STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL012043	A. BUILDING: _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA'S COTTAGE # 2	5824 HOLLAND STREET MORGANTON, NC 28655

(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 000	Initial Comments The Adult Care Licensure Section and the Burke County Department of Social Servicess conduceted an Annual and follow-up survey on 08/21/19.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, record reviews and interviews facility failed to assure that they maintained a readily retrievable record of controlled substances by accurately documenting the receipt, administration and disposition of controlled substances in such an order that there can be accurate reconciliation for 1 of 3 residents	C 342		

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C 342	Continued From page 1 (Resident #3). The findings are: 1. Review of Resident #3's FL2 dated 03/21/19 revealed: -Diagnoses included bipolar schizoaffective disorder, anxiety disorder, borderline intellectual functioning, hypertriglyceridemia, anemia and gastro esophageal reflux disorder. -There was an order for Atorvastatin 10 mg 1 tablet by mouth at bedtime. (Atorvastatin is to treat hypertriglyceridemia. -There was an order for Benztropine 1mg tab twice a day (used to treat side effects of certain psychiatric drugs) . -There was an order for Buspirone 15mg 1 tablet three times a day (used to treat symptoms of anxiety) -There was an order for Omeprazole 20mg 1 tablet by mouth daily (used to treat esophageal reflex disorder) -There was an order for Sumatriptan 50mg 1 tablet by mouth daily PRN (used to treat migraine headaches) -There was an order for Clonazepam 0.5mg 1 tablet by mouth every night at bedtime. (used to treat panic attacks.) -There is an order for FeSoy 325mg 1 tablet by mouth twice a day (used to treat anemia) -There is an order for Naproxen 220mg every 12 hrs. PRN (used to treat for migraine headaches) -There was an order for Topiramate 25mg 1 capsule by mouth every night at bedtime. (used to treat migraine Headaches) -There was an order for Trintellix 20mg 1 tablet by mouth (used to treat major depressive disorder) Review of Resident #3's physician orders revealed an order dated 06/21/19 for	C 342		

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C 342	Continued From page 2 Hydrocodone Acetaminophen 5-325 1 tablet every six hours PRN for five days. Review of Resident #3's 06/21/19 Medication administration record revealed: -There was an entry for Hydrocodone Acetaminophen 5-325 1 tablet on 06/22/19, 1 tablet on 06/23/19, 1 tablet administered twice on 06/24/19, and 1 tablet on 06/25/19 -Documentation for Hydrocodone Acetaminophen 5-325 mg was blank for 06/21/19 and 06/26/19 with no reason for the omission Review of Resident #3's Physician orders revealed an order dated 07/24/19 for Junel FE 1/20 (28) 1 pill by mouth every day for birth control. Review of Resident #3's 08/09/19 Medication administration record revealed documentation for Junel FE 1/20 (28) was blank with no reason for the omission. Review of narcotic inventory sheet for June 2019, revealed: -Pharmacy Label for Hydrocodone Acetaminophen 5-325mg on June 21, 2019. The administration direction on the narcotic inventory sheet label stated take 1 tablet by mouth every 6hrs as needed for pain for five days, 20 tablets. -There was hand written entry on the narcotic inventory sheet for Hydrocodone Acetaminophen 5-325 1tablet on 06/21/19 at 8:00 pm, 1 tablet on 06/22,2019 l at 10:15am and 1 tablet on 06/23/19 at 8:00pm, 1 tablet on 06/24/19 at 9:00am and 1 tablet at 8:00pm, 1 tablet on 06/25/19 at 9:57am and 1 tablet at 6:56pm, 1 tablet on 06/26/19 at 9:32am and 1 tablet 7:14pm and 1 tablet on 06/26/19 at 7:56pm. -The documentation for Hydrocodone	C 342		

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C 342	Continued From page 3 Acetaminophen 5-325 mg on the narcotic inventory sheet for June 2019 did not accurately match with the documentation for Hydrocodone Acetaminophen 5-325 mg on the medication administration record documentation on medication administration record for June 2019. -There was a total of 10 Hydrocodone Acetaminophen 5-325mg tablets of the 20 Hydrocodone Acetaminophen 5-325mg delivered to the facility that were administered to Resident # 3 from June 21, 2019 to June 26, 2019. Review of the medication disposition sheet for June 2019 revealed: -On 06/28/19 facility sent 8 Hydrocodone Acetaminophen 5-325mg tablets back to the pharmacy. -On 06/28/19 the pharmacist signature verified that the pharmacy received 8 Hydrocodone Acetaminophen 5-325mg tablets from the facility. - The facility should have sent 10 of 20 unused Hydrocodone Acetaminophen 5-325mg tablets back to the pharmacy. Interview with the supervisor in charge (SIC) on 08/21/2019 at 3:00pm revealed: -He stated normally he worked at the other facility. -He stated he did not administer medication at this facility. -He stated the facility's medication administration policy states medication staff must maintain an accurate medication administration record. - He stated all narcotic medications delivered to facility must be accurately documented on both the medication administration record and the narcotic inventory sheet soon after the narcotic medication is delivered into the facility. He stated all narcotic medications administered to a Resident must be recorded accurately on the	C 342		

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C 342	Continued From page 4 medication administration record soon after it is administered to the resident. - He stated remaining unused narcotic medications must be sent back to the pharmacy and the verification documentation must be maintained at the facility at all time. -He stated he did not know the reason why the usual supervisor in charge for this facility failed to document the Hydrocodone Acetaminophen 5-325mg 1 tablet administered on 06/21/19 and 06/26/19, and the second tablet administered on 06/ 22/2019, 06 /23/ 2019 and 06/25/19 on the June 2019 medication administration record. - He stated he did not know why the usual supervisor in charge for this facility failed to document administration of Junel FE 1/20 (28) 1 tablet every day on the 08/09/2019 medication administration record. -He stated he did not know the reason why the usual supervisor in charge failed to document the reason for not administering Junel FE 1/20 (28) to the resident on 08/09/2019. Telephone interview with Resident #3 on 08/21/19 at 3:30pm revealed: -She stated she received two tablets of Hydrocodone Acetaminophen 5-325 mg for five days.	C 342		