scan & email to [redacted] 5/6/22 @ 3pm

PRINTED: 03/22/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051001	A. BUILDING: III. B. WING	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOME CARE OF JOHNSTON COUNTY III	474 JERRY ROAD SELMA, NC 27576

& mailed original

(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 conducted an annual survey on 03/03/22 and 03/04/22.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 residents sampled (#2, #3) who was prescribed an antipsychotic (#2) and an anti-anxiety (#3). The findings are: Review of the facility's Medication Policies and Procedures revised on 09/18/20 revealed: -Medication orders will be verified by staff with a prescribing practitioner when orders received where not clear or incomplete. -Clarification would be documented in the resident's record. -As needed (PRN) medication orders were to	D 344	ADMINISTRATOR WILL HAVE MEDICATION ORDERS FOR THE RESIDENTS UPON ADMISSION OR READMISSION SIGNED AND DATED WITHIN 24 HOURS OF ADMISSION OR READMISSION TO OUR FACILITY. ADMINISTRATOR WILL MAKE SURE ORDERS ARE CLEAR AND COMPLETE WHICH INCLUDES PRN MEDICATIONS TO INCLUDE SPECIFIC USE AND ROUTES OF ADMINISTRATION FOR ALL MEDICATIONS SCHEDULED AND PRN. ADMINISTRATOR AND RCC COMPLETED 100% OF CHART AUDITS AND MEDICATION next page	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	~~04-11-2022~~

STATE FORM 6899 MHJM11 If continuation sheet 1 of 17

Revised and edited w/ medical 5/6/2022 @ W 05/10/2022

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D 344	Continued From page 1 include the specific reason for use. 1. Review of Resident #3's current FL-2 dated 08/24/21 revealed diagnoses included anxiety, chronic pain syndrome, diabetes mellitus (DM) type II, hypertension (HTN), and opioid dependence. Review of Resident #3's physician's order sheet dated 01/28/22 revealed: -There was an order for Buspirone 10 milligrams (mg) three times a day as needed (used to treat anxiety). -The indication for Buspirone was not documented. Review of a resident's local hospital discharge summary dated 02/24/22 revealed: -Resident #3 was admitted on 02/22/22. -Admission diagnoses included acute encephalopathy and malignant neoplasm of the right breast. -The resident had a past medical history of depression. -There was an order for Buspirone 10mg three times a day as needed. -The indication for Buspirone was not documented. Review of a resident's local hospital after visit summary sheet dated 02/24/22 revealed -There was documentation that no changes had been made to Resident #3's medications. -Buspirone 10mg three times a day as needed was documented on the resident's medication list. -The indication for Buspirone was not documented. -The bottom right of the after-visit summary sheet was initialed by the Administrator.	D 344	CLARIFICATION REVIEWS FROM PCP AND UPDATED ORDERS FOR EVERY RESIDENT. ADMINISTRATOR WILL COMPARE PHYSICIAN ORDERS, MAR and medications to make SURE THEY MATCH. THIS WILL BE DONE BY WEEKLY RANDOM CHART AUDITS AND OBSERVATION OF MED PASSES BY THE ADMINISTRATOR AND/OR RCC. DD Wilds ADMINISTRATOR	4/11/22

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D 344	Continued From page 2 Review of Resident #3's January 2022 medication administration record (MAR) on 03/04/22 revealed: -There was an electronic entry for Buspirone 10mg one tablet three times daily. -There was an "X" documented over the Buspirone 10mg one tablet three times daily electronic entry. -There was handwritten of "see change" documented in the date section beside Buspirone 10mg one tablet three times daily. -There was a handwritten entry for Buspirone 10mg three times a day as needed for anxiety located at the bottom of the MAR. -Beside the Buspirone 10mg as needed, there was a handwritten "PRN" documented in the section labeled "hour" -There was no documentation Buspirone as needed was administered to the resident. Review of Resident #3's February 2022 MAR on 03/04/22 revealed: -There was an electronic entry for Buspirone 10mg three times a day. -As needed was handwritten beside the electronic entry of Buspirone. -There was no documentation Buspirone as needed was administered to the resident. Review of Resident #3's March 2022 MAR on 03/04/22 revealed: -There was an electronic entry for Buspirone 10mg three times a day as needed. -The indication for Buspirone was not documented. -There was no documentation Buspirone was administered to the resident. Interview with the Administrator on 03/04/22 at 9:10am revealed:	D 344		

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D 344	Continued From page 3 -He was responsible to review resident's hospital discharge summaries. -He was responsible to compare the resident's discharge summary medications to their current MAR for changes. -He was responsible to contact the resident's PCP to clarify the medication orders if different. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/4/22 at 12:30pm revealed: -Resident #3's electronic prescription for Buspar 10mg three times a day as needed was sent to the pharmacy on 02/01/22 by the resident's PCP. -Buspar was used to treat anxiety. -The indication for Buspar as needed was not documented on the prescription. -She did not see where the facility faxed Resident #3's physician orders dated 01/28/22 to the pharmacy. She did not see where the facility faxed Resident #3's hospital discharge summary dated 02/24/22 to the pharmacy. -She expected the facility to have faxed Resident #3's signed physician orders and discharge summary to the pharmacy. Interview with the Administrator on 03/04/22 at 2:10pm revealed: -Buspar was used to treat anxiety. -Resident #3's Buspar order was not a complete order due to there was no indication for when to administer the medication as needed. -Staff would not know when to administer Buspar to Resident #3 because there was no indication for administration documented. Interview with a medication aide (MA) on 03/04/22 at 2:15pm revealed: -Buspar was to be administered to Resident #3	D 344		

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D 344	Continued From page 4 three times a day as needed. -The indication for Buspar was not documented. -She asked the Administrator what the indications for administering Buspar to Resident #3 were. -She did not remember when she asked the Administrator. -The Administrator told her to administer Buspar to Resident #3 when the resident reported that she was feeling jittery, couldn't stay still, or was having a bad day. -Resident #3 would ask for Buspar when she needed it. Interview with Resident #3 on 03/04/22 at 2:30pm revealed: -She would ask for Buspar when feeling anxious. -She did not remember the last time asked for and/or was administered Buspar. Interview with the Administrator on 03/04/22 at 3:00pm revealed: -He expected staff to follow the medication administration policy to make sure medication was being administered correctly and to keep residents safe. Review of Resident #3's medications on hand on 03/04/22 revealed: -There was a medication bottle of Buspar. -The administration label had instructions for Buspar 10mg three times a day. -As needed was handwritten beside the administration instructions. -The indication for administering Buspar as needed was not documented. 2. Review of Resident #2's current FL-2 dated 06/25/21 revealed: -Diagnoses included unspecified dementia without behaviors.	D 344		

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D 344	Continued From page 5 -She was semi-ambulatory. -There was no documentation of orientation status. Review of Resident #2's prescription dated 10/28/21 revealed: - Resident #2's primary care provider (PCP) ordered Seroquel 25 mg tablet one-half to one tablet at bedtime as directed. -No other directions were documented on the prescription. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine (also known as Seroquel, used for psychosis) 25mg one-half to one tablet at bedtime as directed scheduled for administration at 9:00pm. -There was a circle around the one tablet entry. -Quetiapine 25mg was documented as administered 28 of 28 days in February 2022. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for quetiapine 25mg one-half to one tablet at bedtime as directed scheduled for administration at 9:00pm. -There was a circle around the one tablet entry. -Quetiapine 25mg was documented as administered 31 of 31 days in January 2022. Review of Resident #2's Report on Health Services to Residents facility note dated 10/28/21 revealed: -A handwritten note for Seroquel 25 mg at bedtime. -The note documented if too much administer one-half Seroquel 25mg. -The note was signed by the administrator.	D 344		

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D 344	Continued From page 6 Interview with a medication aide (MA) on 03/04/22 at 10:03am revealed: -The order for Seroquel 25mg was administered daily. -She believed the directions indicated for staff to administer one tablet first and if Resident #2 was still agitated an hour or two later to give one-half tablet. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/04/22 at 12:35pm revealed: -The quetiapine order was for one-half to one tablet at bedtime dated 10/28/21. -The pharmacy had a note from Resident #2's PCP that if one tablet was not tolerated (if she was too sleepy), staff could administer one-half tablet. If the resident was not sleeping when taking one-half tablet, staff could administer one tablet. Interview with the Administrator on 03/04/22 at 3:20pm revealed: -He had written the note on the Report on Health Services to Residents on 10/28/21 as documentation of a video visit with Resident #2's PCP. -The directions for the Seroquel were for staff to give one tablet but if Resident #2 was too sleepy to give one-half tablet. -The MAs or the Administrator should have requested clarification from the PCP for one dosage to be given so MAs would not have to choose between two doses. Attempted telephone interview with Resident #2's PCP on 03/04/22 at 3:37pm was unsuccessful.	D 344		

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D 358	Continued From page 7	D 358	ADMINISTRATOR WILL ASSURE THAT OUR FACILITY ADMINISTERS MEDICATIONS AS ORDERED AND IN ACCORDANCE WITH OUR FACILITIES MEDICATION ADMINISTRATION POLICY AND WILL IMMEDIATELY CLARIFY ANY ORDERS WHETHER FROM HOSPITAL ADMISSION AND DISCHARGE OR FROM THEIR PHYSICIAN. ADMINISTRATOR AND RCC COMPLETED 100% OF CHART AUDITS AND MEDICATION CLARIFICATION REVIEWS FROM PCP AND UPDATED ORDERS FOR EVERY RESIDENT. next page	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered and in accordance with the facility's medication administration policy for 1 of 3 residents sampled including errors with medications to treat high blood pressure, opioid overdose, and nausea (#3). The findings are: Review of the facility's Medication Policy and Procedures with a revision date of 09/18/20 revealed prescription medications will be administered in accordance with the prescribing practitioner's orders. Review of Resident #3's current FL-2 dated 08/24/21 revealed diagnoses included anxiety, chronic pain syndrome, diabetes mellitus (DM) type II, hypertension (HTN), and opioid dependence. a. Review of Resident #3's physician's order sheet dated 01/28/22 revealed there was an order for Metoprolol Extended Release (ER) 25mg once daily (used to treat high blood	D 358		

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D 358	Continued From page 8 pressure, chest pain, and heart failure). Review of Resident #3's hospital discharge summary dated 02/24/22 revealed: -The resident was admitted on 02/22/22 for confusion and weakness. -Diagnoses included acute encephalopathy and hypertension. -There was an order for Metoprolol Succinate 12.5mg once daily. -The resident's blood pressure was 141/82. Review of Resident #3's February 2022 medication administration record (MAR) revealed: -There was an electronic entry for Metoprolol Succinate 25mg daily. -There was documentation Metoprolol Succinate 25mg was administered at 8:00am from 02/25/22 - 2/28/22. -There was an electronic entry for temperature and blood pressure on the back of the resident's MAR. -On 02/25/22, there was a blood pressure handwritten as 128 in the temperature slot and 87 in the blood pressure slot. -On 02/28/22, there was a blood pressure handwritten as 126 in the temperature slot and 88 in the blood pressure slot. Review of Resident #3's March 2022 MAR revealed: -There was an electronic entry for Metoprolol Succinate 25mg daily. -There was documentation Metoprolol Succinate 25mg was administered at 8:00am from 03/01/22 to 03/03/22. -On 03/02/22, there was a blood pressure handwritten as 105 in the temperature slot and 88 in the blood pressure slot.	D 358	THIS WILL BE DONE BY THE ADMINISTRATOR REVIEWING ANY PHYSICIAN ORDER CHANGES, MAKING THE CHANGE AND NOTIFYING THE PHARMACY. THE ADMINISTRATOR AND/OR RCC WILL THEN HAVE AN INSERVICE OF PHYSICIAN ORDER CHANGES WITH THE STAFF - ADMINISTRATOR WILL RANDOMLY COMPARE THE ORDERS, MAR, MEDICATION AND LABELS WEEKLY. ADMINISTRATOR 04/11/22	04/11/22

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D 358	Continued From page 9 Interview with the Administrator on 03/03/22 at 4:30pm revealed: -Resident #3's systolic blood pressure was documented in the temperature section on the back of the resident's monthly MARs. -Resident #3's diastolic blood pressure was documented in the blood pressure section on the back of the resident's monthly MARs. Interview with the Administrator on 03/04/22 at 9:10am revealed: -He did not see Resident #3's order for Metoprolol 12.5mg daily on the resident's 02/24/22 hospital discharge summary. -He was responsible to review resident's hospital discharge summaries. -He was responsbile to compare the resident's discharge summary medications to their current MAR for changes. -He was responsible to contact the resident's PCP to clarify discharge medications that were ordered differently. -He did not send Resident #3's 02/24/22 hospital discharge summary to the pharmacy. Interview with the pharmacist for the facility's contracted pharmacy on 03/04/22 at 12:30pm revealed: -Resident #3's most recent order was dated 01/06/22 for Metoprolol 25mg once daily. -The pharmacy had not received Resident #3's hospital discharge summary dated 02/24/22. -Normally, Metoprolol would be decreased if the current dosage was decreasing the blood pressure too low. -Resident #3 could experience low blood pressure from taking a stronger than needed dose of Metoprolol. -She expected the facility to fax physician orders, including hospital discharge summaries, to the	D 358		

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D 358	Continued From page 10	D 358		

pharmacy.

Interview with Resident #3 on 03/04/22 at 2:30pm revealed she had episodes of dizziness but contributed that to chemotherapy.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 03/04/22 at 12:05pm was unsuccessful.

b. Review of Resident #3's hospital discharge summary dated 02/24/22 revealed:
-The resident was admitted on 02/22/22 for possible Aricept (used to treat dementia related to Alzheimer's disease) withdrawal versus effects of polypharmacy (the simultaneous use of multiple drugs to treat disease and health conditions).
-Diagnoses included acute encephalopathy.
-There was an order for Narcan 4mg actuation one spray in either nostril once for known/suspected opioid overdose. May repeat every two to three minutes in alternating nostril until Emergency Medical Services (EMS) arrives.

Review of Resident #3's February 2022 medication administration record (MAR) revealed there was no entry for Narcan.

Review of Resident #3's March 2022 MAR revealed there was no entry for Narcan.

Observation of Resident #3's medications on hand revealed there was no Narcan available for the resident.

Interview with the Administrator on 03/04/22 at 9:10am revealed:
-Resident #3 was prescribed Morphine which was an opioid.
-He did not see Resident #3's order for Narcan on

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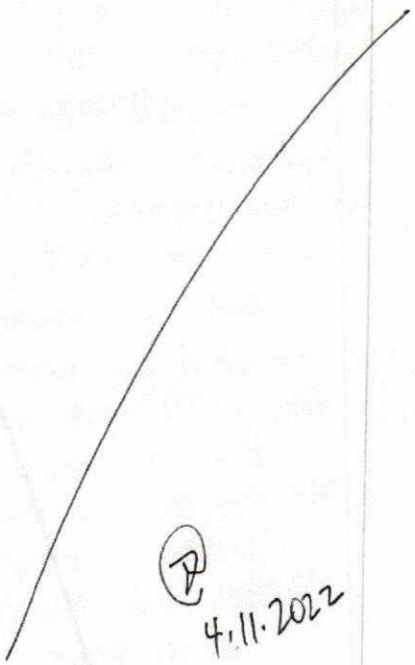
D 358	Continued From page 11 the resident's 02/24/22 hospital discharge summary. -He was responsible to review the resident's hospital discharge summaries. -He was responsible to compare the resident's discharge summary medications to their current MAR for changes. -He was responsible to contact the resident's PCP to clarify discharge medications that were ordered differently. -He did not send Resident #3's 02/24/22 hospital discharge summary to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/04/22 at 12:30pm revealed: -Narcan was a medication used to quickly reverse the effects of opioids such as Morphine. -She expected the facility to fax physician orders, including hospital discharge summaries, to the pharmacy. -She did not see where Resident #3's 02/24/22 hospital discharge summary had been received from the facility. Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 03/04/22 at 12:05pm was unsuccessful.	D 358	 R 4.11.2022	
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.	D 392	ADMINISTRATOR WILL ASSURE THAT OUR FACILITY HAS A READILY RETRIEVABLE RECORD OF CONTROLLED next page	

R 4.11.22

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D 392	Continued From page 12 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure readily retrievable records that accurately reconciled the disposition and administration of controlled substances for 1 of 3 residents sampled (#3) for medications to treat pain. The findings are: Review of Resident #3's current FL-2 dated 08/24/21 revealed diagnoses included anxiety, chronic pain syndrome and opioid dependence. a. Review of an electronic physician's order dated 02/24/22 revealed there was an order for Oxycodone 10-325mg four times a day while awake (a combination medication that containes an opioid used to treat pain). Observation of Resident #3's medications on hand on 03/03/22 at 4:05pm revealed there were 72 tablets of Oxycodone 10/325mg remaining. Review of Resident #3's controlled substance (CS) log for March 2022 on 03/03/22 at 4:07pm revealed: -On 03/01/22 during first shift there were 79 tablets of Oxycodone documented. -On 03/02/22 during first shift and second shifts there were 75 tablets of Oxycodone documented. -On 03/03/22 during first shift there were 72 tablets of Oxycodone documented. -A line was drawn through 72 and a 74 documented above. -There was no documentation that indicated each time Resident #3 was administered Oxycodone.	D 392	SUBSTANCES BY DOCUMENTING THE RECEIPT, ADMINISTRATION AND DISPOSITION OF CONTROLLED SUBSTANCES ON A CONTROLLED SUBSTANCE LOG TALLY SHEET. I REALIZE THAT OUR NARCOTIC LOG, WHICH WE HAVE BEEN USING, FOR A COUNT AT EACH SHIFT CHANGE WAS NOT ADEQUATE TO PROTECT EVERYONE AND THAT OUR STAFF INITIALING, DATING AND RECORDING THE TIME GIVEN ON THE BACK OF THE BUBBLE PUNCH CARD AT EACH ADMINISTRATION WOULD NOT BE A next page	

D 4/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051001	A. BUILDING _____ B. WING _____	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOME CARE OF JOHNSTON COUNTY III	474 JERRY ROAD SELMA, NC 27576

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D 392	Continued From page 13 -There was no documentation that kept an accurate reconciliation of the number of Oxycodone pills administered to the resident and the number of pills that remained. Review of Resident #3's March 2022 medication administration record (MAR) revealed: -There was an electronic entry for Oxycodone 10-325mg one tablet four times daily while awake at 7:00am, 12:00pm, 5:00pm, and 10:00pm. -There was documentation Oxycodone had been administered on 03/01/22 and 03/02/22 at 7:00am, 12:00pm, 5:00pm, and 10:00pm. -There was documentation Oxycodone had been administered on 03/03/22 at 7:00am and 12:00pm. Interview with the mediation aide (MA) on 03/03/22 at 4:07pm revealed: -She did not document on Resident #3's CS log each time she administered Oxycodone to the resident. -A CS count was performed each shift change by the oncoming and outgoing MA to capture the total number of Oxycodone tablets that remained for Resident #3. Refer to interview with the MA on 03/03/22 at 4:07pm. Refer to interview with the Administrator on 03/03/22 at 4:20pm. Refer to telephone interview with a pharmacist for the facility's contracted pharmacy on 03/04/22 at 12:30pm. b. Review of Resident #3's hospital discharge summary dated 02/24/22 revealed: -The resident was admitted on 02/22/22.	D 392	RETRIEVABLE RECORD AFTER THE EMPTY PUNCH CARD WAS RETURNED TO THE PHARMACY FOR SHREDDING. THIS WILL BE DONE BY THE ADMINISTRATOR DEVELOPING A CONTROL SUBSTANCE LOG TALLY SHEET AND WITH AN INSERVICE ONE ON ONE WITH EACH STAFF MEMBER— THE ADMINISTRATOR AND/OR RCC WILL RANDOMLY COMPARE THE CONTROLLED MEDICATION TO THE MAR TO ~~THE~~ THE next page	

4/11/22

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D 392	Continued From page 14 -Diagnoses included acute encephalopathy and metastatic right breast cancer on palliative chemotherapy. -There was an order for Morphine 30mg one tablet every 12 hours (a narcotic pain medication that contains opioid used to treat pain). Observation of Resident #3's medications on hand on 03/03/22 at 4:05pm revealed there were 30 tablets of Morphine ER 30mg remaining. Review of Resident #3's controlled substance (CS) log for March 2022 on 03/03/22 at 4:07pm revealed: -On 03/01/22 during first shift there were 35 tablets of Morphine 30mg documented. -On 03/02/22 during first shift there were 33 tablets of Morphine 30mg documented. -On 03/02/22 during second shift there were 32 tablets of Morphine 30mg documented. -On 03/03/22 during first shift there were 31 tablets of Morphine 30mg documented. -There was no documentation that indicated each time Resident #3 was administered Morphine. -There was no documentation that kept an accurate reconciliation of the amount of Morphine administered to the resident and the amount that remained. Review of Resident #3's March 2021 medication administration record (MAR) revealed: -There was an electronic entry for Morphine Sulfate ER 30mg take one tablet every 12 hours. -There was documentation Morphine Sulfate ER was administered 03/01/22 and 03/02/22 at 9:00am and 9:00pm. -There was documentation Morphine Sulfate ER was administered on 03/03/22 at 9:00am. Interview with the mediation aide (MA) on	D 392	NARCOTIC LOG AND TO THE CONTROL SUBSTANCE LOG TALLY SHEET WEEKLY. DF White ADMINISTRATOR 4/11/2022	4/11/22

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D 392	Continued From page 15 03/03/22 at 4:07pm revealed: -She had administered Resident #3 one Morphine this morning, 03/03/22. -She did not document on Resident #3's CS log each time she administered Morphine to the resident. -A CS count was performed each shift change by the oncoming and outgoing MA to capture the total number of Morphine tablets that remained for Resident #3. Refer to interview with the MA on 03/03/22 at 4:07pm. Refer to interview with the Administrator on 03/03/22 at 4:20pm. Refer to telephone interview with a pharmacist for the facility ' s contracted pharmacy on 03/04/22 at 12:30pm. Interview with the mediation aide (MA) on 03/03/22 at 4:07pm revealed: -She had not been trained by the facility how to complete a CS log. -She did not know accurate documentation on CS was required including reconciliation of the number of tablets that remained and the number of tablets administered. Interview with the Administrator on 03/03/22 at 4:20pm revealed: -He did not know the facility was required to keep records that accurately reconciled the disposition and administration of controlled substances. -He thought counting the remaining amount of CSs at each shift change was sufficient practice. Telephone interview with a pharmacist for the facility's contracted pharmacy on 03/04/22 at	D 392		

4.11.22

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D 392	Continued From page 16 12:30pm revealed: -She preferred the facility to have an ongoing tally to include the exact count of controlled substances for reconciliation. -An ongoing tally would document exactly how much of the controlled substance was administered and was remaining. -If the facility did not have an ongoing accurate count of controlled substances the facility was at risk for being unable to accurately account for the medications.	D 392		

4.11.22