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MAGNOLIA COTTAGE CARE BLDG #1	5643 HWY 70 DOVER, NC 28526

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 02/28/18 - 03/02/18 and 03/05/18 - 03/06/18.	C 000		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 staff sampled (Staff D) had a criminal background check upon hire in accordance with G. S. 114-19.10 and 131-40. The findings are: Review of Staff D's personnel file revealed: -Staff D's hired date was as 12/08/16. -There was a Health Care Provider/Supervisor in Charge job description signed and dated by Staff D on 12/07/16. -There was no documentation of a state-wide criminal background screening in the record dated on or around 12/08/16. -There was documentation Staff D signed and initialed an acknowledgement form dated 12/08/16 that she was in agreement to having a criminal background check completed and that it was required for employment. Telephone interview with Staff D on 03/01/18 at 8:45 p.m. revealed: -She was hired at the facility on 12/08/16.	C 147		

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C 147	Continued From page 1 -She was hired initially as personal care aide (PCA) and did not start administering medications to the residents at the facility until September or October of 2017. -She remembered when she was first hired that she signed a "paper permission form" to accept or decline a criminal background check. -She remembered that she signed she accepted a criminal background search to be done and after the search was completed she was told by the Administrator that there were no records found. -The criminal background search was done in December of 2017. Interview with the Administrator on 03/01/18 at 9:51 a.m. revealed: -She was responsible for all staff personnel files and was responsible for performing the criminal background checks on all new employees. -She was unable to locate documentation the criminal background was completed. -She remembered that the criminal background check was done on hire for Staff D because she had to pay to have the background search done; however, she did not have a receipt. -She would contact the contracted provider that performed the criminal background search for Staff D to see if a copy of the criminal background check could be retrieved. -She had a copy of the faxed cover sheet that was sent in 2016 with the request for a criminal background check for Staff D, however; she did not have a copy of the confirmation that the faxed request was sent and received. Review of a facility fax cover sheet dated 12/07/16 revealed: -There was documentation on a fax cover letter from the Administrator dated 12/07/16 with	C 147		

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C 147	Continued From page 2 documentation that included Staff D's name in the subject line, and the number of pages was documented as "2". -There was a separate page entitled "North Carolina Criminal History Inquiry" on a letter head from a contracted provider, with Staff D's name, social security number, date of birth and the last known address for Staff D on the form. The remainder of the form was folded upward by the Administrator due to information listed on the lower section included payment authorization with the Administrator's banking account information. -There was no fax confirmation. A second interview with the Administrator on 03/01/08 at 10:44 a.m. revealed: -She had contacted the contracted provider today (03/01/18) who performed the criminal background check for Staff D, however, they were unable to retrieve the original criminal background check done in December of 2016 so the provider performed a second criminal background search for Staff D today (03/01/18). -She did not realize that the original criminal background search was not in Staff D's personnel file. Review of a criminal background inquiry from the facility's contracted criminal background provider revealed: -There was a copy of an email from the facility's contracted criminal background check for Staff D that a request for a background check had been received on 03/01/18. -There was a criminal background inquiry dated 03/01/18 for Staff D.	C 147		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support	C 254		

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C 254	Continued From page 3 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure a registered nurse completed a licensed health professional support (LHPS) evaluation and assessment within 30 days from the date a resident developed a new task for 1 of 2 sampled residents (#3) who had an order for compression stockings. The findings are: Review of Resident #3's current FL-2 dated 01/15/18 revealed diagnoses included deep vein thrombosis bilateral lower limbs, hypertension,	C 254		

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C 254	Continued From page 4 edema, and hypersensitivity lung disease. Review of Resident #3's Resident Register revealed an admission date of 11/29/17. Review of a physician's order for Resident #3 dated 01/15/18 revealed an order for compression stockings during the day. Observation of Resident #3 on 03/02/18, 03/05/18 and 03/06/18 revealed the resident was wearing a compression type stocking on her lower extremities. Based on record review, observation and an attempted interview with Resident #3 on 02/28/18 at 11:04 a.m. revealed the resident was not interviewable. Telephone interview with the contracted registered nurse consultant on 03/06/18 at 3:34 p.m. revealed: -She visited the facility every 3 months and as needed to perform LHPS reviews. -The Administrator normally called her when a resident developed a new LHPS task that required an assessment and evaluation. -She had not been called by the Administrator for Resident #3's compression stockings. Interview with the Administrator on 03/06/18 at 5:40 p.m. revealed: -She was aware that the contracted registered nurse should have been called within 30 days of any resident developing a need for a LHPS task. -She was aware that Resident #3 had an order for compression stockings and "absolutely overlooked" calling the contracted registered nurse when Resident #3's physician ordered the compression stockings.	C 254		

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C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure foods were stored in a manner to prevent contamination as evidenced by not labeling food with contents and date opened, thawing frozen, raw chicken parts at room temperature, dried and sticky substances in the refrigerator's storage areas and leaving expired foods stored in the refrigerator. The findings are: Observation in the kitchen on 02/28/18 at 12:00 p.m. revealed there was a 5.10lbs package of frozen chicken thighs thawing on the kitchen counter. Observation of the refrigerator door storage area on 02/28/18 at 12:16 p.m. revealed: -There was an opened bottle of French style dressing with no opened date and a "best by" date of 12/16/16 with approximately 50% of the dressing remaining. -There was an opened bottle of raspberry vinaigrette dressing with no opened date and a "Best when used by" date of 01/31/18 with less than 50% of the dressing remaining. -There was an opened bottle of balsamic lite vinaigrette dressing with no opened date and a "best when purchased by" date of 09/07/17 with	C 257		

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C 257	Continued From page 6 less than 25% of the dressing remaining. -There was an opened bottle of Vidalia onion dressing with no opened date and a "best by" date of 01/26/17 with approximately 25% of the dressing remaining. -There was an opened bottle of slaw dressing with no opened date and a "best buy" date of 02/05/17 with approximately 50% of the dressing remaining. -There was an opened bottle of zesty lime dressing with no opened date and a "best when used by" date of 02/12/16. -There was an opened 24 ounce bottle of chocolate syrup with a "best by" date of 04/15/17. -There was a purple colored sticky substance approximately 2 inches wide with an empty blue re-sealable storage bag adhered to the same sticky substance in the storage area of the refrigerator door's second left shelf. Observation of the storage shelving in the refrigerator on 02/28/18 at 12:24 p.m. revealed: -There was a container of tea that was not labeled with a date, stored on the top shelf of the refrigerator. -There was a ½ gallon container with a fast food restaurant (named) label for "iced tea" used to store a clear liquid with no labeled date and contents. -There was a ½ gallon container of 2% reduced fat milk with a "best by" date of 10/29/17 with approximately 25% of the milk remaining that had a curdled and thickened appearance, stored on the top shelf of the refrigerator. -There was an opened 24 ounce container of coleslaw with no opened date and an expiration date of 12/10/17 with approximately 50% of the coleslaw remaining, stored on the second shelf of the refrigerator. -There was a takeout container of food with a	C 257		

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resident's first name handwritten on the lid's container that was not labeled with a date or the contents, stored on the second shelf of the refrigerator.
-There was a manufacturer labeled container for Brunswick stew that was used to store cooked pasta in a white colored sauce that was not labeled with a date or contents, stored on the second shelf of the refrigerator.
-There was a manufacturer labeled whipped cream container that was used to store a tan colored, greasy solid substance that was not labeled with a date or the contents, stored on the second shelf of the refrigerator.
-There was a clear container with a manufacturer's label for Greek yogurt containing a beige solid substance that was not labeled with a date or the contents.

Observation of the middle storage compartment of the refrigerator on 02/28/18 at 12:35 p.m. revealed:
-There was an opened package of uncooked bacon that was not labeled with an opened date with 4 slices of the uncooked bacon remaining, stored on top of an opened package of lettuce mix with the opened end folded together that was not labeled with a opened date and 4 slices of individually wrapped cheese slices with no opened date and no outer wrapper with an expiration date.
-There was an opened package of sharp shredded cheese with no opened date with a "best by" date of 06/02/18 and manufacturer's labeled directions to use within 5 days after opening with approximately 25% of the cheese remaining, stored on the bottom surface of the middle storage compartment.
-There was an opened 14 ounce package of deli ham that was not labeled with an opened date

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with approximately 75% of the deli ham remaining, stored on the bottom surface of the middle storage compartment.
-There was an opened package of sugar cured ham that was not labeled with an opened date with approximately 75% of the cured ham remaining, stored on the bottom surface of the middle storage compartment.
-There was scattered loose brown and yellow debris and a peeling dried pinkish red colored substance on the storage areas surface of the middle compartment.

Observation of the refrigerator's right storage compartment on 2/28/18 at 12:38 p.m. revealed there was ½ head of cabbage wrapped in clear plastic wrap that was not labeled with a repackaged date.

Observation of the refrigerator's freezer on 02/28/18 at 12:43 p.m. revealed:
-There was a re-sealable bag with a white colored loose substance that was not labeled with a date or the contents, stored on the top storage shelf of the refrigerator.
-There was an opened package of frozen French fries that was not labeled with a date opened, stored on the bottom shelf of the refrigerator.
-There was a clear container with a green top used to store a green colored substance that was not labeled with a date and the contents, stored on the top storage shelf.
-There was clear container with aluminum foil between the container and the lid that was not labeled with an opened date and the contents used to store a red chunky substance, stored on the top storage shelf.
-There was a plastic bag closed with a rubber band that was not labeled with a date or the contents containing 2 breaded strips of an

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unknown food source.
-There was a re-sealable bag that was not labeled with a date used to store strips of green pepper, stored on the top storage shelf.
-There was a large clear container with a purple top lid that was used to store a red colored chunky substance that was not labeled with the date or the contents.
-There was an opened package of approximately 9 hash browns that were covered in a thick concentration of ice crystals with the opened end of the package folded down with no securement device to seal the package and was not labeled with the opened date.
-There was a manufacturer labeled container for whipped cream used to store frozen strawberries that was not labeled with a date or the contents.
-There was a one gallon re-sealable bag labeled "Leg Quarters" with no date and a second reseal-able bag with no labeled date or the contents that was used to store a white loose powdery substance.
-There was an opened package of 10 link sausages with approximately 50% of the sausages remaining that was not labeled with a date opened.
-There was a re-sealable bag with a brown solid substance that was not labeled with a date or the contents.
-There was a reseal-able bag containing an opened package of seasoning meat with a small block of the meat remaining that had a build-up of ice crystals covering the meat that was not labeled with a date.

Interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 12:45 p.m. revealed:
-She had not noticed the sticky pink/red substance in the refrigerator door's storage area

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and had not seen the peeling dried stain in the middle storage drawer.
-She wiped spills out of the refrigerator when spills occurred and when she saw them.
-She was not sure how long some of the repackaged foods without a labeled date and contents had been in the refrigerator and the freezer.
-The foods that were not labeled with a date and the contents had been placed in the refrigerator by another staff.
-The large container of the red chunky substance was spaghetti sauce that had been cooked over the weekend by another staff.
-The re-sealable bags in the freezer was cornmeal and flour used to coat vegetables and meat was placed in the freezer by another staff.
-The milk with an expiration date of 10/29/17 and some of the other unlabeled foods belonged to another staff.
-She always looked at the expiration dates of all foods before serving it to the residents.

Observation of the kitchen on 02/28/18 at 3:11 p.m. revealed:
-The same uncooked package of thawing chicken thighs that was previously on the kitchen counter was in the sink.
-The meat was no longer thoroughly frozen with the sides of the meat thawed completely and the remaining sections of the meat had thawed from a solid state to softened state.

Interview with the PCA/MA on 02/28/18 at 3:12 p.m. revealed:
-She had removed the frozen chicken thighs from the freezer today (02/28/18), "right after lunch" and had planned to prepare the meat for the residents' supper.
-She usually did not leave raw or uncooked foods

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C 257	Continued From page 11 on the kitchen counter to thaw and "probably got busy" and forgot that the meat was sitting on the counter. -She had thawed frozen foods "sometimes" by placing them in the sink filled with water or thawed the foods in the refrigerator. -She had not received any training in food service, however, had years of cooking experience. -"Night shift" was responsible to clean the refrigerator out and should have checked all foods for expired dates and disposed of them. -She was trained by the Administrator to label all repackaged or opened foods with a date and/or contents. -She usually did not have any left-over foods that required to be repackaged. -She had not served any of the expired foods or any of the foods repackaged without a labeled date and the contents. Interview with the facility nurse on 02/28/18 at 3:20 p.m. revealed: -Staff were responsible for cleaning the refrigerator by removing all of the items, checking and disposing of expired foods and cleaning the storage areas of the refrigerator with water and bleach on the weekends. -Staff were responsible to make sure all foods opened and repackaged were labeled with the contents and date when the food product was opened. -There were several food items in the refrigerator today (02/28/18) that should have been disposed of. -Staff were usually "better about it" and would label and date all foods when they were repackaged or opened. -A lot of the foods in the refrigerator today (02/28/18) that were repackaged belonged to	C 257		

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staff.
-She expected all staff to monitor all of the items in the refrigerator and if any foods were expired and were not labeled with a date or the contents then those foods should had been disposed of.
-The facility nurse and the Administrator monitored the refrigerator and the freezer at least weekly to assure foods were labeled and dated and checked the cleanliness of the refrigerator.
-She last observed the refrigerator on Sunday (02/25/18) but did not notice any foods out of date or opened packages not labeled and dated, however, grocery shopping was done Monday (02/26/18) and some of the foods that were opened could have been done after the groceries had been purchased this week.
-The facility had a cleaning schedule for staff to follow.
-The chicken thighs left out of the refrigerator today (02/28/18) would be discarded.

Review of a cleaning schedule with a handwritten date of "09/12" labeled "Night Shift" revealed there was no cleaning assignment or instructions for cleaning the refrigerator.

Telephone interview with a PCA on 03/05/18 at 9:33 a.m. revealed:
-She was trained by the Administrator that all foods had to be labeled and dated after opening or repackaging.
-She was responsible for cleaning the refrigerator at night when she worked on the weekends by removing all of the items and would "wipe down" the refrigerator.
-All foods were labeled and dated when she cleaned the refrigerator this past weekend (03/03/18 and 03/04/18).
-She worked every other weekend and cleaned the refrigerator prior to this past weekend around

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C 257	Continued From page 13 mid-February 2018 and at that time there was no expired foods and all foods were labeled with a date and or the contents. Interview with the Administrator on 03/05/18 at 2:25 p.m. revealed: -All staff had been told about her expectations for labeling and dating foods when opened. -All staff were responsible for the "care" and "up-keep" of the refrigerator. -Night shift staff were responsible for the weekly overall cleaning of the refrigerator and to dispose of any expired foods immediately. -There should not have been any expired foods stored in the refrigerator. -The Administrator would "spot check" the facility's refrigerator but did not have a routine frequency of how often she monitored the refrigerator. -She last checked the refrigerator last week, however, she only looked at the cleanliness of the refrigerator but would plan to "modify" how she monitored.	C 257		
C 321	10A NCAC 13G .1002 (g) Medication Orders 10A NCAC 13G .1002 Medication Orders g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication;	C 321		

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C 321	Continued From page 14 (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to obtain clarification from the prescribing physician for the indicated use of an as needed medication for 1 of 1 sampled residents who was prescribed an as needed medication used to treat anxiety (#3). The findings are: Review of Resident #3's current FL-2 dated 01/15/18 revealed diagnoses included deep vein thrombosis bilateral lower limbs, hypertension, edema, and hypersensitivity lung disease. Review of a physician's order for Resident #3 dated 01/15/18 revealed an order for Ativan (used to treat anxiety) 0.5mg twice daily as needed. Review of Resident #3's January 2018 medication administration record (MAR) revealed: -There was a handwritten entry for Ativan 0.5mg one tablet twice a day as needed (PRN) for anxiety. -Ativan 0.5mg was documented as administered 2 tablets on 01/16/18 and one tablet four times from 01/20/18 - 01/29/18 for "agitated/restless" and "agitated" and the results were documented as "relaxing", "better, relaxing", "better" and "little better". Review of Resident #3's February 2018 MAR revealed:	C 321		

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C 321	Continued From page 15 -There was a computerized entry for Ativan 0.5mg take one tablet twice a day as needed. -Ativan 0.5 mg as needed was documented as administered 17 times (5 days received twice daily) from 02/02/18 - 02/27/18 for "agitation/fussy" and "agitated" with results documented as "resting", "better" and "little better". Review of Resident #3's March 2018 Mar revealed: -There was a computerized entry for Ativan 0.5mg take one tablet twice a day as needed. -Ativan 0.5mg as needed was not documented as administered. Review of a faxed physician's order for Resident #3 dated 01/31/18 revealed there was a typed entry with a "facility start date" of 01/30/18 that included documentation that the resident continued to be "very hostile, aggressive" (both verbally and physically). The onset of the resident's behavior was around 3:00 p.m. and 9:00 a.m. the next morning. "We are using PRN (as needed) Ativan twice daily". Review of a "Pharmacy Review Sheet" for Resident #3 dated 12/12/17 revealed a pharmacy review had been done by the facility's contracted Registered Nurse after the physician ordered the as needed Ativan on 01/15/18. Based on record review, observation and an attempted interview with Resident #3 on 02/28/18 at 11:04 a.m. revealed the resident was not interviewable. Attempted telephone interview with Resident #3's health care power of attorney (HCPOA) on 03/05/18 at 9:14 a.m. was unsuccessful.	C 321		

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C 321	Continued From page 16 Interview with a Personal Care Aide/Medication Aide (PCA/MA) on 03/06/18 at 1:15 p.m. revealed Resident #3 took Ativan as needed when she was agitated. Confidential interview revealed: -They (confidential interview) thought a lot of as needed medication were given to residents when the medication was not needed. -At times, as needed medication were given to some residents because certain staff and the Administrator did not want residents up and walking around and wanted the residents to stay in a seated position. Interview with the facility's Licensed Practical Nurse (LPN) on 03/06/18 at 5:40 p.m. revealed: -Resident #3's order for Ativan was for anxiety. -She was aware that all as needed medications had to include an indicated use to administer the medication. -The contracted pharmacy provider should had added the use of Ativan for agitation to the order when the February 2018 order was generated by the pharmacy. -She would contact Resident #3's physician who ordered the Ativan and would have the as needed use of the Ativan clarified. Interview with the Administrator on 03/06/18 at 5:40 p.m. revealed: -When a written order was received from the physician, she or the facility nurse would review the order and compare the medication once it was received with the order. -She was not aware that Resident #3's Ativan order and MARS for February and March 2018 did not have instructions for the as needed indicated use of the medication.	C 321		

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C 321	Continued From page 17 Telephone interview with the Certified Nursing Assistant for Resident #3's physician on 03/06/18 at 4:00 p.m. revealed the physician was gone from the office for the day (03/06/18) and was not available at that time for any additional questions.	C 321		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a	C 335		

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C 335	Continued From page 18 separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 6 of 6 sampled residents (#1, #2, #3, #4, #5, #6) including high risk medications such as a controlled pain narcotic, a controlled sedative, a schedule II controlled narcotic and anticoagulants. The findings are: Observation of the facility's medication storage closet on 02/28/18 at 11:45 a.m. revealed: -The door was not locked. -The top drawer of the medication cart was partially opened and was sectioned off with dividers. -In each divided section there were medication cups filled with medications including tablets, capsules, caplets, and gel-caps in various shapes, colors and sizes. -One of the divided sections contained medication cups that were stacked over a second medication cup filled with medications. -There were five divided sections with handwritten labels which included the residents' first name on various types of adherent type paper and tape and one divided section that was not labeled with a resident's name.	C 335		

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C 335	Continued From page 19 -All six of the divided sections contained various types of tape with handwritten labels for the top of each section "PM" and the lower section "AM". There was one divided section that had an additional labeled middle section "12p". -The medication's top drawer storage surface had black, yellow and brown colored loose debris and stains scattered across the surface and in the corners of each divided section. 1. Review of Resident #1's current FL-2 dated 02/22/18 revealed: -Diagnoses included senile dementia, hyperlipidemia, hypertension, gastroesophageal reflux disease, and coronary artery disease. -There were physician's orders which included Atorvastatin (used treat high cholesterol) 20 mg one time daily, Plavix (an anticoagulant) 75mg one time daily, Tricor 48mg (used to treat high cholesterol) one daily, Fish Oil (used to treat inflammation and lower cholesterol levels) 1,000mg 2 tablets twice a day, Isosorbide Mononitrate Extended Release (used to treat chest pains by dilating the blood vessels in a tablet form that keeps the medicine at a steady level in the body for longer periods of time) 30mg ½ tablet one time daily, Metoprolol (used to treat blood pressure, chest pain and heart failure) 25mg one twice a day, Protonix (used to decrease acid in the stomach) 40mg one time daily, Ramipril (used to treat high blood pressure and heart failure) one time daily, Tramadol (a narcotic used to treat moderate to severe pain) 37.5/325mg one twice a day, and Vitamin D (a supplemental vitamin) 2000IU one time daily. Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed: -There were 3 separate medications cups filled with medications.	C 335		

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C 335	Continued From page 20 -Two medication cups were stored in the "PM" section and one in the "AM" section. -One of the medication cups positioned in the "PM" section contained 2 large gel caps, one small, round, white tablet, a larger white, round tablet and one orange colored, oblong shaped tablet. Observation of Resident #3's medications on hand revealed the resident's Tramadol 37.5/325mg was an orange colored, oblong shaped tablet. Interview with a Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 5:03 p.m. revealed the residents' controlled medications and the residents' as needed medications were not supposed to be pre-poured in advance. Interview with a second (PCA/MA) on 03/01/18 at 5:15 p.m. revealed she could remember what some of the residents' medications looked like because the residents' at the facility did not have a lot of medications to take. Refer to an interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the PCA/MA on 02/28/18 at 5:03 p.m. Refer to an interview with the Administrator on 02/28/18 at 5:54 p.m. Refer to an interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m. Refer to a telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m.	C 335		

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C 335	Continued From page 21 Refer to a confidential telephone interview. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. Refer to a review of the facility's "Medication Pre-Pouring 6.1" policy (not dated). Refer to a review of a copy of the "Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18 2. Review of Resident #2's current FL-2 dated 02/23/18 revealed: -Diagnoses included dementia and diabetes type 2 with hyperglycemia. -There were physician's orders which included Allegra (used for hay fever skin hives and itching) 180 mg one time daily, Metformin (used to lower blood sugar) 500mg one time daily, Namenda (used to treat dementia) 28mg one time daily, Remeron (used to treat depression) 30mg one time daily before bedtime, and Seroquel (used to treat schizophrenia, bipolar disorders, and depression) 25mg one time daily at bedtime. Record review for Resident #2 revealed: -There was an FL-2 dated 07/17/17 with a physician's order for Risperidone (used to treat certain mental/mood disorders) 1 mg one time daily at bedtime -There was a physician order dated 02/28/18 to discontinue Risperidone 1 mg daily at bedtime. Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed: -There were 2 separate medications cups filled with various medications. -One medication cup was stored in the "PM"	C 335		

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section and the other medication cup was stored in the "AM" section.

Refer to an interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m.

Refer to a second interview with the PCA/MA on 02/28/18 at 5:03 p.m.

Refer to an interview with the Administrator on 02/28/18 at 5:54 p.m.

Refer to an observation of the Administrator on 02/28/18 at 5:54 p.m.

Refer to an interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m.

Refer to a telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m.

Refer to a confidential telephone interview..

Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m.

Refer to a review of the facility's "Medication Pre-Pouring 6.1" policy (not dated).

Refer to a review of a copy of the "Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18

3. Review of Resident #3's current FL-2 dated 01/15/18 revealed:
-Diagnoses included deep vein thrombosis bilateral lower limbs, hypertension, edema, and hypersensitivity lung disease.
-There were physician's orders which included

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Eliquis (an anticoagulant) 2.5mg one twice daily, Carvedilol (used to treat high blood pressure and heart failure) 12.5mg one time daily, Lasix (used to treat fluid retention) 20 mg, 2 tablets one time daily, Klor-Con (used to treat low potassium) 20meq one time daily, Zocor (used to treat high cholesterol) 40mg one time daily.

Review of subsequent physician's orders for Resident #3 revealed:
-There was an order dated 01/15/18 for Aricept 5mg at bedtime and to start Ativan (used to treat anxiety) 0.5 mg twice daily as needed.
-There was an order dated 01/16/18 to start Vitamin D2 50,000 (used to treat decreased functioning of the parathyroid, softening of the bones and low levels of phosphate) one daily for 16 weeks.
-There was an order dated 02/19/18 to start Seroquel (used to treat mood/mental disorders) 25mg at bedtime and a subsequent order dated 02/27/18 to increase Seroquel to 50 mg at bedtime
-There was an order dated 02/19/18 to decrease Carvedilol to 6.25mg twice.

Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed:
-There were 2 separate medications cups filled with various medications.
-One medication cup was stored in the "PM" section and was stored in a second medication cup and the other medication cup was stored in the "AM" section.

Refer to an interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m.

Refer to a second interview with the PCA/MA on

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C 335	Continued From page 24 02/28/18 at 5:03 p.m. Refer to an interview with the Administrator on 02/28/18 at 5:54 p.m. Refer to an interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m. Refer to a telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m. Refer to a confidential telephone interview. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. Refer to a review of the facility's "Medication Pre-Pouring 6.1" policy (not dated). Refer to a review of a copy of the "Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18 4. Review of Resident #4's FL-2 dated 04/04/17 revealed: -Diagnoses included Alzheimer's disease/dementia, chronic anemia, hypothyroidism, hyperlipidemia, chronic pain. -There were physician's orders which included Aspirin (used as a blood thinner) one time daily, Folic Acid (a vitamin used to treat anemia) 2 tablets one time daily, Synthroid (used to treat hypothyroidism) 75 mcg one time daily, Omeprazole (used to decrease the acid in the stomach) 20 mg one time daily, Vitamin B12 1000mg (used as a vitamin supplement) one time daily, Mag Oxide (a mineral supplement) 400mg twice daily. Oxycodone/APAP (a scheduled II narcotic used to treat moderately severe pain) 5/325mg every 12 hours, Atarax (used for	C 335		

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anxiety, allergies and itching) 25mg one tablet at bedtime, Ativan (used for anxiety) 0.5 mg one tablet at bedtime, Risperdal (used to treat certain mental/mood disorders) 1mg one tablet at bedtime, Zocor (used to treat high cholesterol) 20mg one tablet daily.

Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed:
-There were 2 medications cups filled with medications.
-One of the medication cups was stored in the "PM" section and one medication cup was stored in the "AM" section.
-The medication cup stored in the "PM" section contained one white, oblong shaped, scored tablet, a second white, oblong shaped tablet, one white, small, round tablet, a slightly larger second white, round tablet, a third white, larger round tablet and one mauve colored tablet.

Interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m. revealed the divided section containing medications stored in medications cups that was not labeled with a name was Resident #4's pre-filled medications.

Observation of Resident #4's medications on hand revealed:
-Resident #4's Oxycodone/APAP 5mg/325mg tablets were white, oblong shaped and the tablets were scored.
-Resident #4's Ativan 0.5mg tablets were white, small, round tablets.

Review of Resident #4's March 2018 medication administration record (MAR) revealed:
-The resident was scheduled to receive six medications that included Oxycodone/APAP

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5/325mg one tablet; Hydroxyzine 25 mg, one tablet; Ativan 0.5 mg, one tablet; Risperidone 1mg, one tablet; Zocor 20mg, one tablet; and Magnesium Oxide 400mg, one tablet.

Refer to an interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m.

Refer to a second interview with the PCA/MA on 02/28/18 at 5:03 p.m.

Refer to an interview with the Administrator on 02/28/18 at 5:54 p.m.

Refer to an interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m.

Refer to a telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m.

Refer to a confidential telephone interview.

Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m.

Refer to a review of the facility's "Medication Pre-Pouring 6.1" policy (not dated).

Refer to a review of a copy of the "Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18

5. Review of Resident #5's FL-2 dated 10/25/17 revealed:
-Diagnoses included hypertension, memory loss, low back pain, gastroesophageal reflux disease, constipation, hiatal hernia, generalized osteoarthritis and vitamin D deficiency.
-There were physician's orders which included

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA COTTAGE CARE BLDG #1	5643 HWY 70 DOVER, NC 28526

(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
C 335	Continued From page 27 Aspirin (used as a blood thinner) 81mg one time daily and Multivitamin (a supplemental vitamin) one time daily. Review of subsequent physician's orders for Resident #5 revealed: -There was an order dated 10/25/17 for Trazodone (used to treat insomnia and depression) 50mg one time daily at bedtime. -There was an order dated 10/25/17 for Aricept (used to treat cognition) 5mg one time daily and an additional order dated 11/27/17 to increase Aricept to 10 mg one time daily. -There was an order dated 02/21/18 for Zoloft (used to treat depression and other mental disorders) 50mg start with 25mg one time daily time 7 days, then increase to 50 mg daily. Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed: -There were 3 separate medications cups filled with various medications. -Two of the medication cups were stored in the "PM" section with one of the cups stacked on top of a second medication cup and the other medication cup was stored in the "AM" section. -There was a middle section labeled with "12PM". Refer to an interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the PCA/MA on 02/28/18 at 5:03 p.m. Refer to an interview with the Administrator on 02/28/18 at 5:54 p.m. Refer to an interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m.	C 335		

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C 335	Continued From page 28 Refer to a telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m. Refer to a confidential telephone interview.. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. Refer to a review of the facility's "Medication Pre-Pouring 6.1" policy (not dated). Refer to a review of a copy of the "Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18 6. Review of Resident #6's FL-2 dated 11/13/17 revealed: -Diagnosis included interstitial lung disease, lymphedema, and chronic kidney disease, stage III. -There was an order for Lasix (used as a diuretic) 40mg 1 ½ tablet one time daily. -There was an order for Klor-con (used as a potassium supplement) 40meq one tablet every Monday and Thursday. Review of Resident #6's February 2018 medication administration record (MAR) revealed: -There were 2 additional medications not listed on the FL-2 dated 11/13/17. -There was a computer generated entry for Omeprazole (used to treat gastrointestinal disorders) 20mg one daily every morning time 30 days with a handwritten stop date of 03/09/18. -There was a handwritten entry for Prednisone (used to treat inflammation) 20mg one time daily with a start date of 02/10/18. Observation of the medication cart's top drawer	C 335		

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C 335	Continued From page 29 on 02/28/18 at 11:45 a.m. revealed there was one medication cup filled with various medications stored in the "AM" section along with nasal spray and an inhaler. Refer to an interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the PCA/MA on 02/28/18 at 5:03 p.m. Refer to an interview with the Administrator on 02/28/18 at 5:54 p.m. Refer to an interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m. Refer to a telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m. Refer to a confidential telephone interview. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. Refer to a review of the facility's "Medication Pre-Pouring 6.1" policy (not dated). Refer to a review of a copy of the "Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18 _____ Interview with the Personal Care Aide/Medication Aide (PCA/MA) on 02/28/18 at 11:45 a.m. revealed: -She did not place the medications in the medication cups in the divided top drawer of the medication cart. -The staff member that worked last night	C 335		

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C 335	Continued From page 30 (02/17/18) pre-poured the medication in advance. A second interview with the PCA/MA on 02/28/18 at 5:03 p.m. revealed: -Routinely scheduled medications were allowed to be pre-poured in advance for each staff's shift. -She could not answer why the medications observed on 02/28/18 at 11:45 a.m. were pre-poured by the night shift staff. Interview with the Administrator on 02/28/18 at 5:54 p.m. revealed: -She was not aware that medications pre-poured in advance had to be in a sealed package and labeled with the name and strength of each medication prepared, planned administration time and with the resident's name. -The facility had a policy for pre-pouring medications. Interview with the facility's Licensed Practical Nurse (LPN) on 03/01/18 at 3:10 p.m. revealed: -They were under the "impression" the residents' medication could be pre-poured in advance in an area labeled with the residents' name only. -One of the divided sections in the top drawer of the medication cart with no labeled name did have a labeled name at one time, however, the labeled name had faded. -She and the Administrator had observed staff perform random medication passes and no issues had observed. Telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m. revealed they were not supposed to pre-pour any medication in advance and she had discussed this with the Administrator and the facility nurse this past weekend.	C 335		

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C 335	Continued From page 31 Confidential telephone interview revealed: -Pre-pouring medications was routinely done. -The person (confidential interview) thought the reason pre-pouring of medications in advance was done was because some staff, especially night staff, were not MAs. Interview with the Administrator on 03/05/18 at 2:25 p.m. revealed: -It had been acceptable for staff to pre-pour medications for the staffs' 12 hour shift prior to 02/28/18. -Staff were never supposed to pre-pour more medication in advance than what they would administer during their shift. -Staff were not permitted to pre-fill any of the residents' controlled medications in advance. -Scheduled controlled medications should have been removed from the packaging at the time the medication was scheduled and was not supposed to have "ever" been pre-poured in advance. Review of the facility's "Medication Pre-Pouring 6.1" policy (not dated) revealed: -It shall be the rule of the facility to allow medications that were routine oral medications to be pre-poured at the beginning of the 12 hour shift. -Exception: medications that were PRN (as needed), controlled, or liquid/powder were poured prior to the actual administration and not in advance. -Pre-poured medications would be stored in the residents' individually labeled cube and locked on the medication cart. Review of a copy of the Medication Pre-Pouring 6.1" policy with a revised date on 03/02/18 revealed: -There was one handwritten line drawn over the	C 335		

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C 335	Continued From page 32 labeled name of the policy "Medication Pre-Pouring 6.1" and one line was drawn over "It shall be the rule of the facility to allow medications that are". -There was a handwritten entry "No pre-poured medications allowed" with the Administrator's initials circled below the handwritten entry. _____ The facility's failure to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 6 of 6 sampled residents (#1, #2, #3, #4, #5, #6) including high risk medications such as a controlled pain narcotic, a controlled sedative, a schedule II controlled narcotic and anticoagulants was detrimental to the health, safety and welfare of all six residents in the facility, which constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 03/02/18 revealed: -On 02/28/18, pre-poured medications were destroyed by placing them in "kitty litter" and water and disposed of in the trash. Consulted the facility's contracted provider (named). -All shifts/staff were notified not to pre-pour medications. -In-service provided with shift rotation. -On 03/02/18 all training regarding no pre-poured medications done by the Administrator. -All staff would be in-serviced on all shifts. -Additional training would be provided with the facility's consultant Registered Nurse (RN) and the facility's contracted pharmacy provider (named). Both parties had been notified and in-service training materials had been provided. -Staff to review medication record reviews daily for any changes and to provide continuity. -Staff would receive a formal write-up for any	C 335		

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C 335	Continued From page 33 noted violation. -On 03/01/18, the facility's contracted pharmacy nurse was consulted and notified. -On 03/01/18, the facility's contacted RN was notified. -On 03/01/18, an in-service was provided THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2018.	C 335		
C 340	10A NCAC 13G .1004 (h) Medication Administration 10A NCAC 13G .1004 Medication Administration (h) If medications are not prepared and administered by the same staff person, there shall be documentation for each dose of medication prepared for administration by the staff person who prepared the medications when or at the time the resident's medication is prepared. Procedures shall be established and implemented to identify the staff person who prepared the medication and the staff person who administered the medication. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure procedures were established and implemented to identify the staff person who prepared medications in advance and the staff person who administered the medications for 6 of 6 residents (#1, #2, #3, #4, #5, #6). The findings are:	C 340		

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C 340	Continued From page 34 Observation of the facility's medication storage closet on 02/28/18 at 11:45 a.m. revealed: -The top drawer of the medication cart was partially opened and was sectioned off with dividers. -In each divided section there were medication cups filled with medications including tablets, capsules, caplets, and gel-caps in various shapes, colors and sizes. -One of the divided sections contained medication cups that were stacked over a second medication cup filled with medications. -There were five divided sections with handwritten labels which included the residents' first name on various types of adherent type paper and tape and one divided section that was not labeled with a resident's name. -All six of the divided sections contained various types of tape with handwritten labels for the the top of each section "PM" and the lower section "AM". There was one divided section that had an additional labeled middle section "12p". Review of the facility's "Medication Pre-Pouring 6.1" policy (not dated) revealed it shall be the rule of the facility to allow medications that were routine oral medications to be pre-poured at the beginning of the 12 hour shift. 1. Review of Resident #1's current FL-2 dated 02/22/18 revealed: -Diagnoses included senile dementia, hyperlipidemia, hypertension, gastro esophageal reflux disease, and coronary artery disease. -There were physician's orders which included Atorvastatin (used treat high cholesterol) 20 mg one time daily, Plavix (an anticoagulant) 75mg one time daily, Tricor 48mg (used to treat high cholesterol) one daily, Fish Oil (used to treat	C 340		

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inflammation and lower cholesterol levels) 1,000mg 2 tablets twice a day, Isosorbide Mononitrate Extended Release (used to treat chest pains by dilating the blood vessels in a tablet form that keeps the medicine at a steady level in the body for longer periods of time) 30mg ½ tablet one time daily, Metoprolol (used to treat blood pressure, chest pain and heart failure) 25mg one twice a day, Protonix (used to decrease acid in the stomach) 40mg one time daily, Ramipril (used to treat high blood pressure and heart failure) one time daily, Tramadol (a narcotic used to treat moderate to severe pain) 37.5/325mg one twice a day, and Vitamin D (a supplemental vitamin) 2000IU one time daily.

Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed:
-There were 3 separate medications cups filled with various medications.
-Two medication cups were stored in the "PM" section and one in the "AM" section.

Review of Resident #1's January 2018 medication administration record (MAR) and controlled drug record (CDR) (not dated) revealed:
-There was a handwritten entry on the MAR for Tramadol 37.5/325mg one tablet twice daily to be administered at 8:00 a.m. and 8:00 p.m.
-There was documentation on the resident's CDR that Staff C administered one tablet of Tramadol 37.5/325mg at 7:00 p.m. and the MAR had documentation Staff D administered Tramadol 37.5/325mg at 8:00 p.m. two times on 01/23/18 and 01/26/18.
-There was documentation on the resident's CDR that Staff C administered one tablet of Tramadol 375/325mg at 7:00 a.m. and MAR had documentation Staff A administered Tramadol

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375/325mg at 8:00 a.m. on 01/24/18.
-There was documentation on the resident's CDR that Staff A administered one tablet of Tramadol 37.5/325mg at 7:00 a.m. and the MAR had documentation Staff D administered Tramadol 37.5/325mg at 8:00 a.m. on 01/31/18.
-There was no documentation on the MARs or on the CDR to indicate one staff person prepared the medications in advance while a different staff administered the medication to the resident.

Review of Resident #1's February 2018 MAR and CDR record (not dated) revealed:
-There was a handwritten entry on the MAR for Tramadol 37.5/325mg one tablet twice daily to be administered at 8:00 a.m. and 8:00 p.m.
-There was documentation on the resident's CDR that Staff C administered one tablet of Tramadol 37.5/325mg at 7:00 a.m. and the MAR had documentation Staff A administered Tramadol at 8:00 a.m. five times on 02/02/18, 02/03/18, 02/08/18, 02/13/18 and 02/18/18.
-There was documentation on the resident's CDR that Staff C administered one tablet of Tramadol 37.5/325mg at 7:00 p.m. and the MAR had documentation Staff A administered Tramadol at 8:00 p.m. six times on 02/02/18, 02/03/18, 02/08/18, 02/12/18, 02/13/18, 02/17/18.
-There was documentation on the resident's CDR that Staff A administered one tablet of Tramadol 37.5/325mg at 7:00 a.m. and the MAR had documentation Staff D administered Tramadol at 8:00 a.m. five times on 02/04/18, 02/06/18, 02/07/18, 02/25/18 and 02/26/18.
-There was documentation on the resident's CDR that Staff A administered one tablet of Tramadol 37.5/325mg at 7:00 a.m. and the MAR had documentation Staff C administered Tramadol at 8:00 a.m. six times on 02/05/18, 02/09/18, 02/10/18, 02/14/18, 02/15/18 and 02/19/18.

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C 340	Continued From page 37 -There was documentation on the resident's CDR that Staff A administered one tablet of Tramadol 37.5/325mg at 7:00 p.m. and the MAR had documentation Staff C administered Tramadol at 8:00 p.m. six times on 02/05/18, 02/06/18, 02/09/18, 02/11/19, 02/14/18 and 02/19/18. -There was documentation on the resident's CDR that Staff C administered one tablet of Tramadol 37.5/325mg at 7:00 a.m. and the MAR had documentation Staff D administered Tramadol at 8:00 a.m. two times on 02/16/18 and 02/21/18. -There was no documentation on the MARs to indicate one staff person prepared the medications in advance while a different staff administered the medication to the resident. Based on record review, observations and an attempted interview with Resident #1 revealed the resident was not interviewable. Refer to the interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the Staff C on 02/28/18 at 5:03 p.m. Refer to the confidential telephone interview. Refer to a interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m. Refer to a telephone interview with Staff D on 03/01/18 at 8:45 p.m. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. 2. Review of Resident #2's current FL-2 dated 02/23/18 revealed:	C 340		

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C 340	Continued From page 38 -Diagnoses included dementia and diabetes type 2 with hyperglycemia. -There were physician's orders which included Allegra (used for hay fever skin hives and itching) 180 mg one time daily, Metformin (used to lower blood sugar) 500mg one time daily, Namenda (used to treat dementia) 28mg one time daily, Remeron (used to treat depression) 30mg one time daily before bedtime, and Seroquel (used to treat schizophrenia, bipolar disorders, and depression) 25mg one time daily at bedtime. Record review for Resident #2 revealed: -There was an FL-2 dated 07/17/17 with a physician's order for Risperidone (used to treat certain mental/mood disorders) 1 mg one time daily at bedtime -There was a physician order dated 02/28/18 to discontinue Risperidone 1 mg daily at bedtime. Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed: -There were 2 separate medications cups filled with various medications. -One medication cup was stored in the "PM" section and the other medication cup was stored in the "AM" section. Refer to the interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the Staff C on 02/28/18 at 5:03 p.m. Refer to the confidential telephone interview. Refer to a interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m.	C 340		

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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
C 340	Continued From page 39 Refer to a telephone interview with Staff D on 03/01/18 at 8:45 p.m. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. 3. Review of Resident #3's current FL-2 dated 01/15/18 revealed: -Diagnoses included deep vein thrombosis bilateral lower limbs, hypertension, edema, and hypersensitivity lung disease. -There physician's orders which included Eliquis (an anticoagulant) 2.5mg one twice daily, Carvedilol (used to treat high blood pressure and heart failure) 12.5mg one time daily, Lasix (used to treat fluid retention) 20 mg, 2 tablets one time daily, Klor-Con (used to treat low potassium) 20meq one time daily, Zocor (used to treat high cholesterol) 40mg one time daily. Review of subsequent physician's orders for Resident #3 revealed: -There was an order dated 01/15/18 for Aricept 5mg at bedtime and to start Ativan (used to treat anxiety) 0.5 mg twice daily as needed. -There was an order dated 01/16/18 to start Vitamin D2 50,000 (used to treat decreased functioning of the parathyroid, softening of the bones and low levels of phosphate) one daily for 16 weeks. -There was an order dated 02/19/18 to start Seroquel (used to treat mood/mental disorders) 25mg at bedtime and a subsequent order dated 02/27/18 to increase Seroquel to 50 mg at bedtime. -There was an order dated 02/19/18 to decrease Carvedilol to 6.25mg twice. Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed:	C 340		

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C 340	Continued From page 40 -There were 2 separate medications cups filled with various medications. -One medication cup was stored in the "PM" section and was stored in a second medication cup with medications and the other medication cup was stored in the "AM" section. Refer to the interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the Staff C on 02/28/18 at 5:03 p.m. Refer to the confidential telephone interview. Refer to a interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m. Refer to a telephone interview with Staff D on 03/01/18 at 8:45 p.m. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. 4. Review of Resident #4's FL-2 dated 04/04/17 revealed: -Diagnoses included Alzheimer's disease/dementia, chronic anemia, hypothyroidism, hyperlipidemia, chronic pain. -There were physician's orders which included Aspirin (used as a blood thinner) one time daily, Folic Acid (a vitamin used to treat anemia) 2 tablets one time daily, Synthroid (used to treat hypothyroidism) 75 mcg one time daily, Omeprazole (used to decrease the acid in the stomach) 20 mg one time daily, Vitamin B12 1000mg (used as a vitamin supplement) one time daily, Mag Oxide (a mineral supplement) 400mg twice daily. Oxycodone/APAP (a scheduled II	C 340		

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narcotic used to treat moderately severe pain) 5/325mg every 12 hours, Atarax (used for anxiety, allergies and itching) 25mg one tablet at bedtime, Ativan (used for anxiety) 0.5 mg one tablet at bedtime, Risperdal (used to treat certain mental/mood disorders) 1mg one tablet at bedtime, Zocor (used to treat high cholesterol) 20mg one tablet daily.

Observation of the medication cart's stop drawer on 02/28/18 at 11:45 a.m. revealed:
-There were two separate medication cups filled with various medications.
-One of the medication cups was in the "PM" section and was stored in a second medication cup and the other medication cup was stored in the "AM" section.

Refer to the interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m.

Refer to a second interview with the Staff C on 02/28/18 at 5:03 p.m.

Refer to the confidential telephone interview.

Refer to a interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m.

Refer to a telephone interview with Staff D on 03/01/18 at 8:45 p.m.

Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m.

5. Review of Resident #5's FL-2 dated 10/25/17 revealed:
-Diagnoses included hypertension, memory loss, low back pain, gastro esophageal reflux disease,

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constipation, hiatal hernia, generalized osteoarthritis and vitamin D deficiency.
-There were physician's orders which included Aspirin (used as a blood thinner) 81mg one time daily and Multivitamin (a supplemental vitamin) one time daily.

Review of subsequent physician's orders for Resident #5 revealed:
-There was an order dated 10/25/17 for Trazodone (used to treat insomnia and depression) 50mg one time daily at bedtime.
-There was an order dated 10/25/17 for Aricept (used to treat cognition) 5mg one time daily and an additional order dated 11/27/17 to increase Aricept to 10 mg one time daily.
-There was an order dated 02/21/18 for Zoloft (used to treat depression and other mental disorders) 50mg start with 25mg one time daily time 7 days, then increase to 50 mg daily.

Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed:
-There were 3 medications cups filled with various medications.
-Two of the medication cups were stored in the "PM" section with one of the cups stacked on top of a second medication cup and the other medication cup was stored in the "AM" section.
-There was a middle section labeled with "12PM".

Review of Resident #5's January and February 2018 medication administration record (MAR) revealed the resident took medications twice daily at 8:00 a.m. and 8:00 p.m.

Refer to the interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m.

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C 340	Continued From page 43 Refer to a second interview with the Staff C on 02/28/18 at 5:03 p.m. Refer to the confidential telephone interview. Refer to a interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m. Refer to a telephone interview with Staff D on 03/01/18 at 8:45 p.m. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. 6. Review of Resident #6's FL-2 dated 11/13/17 revealed: -Diagnosis included interstitial lung disease, lymphedema, and chronic kidney disease, stage III. -There was an order for Lasix (used as a diuretic) 40mg 1 ½ tablet one time daily. -There was an order for Klor-con (used as a potassium supplement) 40meq one tablet every Monday and Thursday. Review of Resident #6's February 2018 medication administration record (MAR) revealed: -There were 2 additional medications not listed on the FL-2 dated 11/13/17. -There was a computer generated entry for Omeprazole (used to treat gastrointestinal disorders) 20mg one daily every morning time 30 days with a handwritten stop date of 03/09/18. -There was a handwritten entry for Prednisone (used to treat inflammation) 20mg one time daily with a start date of 02/10/18. Observation of the medication cart's top drawer on 02/28/18 at 11:45 a.m. revealed there was one medication cup filled with various medications	C 340		

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C 340	Continued From page 44 stored in the "AM" section and there was a nasal spray and an inhaler in the upper section. Refer to the interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m. Refer to a second interview with the Staff C on 02/28/18 at 5:03 p.m. Refer to the confidential telephone interview. Refer to a interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m. Refer to a telephone interview with Staff D on 03/01/18 at 8:45 p.m. Refer to an interview with the Administrator on 03/05/18 at 2:25 p.m. Interview with the Staff C (Personal Care Aide/Medication Aide) (PCA/MA) on 02/28/18 at 11:45 a.m. revealed: -The medications in the medication cups would be given to the residents today during her shift. -She did not prepare the medications in the medication cups in the divided top drawer of the medication cart. -The staff member that worked last night (02/27/18) pre-poured the medication in advance. A second interview with the Staff C on 02/28/18 at 5:03 p.m. revealed: -Routinely scheduled medications were allowed to be pre-poured in advance for each staff's shift. -She did not answer why the medications observed on 02/28/18 at 11:45 a.m. were pre-poured by the night shift staff for her to administer today (02/28/18).	C 340		

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C 340	Continued From page 45 Confidential telephone interview revealed the residents' medications were signed off by a staff member, however, a lot of times those medications were not administered by the same staff that had prepared the medication. Interview with Staff A (PCA/MA) on 03/01/18 at 5:15 p.m. revealed: -When she arrived for her shift, there were times that the night shift had the "am" medications prepared and ready to administer in a medication cup for the next shift. -She compared the medication administration record (MAR), the "bubble pack" of each medication with the prepared medications in the medication cups before she administered the medication prepared by other staff. -She could remember what some of the residents' medications looked like because the residents' at the facility did not have a lot of medications to take. -She documented her initials when she administered medications prepared by another staff. Telephone interview with Staff D on 03/01/18 at 8:45 p.m. revealed: -She had never given medication prepared by another staff and had never seen and pre-poured medications in the medication cart. -She knew medications should not have been prepared in advance and given by another staff. -She had never heard of this occurring at the facility until today (03/01/18). Interview with the Administrator on 03/05/18 at 2:25 p.m. revealed: -Staff were expected to administer what they prepared only.	C 340		

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C 340	Continued From page 46 -She was not aware until the last few days that staff were preparing medications in advance beyond their 12 hour shift.	C 340		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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, interviews, and record reviews, the facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and reconciled for 2 of 2 residents sampled (#1, #4) who were prescribed controlled substances including a pain medication used to treat moderate to severe pain (#1), a medication used to treat anxiety and a medication used to treat moderately severe pain (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 02/22/18 revealed: -Diagnoses included senile dementia, hyperlipidemia, hypertension, gastroesophageal reflux disease, and coronary artery disease. -There was an order for Tramadol (a narcotic used to treat moderate to severe pain) 37.5/325mg one twice a day.	C 367		

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C 367	Continued From page 47 Review of Resident #1's January 2018 medication administration record (MAR) revealed: -There was a handwritten entry for Tramadol 37.5/325mg one twice daily scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Tramadol 37.5/325 mg was administered at 8:00 a.m. and 8:00 p.m. from 01/23/18 at 8:00 p.m. through 01/31/18 at 8:00 p.m. Review of Resident #1's February 2018 MAR revealed: -There was a handwritten entry for Tramadol 37.5/325mg one twice daily scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Tramadol 37.5/325 mg was administered at 8:00 a.m. and 8:00 p.m. from 02/01/18 through 02/28/18. Review of Resident #1's March 2018 MAR revealed: -There was a handwritten entry for Tramadol 37.5/325mg one twice daily scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Tramadol 37.5/325 mg was administered at 8:00 a.m. and 8:00 p.m. on 03/01/18 through 03/02/18. Review of Resident #1's controlled drug record (CDR) with a handwritten prescription label (not dated) for Tramadol/APAP 37.5/325mg revealed: -Resident #1's name was not documented on the CDR. -There were handwritten instructions with documentation to give one tablet by mouth twice a day. -"Home supply" was handwritten under the instructions. -There was a documented entry of "20" that was	C 367		

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C 367	Continued From page 48 circled with one line drawn through the entry and an unreadable entry below. -There was a second handwritten entry of "29" that was circled and "2 bottles" documented on the left side of the CDR. -There was a documented entry of "30" entered into the amount received section on the right side of the CDR. -There was no date for the quantity of the tablets received and no totaled number of the tablets received. -There was documentation under the section of the CDR "Administered By" that included a signature of the Personal Care Aides/Medication Aides (PCAs/MAs), dates, times documented as administered at 7:00 a.m. and 7:00 p.m., one was the amount documented as given with each entry, and amount remaining was documented from 01/23/18 - 02/20/18. -On 02/21/18, at 7:00 a.m. there was an entry "dropped" written in the section provided for a signature, and "1" was documented in the amount given section, "1" was documented in the amount remaining section and there was no signature for the entry. -There was a second entry on 02/21/18 at 7:00 a.m. with a PCA/MA's signature, "1" was documented in the amount given section and "0" in the amount remaining section. -The back of the CDR did not have a pre-printed section for documentation and was blank. Review of Resident #1's CDR for Tramadol/APAP 37.5/325mg dated 02/20/18 revealed: -There was a folded CDR dated 02/20/18 stored with the medication that had no entries. -There was a second CDR log dated 02/20/18 with documentation Tramadol/APAP 37.5/325mg had been administered from 02/21/18 through 03/02/18 with a quantity of 38 tablets remaining.	C 367		

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C 367	Continued From page 49 Observation of medications on hand for Resident #2 revealed there were 56 Tramadol/APAP 37.5/325mg tablets dispensed on 02/20/18 with 38 tablets remaining. Review of Resident #1's dispensing records from the facility's contracted pharmacy provider revealed Tramadol 37.5/325mg was dispensed on 02/20/18 with a quantity of 56 tablets. Telephone interview with Resident #1's family member on 03/05/18 at 9:15 p.m. revealed: -The family member was present the day the resident was admitted on 01/23/18 to the facility and provided all of the resident's medications from home. -The family member remembered there was only one bottle of Tramadol 37.5/325mg and estimated the resident had approximately "4 weeks' worth" of medication remaining in the bottle, however, was not sure of an exact number of the tablets that remained. -The resident's labeled frequency instructions for Tramadol 37.5/325mg when she was admitted was for three times daily, however, the frequency had decreased to twice daily prior to the resident being admitted to the facility. -The family member remembered the Administrator was the only one present during the resident's admission. -The family member did not witness anyone counting any of the resident's medication and did not remember signing anything for the amount of medications including Tramadol 37.5/325mg received. Telephone interview with Resident #1's previous pharmacy provider on 03/06/18 at 10:12 a.m. revealed the resident's Tramadol 37.5/325mg	C 367		

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was dispensed on 12/05/18 with a quantity of 120 tablets with directions to take the medication three times daily.

Interview with Personal Care Aide/Medication Aide (PCA/MA) on 03/06/18 at 12:28 p.m. revealed:
-She remembered when Resident #1 was admitted to the facility she took her medications she had brought from home.
-The entry on 02/21/18 that documented "dropped" at 7:00 a.m. was her documentation.
-She could not remember any specific information about the entry except the medication must have been dropped on the floor and she disposed of the tablet by placing the tablet in the sink and flushing the tablet down drain by turning the water on.
-She had been told by the Administrator to call her if a controlled medication was wasted and to waste the tablet by disposing of it in the sink.
-She was not sure if the facility had a policy on disposing or wasting of medications.
-She had never been told that controlled medication had to be witnessed by another staff or the Administrator.

A telephone interview with a second PCA/MA on 03/05/18 at 7:30 a.m. was unsuccessful.

Interview with the facility's Licensed Practical Nurse (LPN) on 03/02/18 at 4:43 p.m. revealed:
-The facility's contracted pharmacy sent extra CDRs "a lot of times".
-She remembered verifying Resident #1's Tramadol 37.5/325mg tablets by counting the tablets with the Administrator the day the resident was admitted.
-There were two bottles of Tramadol 37.5/325mg with one bottle having 29 tablets and the other

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C 367	Continued From page 51 containing 30 tablets. Interview with a Pharmacist Technician with the contracted pharmacy provider on 03/06/18 at 2:15 p.m. revealed the pharmacy did not routinely send extra resident CDRs, however, would send extra CDRs if the facility requested. Interview with the Administrator on 03/05/18 at 2:25 p.m. revealed: -Resident #1 was the first resident she had ever admitted that came in with controlled medications. -She and the facility's LPN counted Resident #1's Tramadol 37.5/325mg tablets the day the resident was admitted. -She did not verify the count of Tramadol 37.5/325mg tablets with the family member or have the family member sign any documents regarding the amount of Tramadol tablets that were taken into the facility for Resident #1 to use. -Staff were expected to call her or the facility LPN for wasting/dropping any controlled medications and to document the medication was wasted on the back of the CDR. -She could not remember if she observed the PCA/MA waste one of Resident #1's Tramadol on 02/21/18. -She was aware that there should be a process in place to provide an accurate reconciliation of controlled medications when released to the facility from a family member for the resident's use. A second interview with the Administrator on 03/06/18 at 1:48 p.m. revealed: -Staff had been trained to notify her or the facility's LPN when a controlled medication needed to be wasted. -She was sure that her expectations of witnessing	C 367		

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MAGNOLIA COTTAGE CARE BLDG #1	5643 HWY 70 DOVER, NC 28526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the wasting of controlled medications had "come up" during in-services, however, she could not say for sure if staff had notified her "every single time" a controlled medication was wasted.
-She expected staff to count controlled medications together at the change of shifts, however, she was unsure how consistent staff were about doing that.

2. Review of Resident #4's FL-2 dated 04/04/17 revealed:
-Diagnoses included Alzheimer's disease/dementia, chronic anemia, hypothyroidism, hyperlipidemia, chronic pain.
-There were orders for Oxycodone/APAP (a scheduled II narcotic used to treat moderately severe pain).
-There were orders for Ativan (used for anxiety) 0.5 mg one tablet at bedtime.

a. Observation of Resident #4's medications on hand revealed there were 27 tablets of Ativan 0.5mg dispensed on 02/22/18 with a quantity of 27 tablets remaining.

Review of Resident #4's control drug record CDR for Ativan 0.5mg one tablet at bedtime revealed a folded CDR with a dispensed date of 02/22/18 with a quantity of 27 tablets stored with the medication that had no entries.

Review of Resident #4's December 2018 MAR revealed:
-There was an entry for Ativan 0.5mg one daily at bedtime scheduled for administration at 8:00 p.m.
-There was documentation Ativan was administered from 12/01/17 - 12/31/17.

Review of Resident #4's CDR dated 10/25/17 for Ativan 0.5mg one tablet at bedtime revealed:

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C 367	Continued From page 53 -The dispensed prescription label was for a quantity of 31 tablets. -There was documentation the Ativan was administered at 8:00 p.m. from 12/01/17 through 12/31/17 with no tablets remaining. Review of Resident #4's January 2018 MAR revealed: -There was an entry for Ativan 0.5mg one daily at bedtime scheduled for administration at 8:00 p.m. -There was documentation Ativan was administered from 01/01/18 - 01/31/18. Review of Resident #4's CDR dated 12/25/17 for Ativan 0.5mg one tablet at bedtime revealed: -The dispensed prescription label was for a quantity of 31 tablets. -There was documentation the Ativan was administered at 8:00 p.m. from 01/01/18 with the last entry on 01/31/18 with no tablets remaining. Review of Resident #4's February 2018 MAR revealed: -There was an entry for Ativan 0.5mg one daily at bedtime scheduled for administration at 8:00 p.m. -There was documentation Ativan was administered from 02/01/18 - 02/28/18. Review of Resident #4's March 2018 MAR revealed: -There was an entry for Ativan 0.5mg one daily at bedtime scheduled for administration at 8:00 p.m. -There was documentation Ativan was administered on 03/01/18 at 8:00 p.m. Review of Resident #4's CDR dated 11/25/17 for Ativan 0.5mg one tablet at bedtime revealed: -The dispensed prescription label was for a quantity of 30 tablets. -There was documentation Ativan was	C 367		

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C 367	Continued From page 54 administered with signatures of the Personal Care Aide/Medication Aides (PCA/MAs), the dates and time administered, documentation of the amount given and the amount of medication remaining from 02/01/18 - 03/01/18 at 8:00 p.m. with no tablets remaining. -There was an entry that covered 2 entry spaces not dated between 02/27/18 and 02/28/18 with documentation on the first entry space that included a PCA/MAs signature, "dropped "with an unreadable entry that had been written over in the time administered section, a "1" entered in the amount given section and a "2" in the amount remaining section with both numbers marked through with 2 straight lines. The entry space below had "2/2" in the date section with multiple lines marked through the entry, a "1" in the amount given section with one line marked through the entry and a "2" in the amount remaining section. The entry above dated 02/27/18 at 8:00 p.m. had an entry of "3" in the amount remaining. -There was no documentation on the back of the CDR. Review of Resident #4's dispensing records from the facility's contracted pharmacy provider revealed: -There was a copy of a prescription dated 10/13/17 for Ativan 0.5mg tablets, take one at bedtime for sleep with five authorized refills with a quantity of 30 tablets. -A batch history with a dispensed date on 02/15/18, 01/18/18, 12/17/17, 11/17/17, 10/18/17, and 10/17/18 for Ativan 0.5 mg. Review of Resident #4's CDRs revealed there was no CDR for the Ativan 0.5 mg tablets dispensed on 01/18/18 available.	C 367		

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C 367	Continued From page 55 Interview with the facility's Licensed Practical Nurse (LPN) on 03/02/18 at 5:21 p.m. revealed all of Resident #4's MARS from December 2017 and the previous months had been shredded. Interview with Personal Care Aide/Medication Aide (PCA/MA) on 03/06/18 at 12:28 p.m. revealed: -The two entry spaces not dated between 02/27/18 and 02/28/18 with "dropped" was her documentation. -She could not remember any specific information about the entry except the medication must have been dropped on the floor and she disposed of the tablet by placing the tablet in the sink and flushing the tablet down drain by turning the water on. -She had been told by the Administrator to call her if a controlled medication was wasted and to waste the tablet by disposing of it in the sink. -She was not sure if the facility had a policy on disposing or wasting of medications. -She had never been told that controlled medication had to be witnessed by another staff or the Administrator. -Staff performed control counts together at change of shift. A telephone interview with a second PCA/MA on 03/05/18 at 7:30 a.m. was unsuccessful. Telephone interview with the contracted LHPS nurse on 03/06/18 at 3:34 p.m. revealed she did not know that facility only kept three months of resident MARS and CDRs but there was only so much paperwork that could be stored at smaller facilities. Interview with the Administrator on 03/05/18 at 2:25 p.m. revealed:	C 367		

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C 367	Continued From page 56 -Staff were expected to call her or the facility's LPN for wasting/dropping any controlled medications and to document the medication was wasted on the back of the CDR. -She could not remember if she observed the PCA/MA waste one of Resident #4's Ativan around 02/27/18 or 02/28/18. A second interview with the Administrator on 03/06/18 at 1:48 p.m. revealed: -Staff had been trained to notify her or the facility's LPN when a controlled medication needed to be wasted. -She was sure that her expectations of witnessing the wasting of controlled medications had "come up" during in-services, however, she could not say for sure if staff had notified her "every single time" a controlled medication was wasted. -She expected staff to count controlled medications together at the change of shifts, however, she was unsure how consistent staff were about doing that. -She kept the resident "records", however, only kept 3 months of the residents' MARS and CDRs. -She thought 3 months of the residents' MARS and CDRs was all that was needed. Telephone interview with the facility's contracted pharmacy provider on 03/06/18 at 2:19 p.m. revealed it was important to keep residents' MARS and CDRs in order to provide an accurate account of the controlled medications that had been dispensed and administered to the residents. b. Observation of Resident #4's medications on hand revealed there were 60 tablets of Oxycodone/APAP 5-325mg dispensed on 02/06/16 with a quantity of 12 tablets remaining.	C 367		

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C 367	Continued From page 57 Review of Resident #4's December 2017 MAR revealed: -There was computer generated entry for Oxycodone/APAP 5-325mg take one every 12 hours scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Oxycodone/APAP 5-325mg was administered from 12/01/17 - 12/31/18. Review of Resident #4's control drug record CDR for Oxycodone/APAP 5-325 mg one tablet every 12 hours with a dispensed date of 11/03/18 revealed: -There was a quantity of 60 tablets. -There was documentation the Oxycodone/APAP 5-325mg tablet had been administered from 11/06/17 through 12/05/17 at 8:00 p.m. with no tablets remaining. Review of Resident #4's CDR for Oxycodone/APAP 5-325 mg one tablet every 12 hours with a dispensed date of 12/01/18 revealed: -There was a quantity of 60 tablets. -There was documentation Oxycodone/APAP 5-325mg tablet had been administered from 12/06/18 through 01/04/18 at 8:00 p.m. with no tablets remaining. Review of Resident #4's January 2018 MAR revealed: -There was a computer generated entry for Oxycodone/APAP 5-325mg take one every 12 hours scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Oxycodone/APAP 5-325mg was administered from 01/01/18 - 01/31/18.	C 367		

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C 367	Continued From page 58 Review of Resident #4's CDR for Oxycodone/APAP 5-325 mg one tablet every 12 hours with a dispensed date of 01/02/18 revealed: -There was a quantity of 60 tablets. -There was documentation the Oxycodone/APAP 5-325mg tablet had been administered from 01/05/18 through 02/03/18 at 8:00 p.m. with no tablets remaining. -There was no documentation for the administration of Oxycodone/APAP 5-325 twice daily for 02/04/18, 02/05/18 and 02/06/18. Review of Resident #4's February 2018 MAR revealed: -There was a computer generated entry for Oxycodone/APAP 5-325mg take one every 12 hours scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Oxycodone/APAP 5-325mg was administered from 02/01/18 - 02/28/18. Review of Resident #4's March 2018 MAR revealed: -There was a computerized entry for Oxycodone/APAP 5-325mg take one every 12 hours scheduled for administration at 8:00 a.m. and 8:00 p.m. -There was documentation Oxycodone/APAP 5-325mg was administered from 03/01/18 - 03/02/18 through the 8:00 a.m. dose. Review of Resident #4's CDR for Oxycodone/APAP 5-325 mg one tablet every 12 hours with a dispensed date of 02/06/18 revealed: -There was a quantity of 60 tablets. -There was documentation the Oxycodone/APAP	C 367		

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C 367	Continued From page 59 5-325mg tablet had been administered from 02/07/18 through 03/02/18 at 7:00 a.m. with 12 tablets remaining. -There was an entry signed by a Personal Care Aide/Medication Aide (PCA/MA) dated 02/28/18 with an entry that documented "dropped" "1", amount given was documented as "1" and the amount remaining was 16. The entry above dated 02/27/18 at 8:00 p.m. had an entry of "17" in the amount remaining section. -There was no documentation for the administration of Oxycodone/APAP 5-325 twice daily for 02/04/18, 02/05/18 and 02/06/18. -There was no documentation on the back of the CDR. Review of Resident #4's dispensing records from the facility's contracted pharmacy provider revealed: -There were sixty tablets of Oxycodone/APAP 5-325mg was dispensed on 02/06/18. -There were sixty tablets of Oxycodone/APAP 5-325mg was dispensed on 01/02/18. -There were sixty tablets of Oxycodone/APAP 5-325mg was dispensed on 12/01/17. -There were sixty tablets of Oxycodone/APAP 5-325mg was dispensed on 11/03/17. -There were sixty tablets of Oxycodone/APAP 5-325mg was dispensed on 09/06/17. Interview with the facility's Licensed Practical Nurse (LPN) on 03/02/18 at 5:21 p.m. revealed all of Resident #4's MARS from December 2017 and the previous months had been shredded. Interview with Personal Care Aide/Medication Aide (PCA/MA) on 03/06/18 at 12:28 p.m. revealed: -The entry dated 02/28/18 on Resident #4's CDR was her documentation.	C 367		

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C 367	Continued From page 60 -She could not remember any specific information about the entry for Resident #4 on the CDR on 02/28/18 except the medication must have been dropped on the floor and she disposed of the tablet by placing the tablet in the sink and flushing the tablet down drain by turning the water on. -She had been told by the Administrator to call her if a controlled medication was wasted and to waste the tablet by disposing of it in the sink. -She was not sure why there was no documentation on Resident #4's MARS that the resident received Oxycodone/APAP 5-325 twice daily for 02/04/18, 02/05/18 and 02/06/18 and there were no entries on the resident's CDR. -She was not sure if the facility had a policy on disposing or wasting of medications. -She had never been told that controlled medication had to be witnessed by another staff or the Administrator. -Staff performed control counts together at change of shift. A telephone interview with a second PCA/MA on 03/05/18 at 7:30 a.m. was unsuccessful Interview with the Administrator on 03/05/18 at 2:25 p.m. revealed: -Staff were expected to call her or the facility's LPN for wasting/dropping any controlled medications and to document the medication was wasted on the back of the CDR. -She could not remember if she observed the PCA/MA waste one of Resident #1's Oxycodone on 02/28/18. Interview with the Administrator on 03/06/18 at 1:48 p.m. revealed: -Staff had been trained to notify her or the facility's LPN when a controlled medication needed to be wasted.	C 367		

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C 367	Continued From page 61 -She was sure that her expectations of witnessing the wasting of controlled medications had "come up" during in-services, however, she could not say for sure if staff had notified her "every single time" a controlled medication was wasted. -She expected staff to count controlled medications together at the change of shifts, however, she was unsure how consistent staff were about doing that. -She kept the resident "records', however, only kept 3 months of the residents' MARS and CDRs. -She thought 3 months of the residents' MARs and CDRs was all that was needed. Telephone interview with the facility's contracted pharmacy provider on 03/06/18 at 2:19 p.m. revealed it was important to keep residents' MARs and CDRs in order to provide an accurate account of the controlled medications that had been dispensed and administered to the residents. The facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and reconciled for Resident #1 and Resident #4 who were prescribed controlled substances for the treatment of moderate to severe pain (#1), a medication to treat anxiety and a medication to treat moderately severe pain (#4) was detrimental to the health, safety and welfare of the residents due to the inability to provide an accurate reconciled account of the ordered controlled medications which constitutes a Type B Violation Review of a Plan of Protection dated 03/06/18 revealed: -Staff would be in-serviced on control forms- date matching blister packs.	C 367		

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C 367	Continued From page 62 -Keep all medication administration records (MARs) and control sheets, not removing from MAR (only nurse and administrator) to remove the control sheets from the MAR. -All staff to be in-serviced on documentation on control sheet for wasting/dropping controls-notify nurse or Administrator to witness the disposal of wasted controls. In-service to be completed by 03/10/18. -The Administrator would keep copies of all returned medication. -The Administrator would keep readily retraceable MAR/control records. -The complete record would be maintained for up to 2 years following a death or discharge. -Policy revisions would be completed to include "wasting of controls". -Training would be provided to ensure that both shifts review control counts. -Documentation would be completed by the Administrator regarding time frame for Administrator and nurse to review control count in all homes-performed weekly. -Tracking system in place for all returns, changes and all medication cart count reviews for weekly audits. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2018	C 367		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a	C 368		

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C 368	Continued From page 63 common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure a Schedule II controlled substance was stored under double lock for 1of 6 sampled residents (Residents #4). The findings are: Review of Resident #4's FL-2 dated 04/04/17 revealed: -Diagnoses included Alzheimer's disease/dementia, chronic anemia, hypothyroidism, hyperlipidemia, chronic pain. -There was an order for Percocet (a narcotic used to treat moderately severe pain) 5/325mg every 12 hours. Observation of the facility's medication storage closet on 02/28/18 at 11:45 a.m. revealed: -The door to the medication storage closet was not locked when the Personal Care Aide/Medication Aide (PCA/MA) opened the door without using a key. -There was an unlocked metal box with dingy stained paper type tape covering the metal box's keyhole, stored on an upper shelf of the closet. -The unlocked metal box was used to store the residents' controlled medications including Resident #4's Percocet 5/325mg. Interview with the PCA/MA on 02/28/18 at 11:45 a.m. revealed she was not sure why there was tape over the keyhole on the metal box used to store the controlled medication because it was usually locked.	C 368		

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C 368	Continued From page 64 Interview with the facility's Licensed Practical Nurse (LPN) on 02/28/18 at 5:15 p.m. revealed: -The facility's medication storage closet should have been locked at all times. -Controlled medications including Resident #4's Percocet was supposed to be kept in the facility's locked medication storage closet and double locked inside the metal box. -She was not sure why the metal box was not locked and was not sure why there was stained paper tape covering the keyhole and it must had happened with the night shift last night (02/27/18). Observation on 03/01/18 at 7:45 a.m. revealed the Administrator attempted to lock the metal box used to store the resident's controlled medications using the key designated for the box, however, the Administrator could not get the key to fit into the lock of the metal box, "I can't get it to go in there". Interview with the Administrator on 03/01/18 at 7:45 a.m. revealed: -She was not sure what had happened to the metal box used to store the resident's controlled medications and noticed that the top of the box was warped. -She could not answer why there was tape over the metal box's keyhole. A second interview with the Administrator on 03/05/18 at 2:25 p.m. revealed: -She thought the metal box used to store the residents' controlled medication had not been "broken" long and must have occurred sometime last week. -She thought the box had fallen or had been dropped since the metal box's lid was warped. -Staff had not reported to her that the metal box	C 368		

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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
C 368	Continued From page 65 would not lock and staff should have notified her immediately.	C 368		
C 376	10A NCAC 13G .1009(a)(2) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the quarterly on-site medication reviews included a review of all aspects of the facility's systems for medication administration, administration of controlled substances and medication storage for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 02/22/18 revealed diagnoses included senile dementia, hyperlipidemia, hypertension, gastroesophageal reflux disease, and coronary	C 376		

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	FCL052004	A. BUILDING: _____ B. WING _____	C 03/06/2018

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C 376	Continued From page 66	C 376		

artery disease.

Review of Resident #1's pharmaceutical reviews revealed:
- A quarterly medication review completed by a registered nurse dated 1/23/18 and 01/15/18.
-The review revealed no recommendations by the registered nurse.

Observation of the medication cart's top drawer labeled with Resident #1's first name on 02/28/18 at 11:45 a.m. revealed:
-There were 3 separate medications cups filled with various medications.
-Two medication cups were stored in the "PM" section and one in the "AM" section.

Refer to the telephone interview with the contracted registered nurse on 03/06/18 at 3:34 p.m.

Refer to the interview with the Administrator on 03/06/18 at 6:23 p.m.

2. Review of Resident #2's current FL-2 dated 02/23/18 revealed diagnoses included dementia and diabetes type 2 with hyperglycemia.

Observation of the medication cart's top drawer labeled with Resident #2's first name on 02/28/18 at 11:45 a.m. revealed:
-There were 2 separate medications cups filled with various medications.
-One medication cup was stored in the "PM" section and the other medication cup was stored in the "AM" section.

Review of Resident #2's pharmaceutical reviews revealed:
- A quarterly medication review completed by a

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C 376	Continued From page 67	C 376		

registered nurse dated 12/12/17 and 09/15/17.
-The review revealed no recommendations by the registered nurse.

Refer to the telephone interview with the contracted registered nurse on 03/06/18 at 3:34 p.m.

Refer to the interview with the Administrator on 03/06/18 at 6:23 p.m.

3. Review of Resident #3's current FL-2 dated 01/15/18 revealed diagnoses included deep vein thrombosis bilateral lower limbs, hypertension, edema, and hypersensitivity lung disease.

Observation of the medication cart's top drawer with divided sections that was labeled with Resident #3's first name, stored in the facility's medication storage closet on 02/28/18 at 11:45 a.m. revealed:
-There were 2 separate medications cups filled with various medications.
-One medication cup was stored in the "PM" section and on top of a second medication cup and the other medication cup was stored in the "AM" section.

Review of Resident #3's pharmaceutical review revealed:
- A quarterly medication review completed by a registered nurse dated 12/27/18.
-The review revealed no recommendations by the registered nurse.

Refer to the telephone interview with the registered nurse on 03/06/18 at 3:34 p.m.

Refer to the interview with the Administrator on 03/06/18 at 6:23 p.m.

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C 376	Continued From page 68 Telephone interview with the contracted registered nurse on 03/06/18 at 3:34 p.m. revealed: -She was contracted by the facility to perform quarterly LHPS reviews and pharmaceutical reviews. -She had been contracted with the facility for a few years. -She checked the residents' FL-2 and all orders with the medication administration record (MAR) to make sure they matched. -She observed staff administering medications by watching 1 staff per house when she made visits to the facility. -Staff "pulled the MAR", moved the medication cart to wherever the resident was in the home, gathered all of the residents' medication, "pop out each medicine", gave the medication to the resident, then came back to the MAR and signed that the medication was given. -She had never noticed that pre-pouring was an "issue" at the facility. -They were not supposed to pre-pour any medication in advance and she had discussed this with the Administrator and the facility nurse and the staff this past weekend. -She had never checked the residents' medications in the medication cart "drawer by drawer". Interview with the Administrator on 03/06/18 at 6:23 p.m. revealed she did not know that she was responsible for ensuring that review of the inspections of storage areas of medication and review of procedures for administration was done by the contracted nurse who performed pharmacy reviews for the facility.	C 376		

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C 912	Continued From page 69	C 912		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration, medication aide training requirements and controlled substances. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 6 of 6 sampled residents (#1, #2, #3, #4, #5, #6) including high risk medications such as a controlled pain narcotic, a controlled sedative, a schedule II controlled narcotic and anticoagulants. [Refer to Tag 335 10A NCAC 13G .1004(f) Medication Administration (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to assure 2 of 3 Medication Aides (Staff A, Staff D) who administered medications in the facility had completed the 5 hour and 10 hour or the 15 hour state approved medication administration course or the Medication Aide	C 912		

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C 912	Continued From page 70 Verification form as required. [Refer to Tag 935 G.S. 131D-4.5(b) ACH Medication Aide Training & Competency Evaluation (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and reconciled for 2 of 2 residents sampled (#1, #4) who were prescribed controlled substances including a pain medication used to treat moderate to severe pain (#1), a medication used to treat anxiety and a medication used to treat moderately severe pain (#4). [Refer to Tag 367 10A NCAC 13G .1008 (a) Controlled Substances (Type B Violation)].	C 912		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	C935		

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C935	Continued From page 71 procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 2 of 3 Medication Aides (Staff A, Staff D) who administered medications in the facility had completed the 5 hour and 10 hour or the 15 hour state approved medication administration course or the Medication Aide Verification form as required. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A's hired date was documented as 04/28/15. -There was a Health Care Provider/Supervisor in	C935		

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C935	Continued From page 72 Charge job description signed and dated by Staff A. -Staff A completed the Medication Aide Clinical Skills checklist on 09/17/15. -Staff A completed the Medication Aide Exam on 04/10/12. -There was no verification of Staff A working as a Medication Aide (MA) in previous 24 months in an adult care home. -There was no documentation of Staff A completing the 5 hour, 10 hour, or 15 hour state approved medication aide training courses. Interview Staff A on 03/01/18 at 5:15 p.m. revealed: -She had worked at the facility for 4 to 5 years and started administering medications to the resident's a few months after she started her employment. -She thought she had taken all of the required courses to work as a MA, however, was not sure if she had received a certificate for a 15 hour medication administration course. Review of the Medication Administration Records (MARs) for January and February 2018 revealed Staff A administered medications to all residents in the facility during the shifts worked. Refer to the facility's policy on "Medication Staff Training 4.1" Refer to the interview with the Administrator on 03/02/18 at 11:05 a.m. 2. Review of Staff D's personnel file revealed: -Staff D's hired date was documented as 12/08/16. -There was a Health Care Provider/Supervisor in Charge job description signed and dated by Staff	C935		

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C935	Continued From page 73 D on 12/07/16. -Staff D completed the Medication Aide Clinical Skills checklist on 06/13/17. -Staff D passed the written Medication Aide Exam on 06/12/17. -There was no documentation of Staff D completing the 5 hour, 10 hour, or 15 hour state approved medication aide training courses. Telephone interview with Staff D on 03/01/18 at 8:45 p.m. revealed: -She was hired at the facility on 12/08/16. -She was hired initially as Personal Care Aide (PCA) and did not start administering medications to the residents at the facility until September or October of 2017 as a Medication Aide (MA). -She did not remember taking a state approved medication aide training course and receiving a certificate. Review of the Medication Administration Records (MARs) for January and February 2018 revealed Staff D administered medications to all residents in the facility during the shifts worked. Refer to the facility's policy on "Medication Staff Training 4.1" Refer to the interview with the Administrator on 03/02/18 at 11:05 a.m. Review of the facility's policy on "Medication Staff Training 4.1" (not dated) revealed only staff that had successfully completed the written medication exam and had been validated on the medication administration checklist could give medications or treatments. Interview with the Administrator on 03/02/18 at 11:05 a.m. revealed:	C935		

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C935	Continued From page 74 -She was responsible to assure all training was done for staff. -She had many of the same staff employed at the facility for years and there had not been many new staff hired until the last year or so. -She was not aware of the latest requirements that started in 2013 regarding the required medication administration course for Medication Aides (MAs). The facility failed to assure 2 of 3 sampled Medication Aides (Staff A, Staff D) obtained the required training prior to administering medications which was detrimental to the health, welfare, and safety of the residents. This non-compliance constitutes a TYPE B VIOLATION. Review of the Plan of Protection submitted by the facility on 2/28/18 revealed: -The facility nurse (Licensed Practical Nurse) will administer all residents' medications until Medication Aides (MAs) have completed approved training according to state requirements. -The Administrator will contact the pharmacy provider/nurse regarding the scheduling of (15 hour training). -All newly hired MAs will receive the required training (prior to administering medications). THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2018.	C935		