PRINTED: 01/13/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011296	A. BUILDING _____ B. WING _____	01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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 Buncombe County Department of Social Services conducted an annual and follow up survey on 01/07/20.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff C's personnel record revealed: -There was no date of hire. -There was no documentation of a HCPR check for Staff C. Interview with the Administrator on 01/07/20 at 4:45pm revealed: -Staff C had been hired February 2019 as Maintenance Staff. -She knew a HCPR check was required for newly hired staff. -She was responsible for completing the HCPR	D 137	To Correct and Prevent Future Problems Administrator will Periodically Check personnel Records to insure all Needed documentation is in Files. As well as Time of Hire. Registry Check was Finished Before Surveyors left Bldg	1/9/20 Work

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Hollis — TITLE: Admin — (X6) DATE: 1/29/20

STATE FORM 6899 — 162P11 — If continuation sheet 1 of 22

Reviewed and accepted 3/25/20
RPacheco

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D 137	Continued From page 1 checks. -She had completed a HCPR check for Staff C upon hire but could not find the paperwork. Attempted telephone interview with Staff C on 01/07/20 at 4:48pm was unsuccessful. Review of a HCPR check for Staff C dated 01/07/20 revealed there were no substantiated findings.	D 137		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the care plan assessor had signed the care plan upon its completion for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/13/19 revealed: -Diagnoses included traumatic brain injury, cerebral vascular accident, and seizures. -Resident #1 was documented as ambulatory with no assistive devices and continent of bowel and bladder. Review of Resident #1's Care Plan dated 06/13/19 revealed: -There was documentation that Resident #1 was totally dependent on staff for all Activities of Daily Living (ADLs).	D 262	To Correct and Prevent future problems Administrator and RN [redacted] will retrain STC on how to properly fill out Care plans. [redacted] RN will review Care plans in the the Sales every month to assure they are Completed Correctly	1/11/20

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D 262	Continued From page 2 -There was no signature or date documented under the Assessor Certificate Section. Refer to the interview with the Medication Aide (MA) on 01/07/20 at 3:55pm. Refer to the interview with the Supervisor on 01/07/20 at 4:45pm. Refer to the interview with the Administrator on 01/07/20 at 3:14pm. 2. Review of Resident #2's current FL2 dated 07/30/19 revealed diagnoses included chronic kidney disease, dysphagia, schizoaffective disorder, cognitive communication deficit, bladder neck obstruction and gastroesophageal reflux disease. Review of Resident #2's Care Plan dated 02/07/19 revealed; -There was no documentation of any Activities of Daily Living completed on the care plan. -There was no signature or date documented under the Assessor Certification section. Refer to the interview with the Medication Aide (MA) on 01/07/20 at 3:55pm. Refer to the interview with the Supervisor on 01/07/20 at 4:45pm. Refer to the interview with the Administrator on 01/07/20 at 3:14pm. 3. Review of Resident #3's current FL2 dated 11/25/19 revealed: -Diagnoses of dysphagia-oral phase, adult failure to thrive, anemia in chronic renal failure, unspecified protein calorie malnutrition, thiamine	D 262		

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D 262	Continued From page 3	D 262		

deficiency, aspiration with respiration symptoms, alcohol abuse and hypertension.
-Resident #3 was documented as ambulatory with no assistive devices and continent of bowel and bladder.

Review of Resident #3's Care Plan dated 11/26/19 revealed:
-There was no documentation of any Activities of Daily Living completed on the Care Plan.
-There was no signature or date documented under the Assessor Certification section.

Refer to the interview with the Medication Aide (MA) on 01/07/20 at 3:55pm.

Refer to the interview with the Supervisor on 01/07/20 at 4:45pm.

Refer to the interview with the Administrator on 01/07/20 at 3:14pm.

Interview with the MA on 01/07/20 at 3:55pm revealed:
-She was not responsible for the resident care plans.
-The Supervisor was responsible for the care plans.

Interview with the Supervisor on 01/07/20 at 4:45pm revealed:
-She was responsible for completing the care plans.
-Once yearly she copies the previous assessment and sends the care plan and FL2 to the residents physician to be completed and signed.
-The physician or nurse practioner are responsible for completing the activities of daily living portion on the care plan.
-She forgot to fill out the care plan and sign it.

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D 262	Continued From page 4 -She was not aware she was supposed to sign the Assessor Certification section of the residents care plan but she was now. -She had not had any training related to the care plans and what was expected. Interview with the Administrator on 01/07/20 at 3:14pm revealed: -The Supervisor was responsible for completing the care plans, signing as the assessor, and ensuring the physician reviewed them. -The Supervisor should "know" the resident and not copy the previous care plan. -The Supervisor had received training on care plans. -The Administrator did not know why the care plans were not signed by the assessor or accurate.	D 262		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement an activity program that promoted the active involvement of the residents.	D 315	To Correct and Prevent future problems [redacted], employee who does Activity will return to work. She was out on leave [redacted]. All employees included Adm Have been doing activity's until she can return to work. Activity Calendar was on desk in office. was posted brown [illegible] of Bldg. If future if this occurs Adm will designate one person to do activity.	2/3/20 MOK

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D 315	Continued From page 5	D 315		

The findings are:

Review of the facility's activity calendar on 01/07/20 revealed:
-There were two pages tacked to a bulletin board in the hallway.
-On page one, there were 8 hours of various activities listed from 12/01/19-12/07/19 and 13 hours of various activities were listed from 12/8/19-12/14/19.
-On page two, the week of 12/15/19-12/22/19 was missing and no activities were listed from 12/23/19-12/31/19.

There was no activity calendar was posted for January 2020.

Interview with one resident on 01/07/20 at 9:12am during the initial tour revealed:
-He had been a resident in the facility for 1 week.
-There were no scheduled activities in the facility.
-There were games on top of the refrigerator but he did not enjoy those.
-He would like to participate in some activities other than board games.

Interview with a second resident on 01/07/20 at 9:23am revealed:
-There was no staff in the facility to conduct activities.
-The previous staff who conducted the activities had resigned a "few months" ago.
-He would like some scheduled activities because there was nothing to do but "smoke".

Interview with a third resident on 01/07/20 at 9:30am revealed:
-There were no scheduled activities offered in the facility.

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D 315	Continued From page 6 -Most of the residents just did "their own thing" Interview with a fourth resident on 01/07/20 at 9:38am revealed: -There was no staff in the facility to conduct activities. -She usually just played cards. -She would participate in scheduled activities if they were offered. Interview with a fifth resident on 01/07/20 at 9:50am during the initial tour revealed: -He had not observed any scheduled activities. -Sometimes a couple of residents would play cards on their own. -The residents mainly did their own thing or nothing at all. -He would participate in activities if they had them. -There used to be a person who did activities but she had not been there in a long time. Observation on 01/07/20 revealed various board games on top of the refrigerator. Interview with the Administrator on 01/07/20 at 3:50pm revealed: -The Activity Director had been out on leave for about a month. -She and the other 2 staff had provided 3 hours of activities each day. -They (staff) were doing the best they could until the Activity Director returned to the facility. Interview with the Supervisor on 01/07/20 at 4:30pm revealed: -Staff had played cards and worked on art projects with the residents. -They (staff) try to do some activity with the residents daily.	D 315		

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D 368	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) related to a medication used to treat seizures (#1) and a medication used for pain relief (#3). The findings are: 1. Review of Resident #1's current FL2 dated 06/13/19 revealed: -Diagnoses included traumatic brain injury and seizure disorder. -Medication orders included Vimpat 50mg twice daily for seizures. Review of Resident #1's 12/10/19 - 12/31/19 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Vimpat 50mg twice daily with administration times of 8:00am and 8:00pm. -There was documentation the Vimpat 50mg had been administered from 12/10/19 - 12/31/19 at 8:00am and 8:00pm. Review of Resident #1's 01/01/20 - 01/07/20	D 368	[redacted] RN will retrain staff on Medication Administration and Documentation including Controll Substances She will also instruct on dating each Controll Medication when it is started. [redacted] will monitor the documentation every 2 weeks for 3 months then every month after that for 6 months to ensure staff is administering and Documenting Correctly This should correct and prevent further problems.	1/25/20 MLK

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D 358	Continued From page 8	D 358		

eMAR revealed:
-There was an entry for Vimpat 50mg twice daily with administration times of 8:00am and 8:00pm.
-There was documentation the Vimpat 50mg had been administered from 01/01/20 - 01/06/20 at 8:00am and 8:00pm.

Observation of Resident #1's medications on hand on 01/07/20 at 12:20pm revealed:
-There was one bubble pack labeled Vimpat 50mg take one tablet twice daily with a dispensed date of 12/10/19.
-The bubble pack had an orange sticker with A.M. printed on it.
-Thirty tablets had been dispensed with 10 tablets remaining in the bubble pack.
-There was a second bubble pack labeled Vimpat 50mg take one tablet twice daily with a dispensed date of 12/10/19.
-The bubble pack had a green sticker with P.M. printed on it.
-Thirty tablets had been dispensed with 8 tablets remaining in the bubble pack.

Telephone interview with a representative from the facility's contracted pharmacy on 01/07/20 at 12:30pm revealed:
-The pharmacy had an order for Resident #1 for Vimpat 50mg twice daily for seizures dated 03/18/19.
-The pharmacy had dispensed two bubble packs of Vimpat 50mg tablets with 30 tablets in each card on 12/10/19 to the facility.
-One bubble pack was the morning dose of Vimpat and the second bubble pack was the evening dose of Vimpat.

Review of the Vimpat 50mg controlled substance record on 01/07/20 revealed:
-A total of 29 tablets were documented as

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D 358	Continued From page 9	D 358		

administered from 12/10/19 to 01/07/20 at 9:00am.
-A total of 28 tablets were documented as administered from 12/10/19 to 01/06/20 at 9:00pm.
-There was no declining inventory on the controlled substance record.

There would have been 1 tablet remaining in the "AM" bubble pack had 29 tablets been administered from 12/10/19 to 01/07/20 at 9:00am, there were 10 tablets remaining.

There would have been 2 tablets remaining in the "PM" bubble pack had 28 tablets been administered from 12/10/19 to 01/06/20 at 9:00pm, there were 8 tablets remaining.

Interview with the Medication Aide (MA) on 01/07/20 at 3:06pm revealed:
-She had administered the Vimpat to Resident #1 during her shifts.
-She knew to administer as ordered because she had been trained.
-She did not know why there were more tablets in the bubble packs than there should have been.

Interview with the Administrator on 01/07/20 at 3:13pm revealed:
-The MAs should be administering the medications as ordered.
-The MAs had received training on medication administration.
-The Administrator did not know why there were more tablets in the bubble packs than there should have been.

Interview with a consulting Physician at Resident #1's Physician's office on 01/07/20 at 3:30pm revealed:

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D 358	Continued From page 10	D 358		

-Resident #1 was prescribed the Vimpat for a history of seizures.
-The Resident was prescribed three different medications for seizures.
-Resident #1 had not had any seizures this year.
-Not receiving the medication as ordered "slightly" increased the Resident's risk of having a seizure.
-The facility should be administering the medication as ordered.

Interview with Resident #1 on 01/07/20 at 3:35pm revealed:
-He had seizures due to epilepsy (seizure disorder).
-His last seizure was in 2018.
-He did not know what medications were administered to him by the MAs.
-The MAs administered medications to him in the morning and in the evening.

Interview with a second MA on 01/07/20 at 4:29pm revealed:
-She always administered the Vimpat to Resident #1 during her shifts.
-She did not know why there were more tablets in the bubble packs than there should have been.

Review of the facility's Medication Administration Policy and Procedure dated 05/2010 revealed medications would be administered in accordance with the prescribing practioner's orders.

2. Review of Resident #3's current FL2 dated 11/25/19 revealed diagnoses included dysphagia-oral phase, adult failure to thrive, anemia in chronic renal failure, unspecified protein calorie malnutrition, thiamine deficiency, aspiration with respiration symptoms, alcohol abuse and hypertension.

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D 358	Continued From page 11	D 358		

Review of Resident #3's physician's orders dated 12/30/19 revealed morphine sulfate (treats pain) solution 10mg/5ml take 5ml as needed every 4 hours.

Continued review of Resident #3's physician's orders revealed a telephone order dated 01/03/20 to "give 10ml every 4 hours for cancer pain in mouth" not signed by physician.

Review of Resident #3's December 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for morphine sulfate 10mg/5ml every 4 hours as needed.
-There was documentation that the morphine sulfate had been administered one time on 12/31/19 with no time documented.

Review of Resident #3's January 2020 eMAR revealed:
-There was an entry for morphine sulfate 10mg/5ml every 4 hours as needed.
-There was documentation the morphine sulfate had been administered 3 times on 01/01/20 with no documented times.
-There was documentation the morphine sulfate had been administered 2 times on 01/02/20 with no documented times.
-There was documentation the morphine sulfate had been administered 1 time on 01/07/20 with no documented time.
-There was documentation that 10ml of morphine sulfate had been administered on 01/07/20 with no documented time.

Observation of Resident #3's medications on hand on 01/07/20 at 12:19pm revealed:
-There was one bottle labeled morphine sulfate

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D 358	Continued From page 12	D 358		

360ml dispensed 12/30/19, with 240ml left in the bottle.
-There was a second bottle labeled morphine sulfate 120ml dispensed 12/30/19, with 60ml left in the bottle.

Review of Resident #3's morphine sulfate control substance record on 01/07/20 revealed:
-Morphine sulfate 10mg/5ml, 120ml dispensed 12/30/19 was printed on the label.
-There was documentation 5ml was administered on 12/30/19 at 9:00pm and 12/31/19 - 01/02/20 at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was documentation 10ml was administered on 01/03/20 at 1:00pm, 6:00pm, and 10:00pm.
-There was documentation 10ml was administered on 01/04/20 at 9:00am, 1:00pm, 5:00pm and 9:00pm.
-There was documentation the declining inventory was zero on 01/04/20 at 1:00pm.
-There was documentation that a total of 120ml was administered but, 60 ml were left in the 120ml bottle of morphine sulfate.

Review of a second morphine sulfate control substance record for Resident #3 on 01/07/20 revealed:
-Morphine sulfate 10mg/5ml, 360ml dispensed on 12/30/19 was printed on the label.
-There was documentation that 10ml had been administered on 01/04/20 at 5:00pm and 9:00pm, 01/05/20 - 01/06/20 at 9:00am, 1:00pm, 5:00pm, and 9:00pm, and on 01/07/20 at 9:00am.
-There was documentation the declining inventory was 10ml on 01/07/20 at 9:00am.
-There was documentation that a total of 110ml had been administered, but 240ml were left in the 360ml bottle.

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WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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 358	Continued From page 13 Interview with the Medication Aide (MA) on 01/07/20 at 12:35pm revealed: -The pharmacy had sent a 1ml syringe with the morphine sulfate. -The MA had been filling the syringe with the morphine sulfate up to the 0.5ml mark and administered the medication to Resident #3. -The Nurse Consultant had instructed her to use the 5ml mark on a 30ml plastic medication cup to administer the morphine sulfate. Review of Nurses' Notes for Resident #3 revealed: -On 12/29/19 at 9:00am "You can tell he (Resident #3) is hurting when he 'trys' to drink or eat." -On 12/29/19 at 6:00pm Resident #3 "said the pain is very bad and it is hard to get the pills down so I am putting the pain meds in water so it will be easy to take." -On 01/03/20 "(Nurse from doctor's office) called and said to give him morphine 10ml every 4 hours for cancer pain in mouth." -On 01/04/20 Resident #3 "said the morphine 10ml is helping a lot more than the 5ml." Interview with the Administrator on 01/07/20 at 3:50pm revealed: -The Administrator reviewed the documentation every 2 weeks when the Nurse Consultant was in the facility and reviewed the documentation. -The Administrator would have the Nurse Consultant retrain the staff on control sheets. -She did not know why the medication was not administered correctly.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 14 (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure records of the receipt and administration of controlled substances were accurate for 2 of 3 sampled residents (#1 and #3) who were prescribed controlled substances. The findings are: 1. Review of Resident #1's current FL2 dated 06/13/19 revealed: -Diagnoses included traumatic brain injury and seizure disorder. -Medication orders included Vimpat 50mg twice daily for seizures. Review of the Vimpat 50mg controlled substance record on 01/07/20 revealed: -Vimpat 50mg take 1 "2xs" a day was hand written at the top of the record. -There was no quantity received or date received. -A total of 29 tablets were documented as administered from 12/10/19 to 01/07/20 at 9:00am. -A total of 28 tablets were documented as administered from 12/10/19 to 01/06/20 at 9:00pm. -There was no declining inventory on the controlled substance record.	D 392	[redacted] RN will retrain Staff on Administration; Documentation of Medication to include Controlled Substances She will also include training To date Controlled Medication when starting new packet or bottle. She will retrain back to use Measuring Cups & Syringes. RN will Monitor the documentation of Medication Administration of Controlled Substances for every 2 mth for 3 months then once a month for 6 months To insure Staff is Properly Trained on Administration & Documentation of Medication. This Should Correct and Prevent Problem	[redacted] MGK 1/25/2

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D 392	Continued From page 15	D 392		

Review of Resident #1's 12/10/19 - 12/31/19 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Vimpat 50mg twice daily with administration times of 8:00am and 8:00pm.
-There was documentation the Vimpat 50mg had been administered from 12/10/19 - 12/31/19 at 8:00am and 8:00pm.

Review of Resident #1's 01/01/20 - 01/07/20 eMAR revealed:
-There was an entry for Vimpat 50mg twice daily with administration times of 8:00am and 8:00pm.
-There was documentation the Vimpat 50mg had been administered from 01/01/20 - 01/06/20 at 8:00am and 8:00pm.

Observation of Resident #1's medications on hand on 01/07/20 at 12:20pm revealed:
-There was one bubble pack labeled Vimpat 50mg take one tablet twice daily with a dispensed date of 12/10/19.
-The bubble pack had an orange sticker with A.M. printed on it.
-Thirty tablets had been dispensed with 10 tablets remaining in the bubble pack.
-There was a second bubble pack labeled Vimpat 50mg take one tablet twice daily with a dispensed date of 12/10/19.
-The bubble pack had a green sticker with P.M. printed on it.
-Thirty tablets had been dispensed with 8 tablets remaining in the bubble pack.

There would have been 1 tablet remaining in the "AM" bubble pack had 29 tablets been administered from 12/10/19 to 01/07/20 at 9:00am, there were 10 tablets remaining.

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D 392	Continued From page 16	D 392		

There would have been 2 tablets remaining in the "PM" bubble pack had 28 tablets been administered from 12/10/19 to 01/06/20 at 9:00pm, there were 8 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 01/07/20 at 12:30pm revealed:
-The pharmacy had an order for Resident #1 for Vimpat 50mg twice daily for seizures dated 03/18/19.
-The phamacy had dispensed two bubble packs of Vimpat 50mg tablets with 30 tablets in each card on 12/10/19 to the facility.
-One bubble pack was the morning dose of Vimpat and the second bubble pack was the evening dose of Vimpat.

Interview with the Medication Aide (MA) on 01/07/20 at 3:06pm revealed:
-She had administered the Vimpat to Resident #1 during her shifts.
-She knew to document the declining inventory on the controlled substance record because she had been trained.
-She had documented the declining inventory on other controlled substance records.
-She did not know what had happened with the Vimpat controlled substance record.

Interview with the Administrator on 01/07/20 at 3:13pm revealed:
-The MAs had received training on controlled substance documentation from the Nurse Consultant.
-The Administrator did not know why the MAs had not documented accurately on the Vimpat controlled substance record.

Interview with a second MA on 01/07/20 at

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D 392	Continued From page 17	D 392		

4:29pm revealed:
-She had noticed that there was no declining inventory on the controlled substance record on Sunday (01/04/19) and was going to correct it but had forgotten to.
-She knew to document the declining inventory but did not know why she had not done so.
-She had received training on controlled substance documentation.

2. Review of Resident #3's current FL2 dated 11/25/19 revealed diagnoses included dysphagia-oral phase, adult failure to thrive, anemia in chronic renal failure, unspecified protein calorie malnutrition, thiamine deficiency, aspiration with respiration symptoms, alcohol abuse and hypertension.

Review of Resident #3's physician's orders dated 12/30/19 revealed morphine sulfate (treats pain) solution 10mg/5ml take 5ml as needed every 4 hours.

Continued review of Resident #3's physician's orders revealed a telephone order dated 01/03/20 to "give 10ml every 4 hours for cancer pain in mouth" not signed by physician.

Review of Resident #3's December 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for morphine sulfate 10mg/5ml every 4 hours as needed.
-There was documentation that the morphine sulfate had been administered one time on 12/31/19 with no time documented.

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D 392	Continued From page 18	D 392		

Review of Resident #3's January 2020 eMAR revealed:
-There was an entry for morphine sulfate 10mg/5ml every 4 hours as needed.
-There was documentation the morphine sulfate had been administered 3 times on 01/01/20 with no documented times.
-There was documentation the morphine sulfate had been administered 2 times on 01/02/20 with no documented times.
-There was documentation the morphine sulfate had been administered 1 time on 01/07/20 with no documented time.
-There was documentation that 10ml of morphine sulfate had been administered on 01/07/20 with no documented time.

Observation of Resident #3's medications on hand on 01/07/20 at 12:19pm revealed:
-There was one bottle labeled morphine sulfate 360ml dispensed 12/30/19, with 240ml left in the bottle.
-There was a second bottle labeled morphine sulfate 120ml dispensed 12/30/19, with 60ml left in the bottle.

Review of Resident #3's morphine sulfate control substance record on 01/07/20 revealed:
-Morphine sulfate 10mg/5ml, 120ml dispensed 12/30/19 was printed on the label.
-There was documentation 5ml was administered on 12/30/19 at 9:00pm and 12/31/19 - 01/02/20 at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was documentation 10ml was administered on 01/03/20 at 1:00pm, 6:00pm, and 10:00pm.
-There was documentation 10ml was administered on 01/04/20 at 9:00am, 1:00pm, 5:00pm and 9:00pm.

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D 392	Continued From page 19	D 392		

-There was documentation the declining inventory was zero on 01/04/20 at 1:00pm.
-There was documentation that a total of 120ml was administered but, 60 ml were left in the 120ml bottle of morphine sulfate.

Review of a second morphine sulfate control substance record for Resident #3 on 01/07/20 revealed:
-Morphine sulfate 10mg/5ml, 360ml dispensed on 12/30/19 was printed on the label.
-There was documentation that 10ml had been administered on 01/04/20 at 5:00pm and 9:00pm, 01/05/20 - 01/06/20 at 9:00am, 1:00pm, 5:00pm, and 9:00pm, and on 01/07/20 at 9:00am.
-There was documentation the declining inventory was 10ml on 01/07/20 at 9:00am.
-There was documentation that a total of 110ml had been administered, but 240ml were left in the 360ml bottle.

Interview with the Medication Aide (MA) on 01/07/20 at 12:35pm revealed:
-The pharmacy had sent a 1ml syringe with the morphine sulfate.
-The MA had been filling the syringe with the morphine sulfate up to the 0.5ml mark and administered the medication to Resident #3.
-The Nurse Consultant had instructed her to use the 5ml mark on a 30ml plastic medication cup to administer the morphine sulfate.

Interview with the Administrator on 01/07/20 at 3:50pm revealed:
-The Administrator reviewed the documentation every 2 weeks when the Nurse Consultant was in the facility and reviewed the documentation.
-The Administrator would have the Nurse Consultant retrain the staff on control sheets.

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D992	Continued From page 20	D992		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.	D992	This employee is spouse To SIC who lives in facility. I had Controlled Substance Screening on him when he started working nights initially at that time he was not an employee. In future I will screen at Time of employment regardless of prior screening. Employee was rescreened 1/29/20 by [redacted] Rn. MOK screening negative This will correct and Prevent future problems	1/29/20

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D992	Continued From page 21	D992		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff C).

The findings are:

Review of Staff C's personnel record revealed:
-There was no date of hire.
-There was documentation of an examination and screening for the presence of controlled substances dated 08/25/15.

Interview with the Administrator on 01/07/20 at 4:45pm revealed:
-Staff C was hired as the Maintenance Staff in 02/2019.
-She had completed a controlled substance screen 08/25/15 when Staff C was visiting his spouse (staff person) in the facility during the evening hours.
-She had not completed another controlled substance screen after Staff C had been hired in 02/2019.

Attempted telephone interview on 01/07/20 at 4:48pm was unsuccessful.