STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063011	A. BUILDING: _____ B. WING _____	R 05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	820 S. MCNEILL STREET CARTHAGE, NC 28327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Moore County Department of Social Services conducted a follow-up survey and a complaint investigation on May 8-10, 2018.	{D 000}		
{D 375}	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 4 of 4 residents sampled (#13, #15, #16, #17) who self-administered medications had physicians' orders to self-administer including a resident with a pain/fever medication in her room; a resident with cortisone cream in her room for dry skin; a resident with medications in her room for ear wax removal; and a resident with medicated powder for her feet. The findings are:	{D 375}		

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{D 375}	Continued From page 1 1. Review of Resident #16's current FL-2 dated 02/26/18 revealed the resident's diagnoses included chronic obstructive pulmonary disease, physical debility, osteoporosis, depression, hypertension, osteoarthritis, gastroesophageal reflux disease and medication induced psychosis. Observations on 05/08/18 at 11:21am and 05/09/18 at 3:13pm revealed: -Resident #16 had a bottle of acetaminophen 500mg tablets (Tylenol) inside of an open sewing box on a table by the window. -There was no prescription label on the Tylenol. -Resident #16 did not have a roommate. Review of Resident #16's current Assessment and Care Plan dated 03/13/17 revealed: -The resident was oriented and had adequate memory. -The resident required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transferring. -There was no documentation regarding self-administration of medications. Interview with Resident #16 on 05/08/18 at 3:13pm revealed: -She rarely takes Tylenol and could not remember the last time she took a tablet. -She kept the bottle of Tylenol in her sewing box where it had been for "a long time." -The staff had never told her that she could not have Tylenol in her room. -The sewing box lid was usually closed and no one knew she had it in her room. -She never asked the facility if she could have Tylenol in her room. -Several staff entered her room daily and never mentioned anything to her about having medication in her room.	{D 375}		

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{D 375}	Continued From page 2 -She used Tylenol on occasion if she had a headache but she could not recall the last time she took a tablet. -She purchased the Tylenol herself. -She did not expect the staff to administer her Tylenol as she had the ability to take one herself. Review of Resident #16's physician's orders revealed: -There were no orders for Tylenol. -There was an order for Percocet 5/325mg three times daily. -There were no orders for the resident to self-administer any medications. Interview with the Administrator on 05/09/18 at 3:45pm revealed: -Resident #16 did not have orders to self-administer Tylenol. -She was unaware that there was a container of Tylenol in Resident #16's room. Refer to interview with the facility's provider on 05/09/18 at 3:15pm. Refer to interview with the Administrator on 05/09/18 at 3:50pm. Refer to the facility's written policy for medication policy. 2. Review of Resident #17's current FL-2 dated 04/27/17 revealed the resident's diagnoses included dysthymic disorder, depression, hypertension, gastroesophageal reflux disease, dementia, overactive bladder, chronic headaches and peripheral vascular disease. Observations on 05/08/18 at 11:21am and 05/09/18 at 3:13pm revealed:	{D 375}		

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{D 375}	Continued From page 3 -Resident #17 had a tube of Cortisone 10 brand 1% hydrocortisone cream (Cortisone) on her nightstand in her room. -There was no prescription label on the Cortisone tube. -Resident #17 did not have a roommate. Review of Resident #17's current Assessment and Care Plan dated 03/13/17 revealed: -The resident was oriented and had adequate memory. -The resident required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transferring. -There was no documentation regarding self-administration of medications. Interview with Resident #17 on 05/08/18 at 3:13pm revealed: -She applied the Cortisone to her skin when she felt occasional itching. -She had a history of dry skin and the Cortisone cream helped. -The staff had never told her that she could not have Cortisone in her room. -She never asked the facility if she could have Cortisone in her room. -Several staff entered her room daily and never mentioned anything to her about having medication in her room. -She purchased the Cortisone herself or would ask someone she knew to purchase it. -She did not expect the staff to administer the Cortisone as she had the ability to apply it herself. Review of Resident #17's physician's orders revealed: -There were no orders for Tylenol. -There were no orders for the resident to self-administer any medications.	{D 375}		

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{D 375}	Continued From page 4 Interview with the Administrator on 05/09/18 at 3:45pm revealed: -Resident #17 did not have orders to self-administer Cortisone. -She was unaware that there was a container of Cortisone in Resident #17's room. Refer to interview with the facility's provider on 05/09/18 at 3:15pm. Refer to interview with the Administrator on 05/09/18 at 3:50pm. Refer to the facility's written policy for medication policy. 3. Review of Resident #13's current FL-2 dated 01/19/18 revealed the resident's diagnoses included history of lung cancer, chronic pulmonary obstructive disease (COPD), hypertension, depression, dementia, anxiety, allergies, glaucoma, coronary artery disease (CAD), diabetes mellitus, asthma and angina. Observations on 05/08/18 at 11:11am and 05/09/18 at 3:18pm revealed: -Resident #13 had earwax removal drops on the bedside table in her room. -There was no prescription label on the earwax drops. -Resident #13 did not have a roommate. Review of Resident #13's current Assessment and Care Plan dated 03/17/18 revealed: -The resident was sometimes forgetful and needed reminders. -The resident required limited assistance with toileting and bathing. -The resident required supervision when eating.	{D 375}		

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{D 375}	Continued From page 5 -The resident was independent with ambulation, dressing, grooming and transferring. -There was no documentation regarding self-administration of medications. Interview with Resident #13 05/08/18 at 11:12am revealed: -The earwax removal drops were always on her bedside table but could not recall when she first got them. -Her doctor recommended the drops after her last visit to see if it could improve her hearing. -The earwax drops had been used daily over the last week to "clean out all the ear wax to hear better." -The staff left the earwax drops at her bedside after each treatment. -She never administered the earwax drops herself and expected staff to administer them. -She could not remember the names of the staff who administered her ear drops. Review of Resident #13's physician's orders revealed: -There were no orders for earwax drops. -There were no orders for the resident to self-administer any medications. Interview with the Administrator on 05/09/18 at 3:45pm revealed: -Resident #13 did not have orders to self-administer earwax drops. -She was unaware that there was a bottle of earwax removal drops Resident #13's room. Refer to interview with the facility's provider on 05/09/18 at 3:15pm. Refer to interview with the Administrator on 05/09/18 at 3:50pm.	{D 375}		

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{D 375}	Continued From page 6 Refer to the facility's written policy for medication policy. 4. Review of Resident #15's current FL-2 dated 03/12/18 revealed the resident's diagnoses included chronic kidney disease, hypertension, vitamin D deficiency, sinus bradycardia, anemia, osteoarthritis, diabetes mellitus, gastroesophageal reflux disease, hypothyroidism, mild mental retardation and edema. Observations on 05/08/18 at 11:15am and 05/09/18 at 3:18pm revealed: -Resident #15 had miconazole 2% antifungal powder (Desonex) on her nightstand in her room. -There was no prescription label on the Desonex powder. -Resident #15 did not have a roommate. Review of Resident #15's current Assessment and Care Plan dated 03/13/17 revealed: -The resident was oriented and had adequate memory. -The resident required limited assistance with toileting, bathing, dressing and grooming. -The resident required supervision when bathing. -The resident was independent with ambulation and transferring. -There was no documentation regarding self-administration of medications. Interview with Resident #15 on 05/09/18 at 3:18pm revealed: -She used Desonex on her feet daily. -She kept the Desonex on her night stand. -The staff never told her that she could not have Desonex in her room. -She never asked the facility if she could have Desonex in her room.	{D 375}		

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{D 375}	Continued From page 7 -Several staff entered her room daily and never mentioned anything to her about having medication on her nightstand. -She used Desonex to prevent her feet from itching. -She purchased the Desonex herself or family would bring it to her. -She did not expect the staff to administer Desonex to her feet because she had the ability to apply it herself. Review of Resident #15's physician's orders revealed: -There were no orders for Desonex foot powder. -There were no orders for the resident to self-administer any medications. Interview with the Administrator on 05/09/18 at 3:45pm revealed: -Resident #15 did not have orders to self-administer Desonex foot powder. -She was unaware that there was a container of Desonex powder on Resident #15's nightstand in her room. Refer to interview with the facility's provider on 05/09/18 at 3:15pm. Refer to interview with the Administrator on 05/09/18 at 3:50pm. Refer to the facility's written policy for medication policy. Interview with the facility's provider on 05/09/18 at 3:15pm revealed: -The residents with the OTC medications in their rooms were not an immediate concern. -Resident #13, #15, #16, and #17 were cognitively able to administer those medications.	{D 375}		

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{D 375}	Continued From page 8 -Her expectation was for all medications to be safely stored either in the resident's room or the medication room. -There were no residents on the assisted living side of the facility that were a self-medication concern. -There were no residents currently on the assisted living side of the facility with any memory or orientation impairments which would cause them to enter another resident's room and ingest another resident's medication. Interview with the Administrator on 05/09/18 at 3:50pm revealed: -Residents were required to tell the Administrator, the RCC or any staff member if they were to purchase over-the-counter (OTC) medications and bring them into the facility so a medication label could be applied and the medication could be monitored. -Friends and family of residents often brought in OTC meds upon a resident's request. -The rooms where OTC medications were discovered had been checked previously in the past week and none were found. -When OTC or prescription medications were found, the facility confiscated them, informed the residents of the policy, and kept the medications for the residents until such time a self-medication evaluation and order could be requested. -It was difficult to ensure residents complied with the rule as many of the residents did not consider OTC creams and powders as medications. -Personal care staff were instructed to confiscate any medications found in the resident rooms and bring them to the Administrator. -She could not explain why personal care staff had not informed management that there were OTC medications in the resident rooms. -She would reeducate all staff of the facility's	{D 375}		

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{D 375}	Continued From page 9	{D 375}		

policy on medication storage and administration.
-The facility's policy was to have all staff members who identified any medications in any resident rooms to confiscate them, bring them to the medication aide or supervisor, and request a doctor's order for a self-administration assessment.
-All labels must be labeled and approved by a provider.
-The facility kept a log of random room checks for medications.
-The Administrator randomly chose approximately 6 to 10 different rooms each day, completing all room inspections at the facility by the end of each week.
-The residents were educated upon placement at the facility that all OTC medications brought into the facility were to be disclosed to the staff for proper storage.
-All staff would be reminded about the policy and medications being stored in resident rooms immediately.
-The facility had a policy in place for all medications and their storage.

Review of the facility's medication policy revealed:
-Only medications prescribed by a physician (prescription and non-prescription) shall be administered to residents of the facility.
-No medication shall be stored in the resident's room unless prior written authorization was obtained by a physician and the resident was deemed capable of self-administration.
-The facility reserved the right to confiscate all unlocked medications.

Observation of the facility's Random Room Checks for Medications log revealed:
-The log book recorded room checks for medications for all rooms at the facility.

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{D 375}	Continued From page 10 -All rooms were randomly checked at least once per week. -There was only one entry for cough drops that were confiscated, labeled and placed in the medication room since 04/30/18. -There were no other entries for discovered medications in resident rooms.	{D 375}		