed or discontinued at one point, but he always got it like it was ordered. -The Clonazepam was always in stock and administered at 4:00pm to the resident. -Resident #15 did not talk, was never oriented, and did not refuse medications. -She did not recall any time when she did not administer Resident #15's Clonazepam when it was ordered. -"Nobody" at the facility had ever asked her any questions about Resident #15's Clonazepam. Telephone interview with the AIC and Administrator on 02/27/18 at 2:46pm revealed: -The report of Resident #15's lab results was "word of mouth." -The AIC never received a copy of Resident #15's lab results from the PCP.	D 438		

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D 438	Continued From page 103 -The AIC had "no proof" so she did not report it to HCPR. -The AIC and Administrator interpreted the HCPR reporting rule as there was supposed to be a suspected perpetrator; they were not comfortable "accusing someone." -A 24-Hour report had been submitted by the facility to HCPR on 02/26/18 (related to the suspected drug diversion in October 2017 for Resident #15). The facility failed to investigate and report suspected drug diversion to the HCPR after notification by the PCP that Resident #15 had a negative lab result (for labs drawn on 10/11/17) for a controlled substance ordered and documented as administered daily from 10/01/17-10/16/17. The facility failed to investigate Staff E who documented administering Resident #15's medication from 10/08/17-10/11/17. Staff E had refused an onsite drug screen on 10/05/17 and was allowed to continue to work in the facility until approximately 10/12/17, when she electively quit, exposing the residents in the SCU, who were cognitively impaired, to potential subsequent and/or continued drug diversion and exploitation by Staff E. The facility's failure to investigate and report Staff E to HCPR was detrimental to the welfare and health of the residents which constitutes a Type B Violation. Review of the Plan of Protection (POP) submitted by the facility dated 02/23/18 and POP addendum dated 02/28/18 revealed: -Instructions were given to the AIC by the Administrator regarding reporting on 02/12/18 and 02/23/18. -Incidents requiring reporting to HCPR will be reported in accordance with the rule using the 24	D 438			

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D 438	Continued From page 104 hour and 5 day reports. -Reporting to HCPR was completed for three residents using the 24 hour report on 02/26/18. -Administrator will monitor reporting process to ensure that reporting is properly completed. -Monitoring will begin when reporting is required. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2018.	D 438		
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 observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings. The findings are: Based on observations and interviews, the facility failed to assure the facility was free of obstructions and hazards as evidenced by medicated creams and liquids not being stored securely and being accessible to residents in the Special Care Unit (SCU); free-standing, unsecured oxygen canisters; carpeting with gaps, wrinkles, buckling, and raised areas in the	D912		

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D912	Continued From page 105 common areas of the SCU and 3 resident rooms in the Assisted Living (AL) section; and three showers with exposed, rough edges in 3 resident bathrooms in the AL section. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure residents were free of neglect and exploitation as related to medication administration, implementation, controlled substances, and health care personnel registry. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure Medication Aides observed Resident #10 ingest her medication at the time of administration resulting in medications, such as Seroquel and Pravachol, being found in the resident's room during a subsequent medication pass. [Refer to Tag 366, 10A NCAC 13F .1004(i) Medication Administration (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to assure the	D914		

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D914	Continued From page 106 overall management and operations of the facility was maintained in substantial compliance with the rules and statutes for adult care homes which is the responsibility of the Administrator; and the Administrator-in Charge failed to assure the policies, procedures, and overall operations of the facility were carried out in a manner to maintain each residents' rights to be free of harm, neglect, and exploitation, as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes related to medication administration, health care personnel registry, controlled substances, and housekeeping and furnishings which was the Administrator-in Charges responsibility in the absence of the Admininstrator. [Refer to Tag 980, G.S. 131D-25 Implemenation (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer a controlled medication ordered for anxiety as ordered for 1 of 8 residents sampled (#15). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to report allegations of drug diversion and exploitation by Staff E to the North Carolina Health Care Personnel Registry (HCPR) related to Resident #15 who resided in the special care unit. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to assure records for the administration and return of controlled substances to the pharmacy were maintained, accurate, and reconciled at all times for 2 of 8	D914		

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D914	Continued From page 107 residents sampled (#5, #13) for a pain medication (#5) and a medication used to treat insomnia (#13); and controlled substances were documented as administered on the controlled substance log at the time of administration. [Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management and operations of the facility was maintained in substantial compliance with the rules and statutes for adult care homes which is the responsibility of the Administrator; and the Administrator-in Charge failed to assure the policies, procedures, and overall operations of the facility were carried out in a manner to maintain each residents' rights to be free of harm, neglect, and exploitation, as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes related to medication administration, health care personnel registry, controlled substances, and housekeeping and furnishings which was the Administrator's-in Charge responsibility in the absence of the Administrator.	D980		

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D980	Continued From page 108 The findings are: Confidential staff interview revealed: -The Administrator-in-Charge (AIC) was in charge when the Administrator was not there. -The Administrator had not been in the facility "in months." -The last time the Administrator was in the facility (prior to February 2018) was before Thanksgiving (2017). -The Administrator walked around, asked staff questions, and made changes when she was there. -"Sometimes" the Administrator stayed "all day"; other times she was there a "half day." -The staff had the Administrator's telephone number and could call her if they could not get in touch with the AIC. -The AIC was responsive and responded to staff by telephone when she was not there. Confidential interview with a second staff revealed: -[AIC's name] was the "Administrator." -The AIC worked Monday-Friday from 8:00am-5:00pm. -The staff had not seen [Administrator's name] "frequently." -The Administrator walked the building and looked at the residents' rooms, and asked staff questions when she was there. -The Administrator usually only stayed "a day at a time" because she lived "so far away." Confidential interview with a third staff revealed: -The Administrator was in the facility "maybe every one-two months." -[AIC's name] was the person "in charge" at the facility.	D980		

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D980	Continued From page 109 Confidential interview with a concerned citizen revealed: -The Administrator was "never there." -The citizen had only seen the Administrator in the facility "once." Interview with the AIC on 02/22/81 at 4:05pm revealed: -She had been the AIC since June 2017 and was responsible for the building when the Administrator was not there. -She worked Monday-Friday from 8:00am-5:00pm and was on call "24/7" (twenty four hours a day and seven days per week). -At times, on the weekends, the Unit Care Coordinators were on call. -The Administrator came to the facility "when she is needed." -Prior to February 2018, the Administrator was last in the facility in December 2017; she was "here for the day." -She could not recall the last time the Administrator was in the facility prior to December 2017. -The Administrator was always available by phone and was quick to respond when she was needed. -She was trained for her position when she took over as the AIC. -She called the Administrator "whenever I feel like I need help." Interview with the Administrator on 02/22/18 at 5:40pm revealed: -She had no set schedule for when she was in the facility. -"I just pop in." -She was in the facility "sometimes once a month or more often"; she usually stayed one day.	D980		

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D980	Continued From page 110 -When in the facility, she toured the facility and talked with residents and staff. -The AIC was responsible for the facility in her absence. -The AIC had been trained by her and the former AIC. -The AIC called her as needed. -"She generally calls me if she has an issue or question." -She spoke with the AIC by telephone "sometimes daily." -The Administrator could not think of any examples of when the AIC called her; she would call her just to talk. Confidential interviews with a concerned citizen revealed: -There was a video of Staff C, a Medication Aide/Supervisor, sleeping while on duty posted on (named) social media. -Staff who worked at the facility "were used to it because she does it all the time." -Staff C had been seen asleep "5 or 6 times." -Staff C had been seen sleeping as recent as 02/12/2018 between 5:00am and 6:00am. -A staff had reported Staff C's sleeping while on duty to the AIC; the AIC told that staff "don't worry about it, I'll take care of it." Confidential staff interview revealed: -The staff would report issues to the AIC and "she doesn't always follow through." -For "months" prior to the video, Staff C was sleeping while on duty. -This staff had reported Staff C to the AIC; the AIC said she would "handle it." Confidential interview with a family member revealed: -The family had reported housekeeping issues to	D980			

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D980	Continued From page 111 the AIC (dates not provided); the AIC said she would talk to the staff but the issue was still not resolved. -The family had spoken with the AIC regarding issues with dressing the resident; the family was told by the AIC it was a specified shifts responsibility, but the issue was not corrected until after multiple reports to the AIC. Telephone interview with a Pharmacist at the primary pharmacy provider on 02/27/18 at 12:15pm revealed: -The Pharmacist recalled the AIC calling to ask her what to do after some Oxycodone went missing and being notified of a (named) resident's lab results (date not provided). -The pharmacist told her to "check the regulation." Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to assure Medication Aides observed Resident #10 ingest her medication at the time of administration resulting in medications, such as Seroquel and Pravachol, being found in the resident's room during a subsequent medication pass. [Refer to Tag 366, 10A NCAC 13F .1004(i) Medication Administration (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer a controlled medication ordered for anxiety as ordered for 1 of 8 residents sampled (#15). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to report allegations of drug	D980		

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D980	Continued From page 112 diversion and exploitation by Staff E to the North Carolina Health Care Personnel Registry (HCPR) related to Resident #15 who resided in the special care unit. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to assure records for the administration and return of controlled substances to the pharmacy were maintained, accurate, and reconciled at all times for 2 of 8 residents sampled (#5, #13) for a pain medication (#5) and a medication used to treat insomnia (#13); and controlled substances were documented as administered on the controlled substance log at the time of administration. [Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 5. Based on observations and interviews, the facility failed to assure the facility was free of obstructions and hazards as evidenced by medicated creams and liquids not being stored securely and being accessible to residents in the Special Care Unit (SCU); free-standing, unsecured oxygen canisters; carpeting with gaps, wrinkles, buckling, and raised areas in the common areas of the SCU and 3 resident rooms in the Assisted Living (AL) section; and three showers with exposed, rough edges in 3 resident bathrooms in the AL section. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. _____ The Administrator and Administrator-in Charge (AIC) failed to assure the facility's policies and procedures were implemented, maintained, and in substantial compliance with the rules and statutes which resulted in serious physical harm	D980		

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D980	Continued From page 113 to Resident #10 who required emergent treatment on two occasions for possible drug overdose after medications were left in her room; Resident #15, who was constantly disoriented, resided in the SCU, and had diagnoses including advanced Alzheimer's dementia, not receiving a controlled substance as ordered, placing the resident at substantial risk for neglect and exploitation; discrepancies in the reconciliation of controlled substances resulting in failure to account for ten Ambien tablets for Resident #13; failure to report Staff E to HCPR for alleged drug diversion, allowing Staff E to continue to work in the facility until she electively quit which exposed the residents in the SCU, who were cognitively impaired, to potential subsequent and/or continued drug diversion and exploitation by Staff E. The Administrator and AICs failure resulted in risk for serious neglect which constitutes a Type A2 Violation. A Plan of Protection was requested from the facility on 03/22/18. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D980		
D9999	Final Observation Based on the Settlement Agreement between Tara Plantation of Carthage, LLC, and this agency, signed November 29, 2022, the following actions have occurred: 1. Tag 366, 10A NCAC 13F .1004(i) Medication Administration (Type A1 Violation) was reduced to a Type A2 Violation.	D9999		

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D9999	Continued From page 114 2. Tag 980, G.S. 131D-25 Implementation (Type A1 Violation) was reduced to a Type A2 Violation. 3. Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation) was reduced to a Type B Violation.	D9999			