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	HAL049016	A. BUILDING: _____ B. WING _____	06/15/2023

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OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 and follow-up survey from June 13, 2023 to June 15, 2023.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and observations, the facility failed to ensure physician's orders were implemented for 1 of 5 residents related to a medication to prevent constipation (#3). The findings are: Review of Resident #3's FL2 dated 04/24/23 revealed diagnoses that included schizoaffective disorder, chronic obstructive pulmonary disease (COPD), chronic pain, dementia, and a history of a cardiovascular accident (CVA). Review of Resident #3's physician's order dated 05/04/23 revealed an order for docusate sodium 100 mg, one capsule by mouth two times a day (BID) to prevent constipation. Review of Resident #3's May 2023 medication administration record (MAR) revealed there was no entry for docusate sodium 100mg. Review of Resident #3's June 2023 MAR	D 276		

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D 276	Continued From page 1	D 276		

revealed there was no entry for docusate sodium 100mg.

Observation of medications on hand for Resident #3 on 6/15/23 at 11:45am revealed there was no docusate 100mg located on the medication cart.

Attempted telephone interview with Resident #3's Primary Care Physician (PCP) on 06/15/23 at 11:08am was unsuccessful.

Telephone interview with the facility's contracted pharmacy pharmacist on 6/14/23 at 11:44am revealed:
-The pharmacy had not received an order for docusate 100mg BID for Resident #3.
-The facility faxed the orders to the pharmacy; the pharmacy keyed the orders into the system and the pharmacy dispensed from the system.
-The facility had to send the orders to the pharmacy for them to dispense the medication.
-If the resident did not get the docusate 100mg BID, it could eventually cause constipation.

Interview with Resident #3 on 06/14/23 at 11:56am revealed he had never received docusate.

Interview with the Medication Aide on 06/15/23 at 10:45am revealed:
-The PCP usually sent the order to the pharmacy.
-The MA was not sure why the docusate 100mg BID was not on the MAR.
-The resident care coordinator (RCC) received all the orders from an email from the pharmacy.
-The RCC and the MA clarified the orders together.
-It was the responsibility of the MA to put the orders on the MAR.

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D 276	Continued From page 2 Attempted telephone interview with another MA on 06/15/23 at 11:14am was unsuccessful. Interview with the RCC on 06/15/23 at 11:45am revealed: -The PCP sent the orders to the pharmacy electronically. -The facility received the orders through email, printed them and gave them to the RCC. -She was not aware the docusate 100mg BID was not received. -She did not think the PCP sent the order to the pharmacy. -The order was overlooked because the medication did not come in from the pharmacy. -She looked over each progress note but had problems not receiving them a while ago. -Medication cart audits were completed by the contracted pharmacy quarterly. -She tried to complete medication cart audits weekly, but an audit had not been completed in about three weeks. Interview with the Administrator on 06/15/23 at 12:43pm revealed: -It was the responsibility of the RCC to complete the medication cart audits monthly but was not sure if they were being completed. -The contracted pharmacy did a medication cart audit quarterly. -The Administrator expected the orders to be faxed to the pharmacy and the medications to be in the facility. -The RCC read the PCP visit notes but must have missed the docusate 100mg BID order. -This should have been caught on an audit.	D 276		
D 352	10A NCAC 13F .1003(a) Medication Labels	D 352		

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D 352	Continued From page 3 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure insulin pens were properly labeled for 4 of 4 residents observed during a medication administration pass (Residents #2, #6, #7, and #8). The findings are: 1. Review of Resident #2's current FL2 dated 10/17/22 revealed: -Diagnoses included Type 2 diabetes. -There was an order for Novolog100 unit flexpen (a rapid acting insulin used to lower elevated blood sugar levels) inject per sliding scale three	D 352		

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D 352	Continued From page 4 times daily before meals. Review of a medication change request from the facilities contracted pharmacy dated 03/23/23 revealed Resident #2 had an order to receive Humalog 100unit flexpen (a rapid acting insulin used to lower elevated blood sugar levels) in place of the Novolog 100unit flexpen. Observation of the medication pass on 06/13/23 at 11:30am revealed: -The medication aide (MA) removed a Humalog flexpen from the medication cart to administer insulin to Resident #2. -The flexpen was labeled with the resident's name and the label indicated the flexpen was to be discarded after 28 days. -There was no opened or discard date indicated on the flexpen. Review of Resident #2's June 2023 Sliding Scale Insulin Medication Administration Record revealed: -There was an entry for Novolog insulin inject per sliding scale three times daily to be administered at 7:30am, 12:00 noon, and 5:30pm. -Novolog was administered 37 out of 39 possible opportunities. -FSBS ranged from 80-310. Interview with the MA on 06/13/23 at 11:30am and at 12:30pm revealed she had used the pen to administer insulin to Resident #2 at 7:30am and noon that day (06/13/23). Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed eight Humalog flexpens, a 25-day supply, were dispensed on 06/01/23 for Resident #2.	D 352		

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D 352	Continued From page 5 Refer to interview with the MA on 06/13/23 at 12:30pm. Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 06/14/23 at 11:44am. Refer to interview with the RCC on 06/15/23 at 11:44am. Refer to interview with the Administrator on 06/15/23 at 12:42pm. 2. Review of Resident #6's current FL2 dated 02/14/23 revealed: -Diagnoses included Type 2 diabetes. -There was an order for Novolog 100unit inject per sliding scale three times daily before meals. Observation of the medication pass on 06/13/23 at 11:30am revealed: -The MA removed a Novolog flexpen from the medication cart to administer insulin to Resident #6. -The flexpen was labeled with the resident's name handwritten on the pen. -There was no opened or discard date indicated on the flexpen. Interview with the MA on 06/13/23 at 11:30am and at 12:30pm revealed she had used the pen to administer insulin to Resident #6 at 7:30am and noon that day (06/13/23). Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed the pharmacy did not dispense Resident #6's medications.	D 352		

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Refer to interview with the MA on 06/13/23 at 12:30pm.

Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 06/14/23 at 11:44am.

Refer to interview with the RCC on 06/15/23 at 11:44am.

Refer to interview with the Administrator on 06/15/23 at 12:42pm.

3. Review of Resident #7's current FL2 dated 03/20/23 revealed:
-Diagnoses included diabetes.
-There was an order for Humalog 100unit flexpen inject per sliding scale three times daily before meals.

Review of a medication change request from the facilities contracted pharmacy dated 03/21/23 revealed Resident #7 had an order to receive Novolog 100unit flexpen in place of the Humalog 100unit flexpen.

Observation of the medication pass on 06/13/23 at 11:30am revealed:
-The MA removed a Novolog flexpen from the medication cart to administer insulin to Resident #7.
-The flexpen was labeled with the resident's name and the label indicated the flexpen was to be discarded after 28 days.
-There was no opened or discard date indicated on the flexpen.

Interview with the MA on 06/13/23 at 11:30am and at 12:30pm revealed she had used the pen to administer insulin to Resident #7 at 7:30am and

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D 352	Continued From page 7 noon that day (06/13/23). Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed three Novolog flexpens, a 25-day supply, were dispensed on 06/01/23 for Resident #7. Refer to interview with the MA on 06/13/23 at 12:30pm. Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 06/14/23 at 11:44am. Refer to interview with the RCC on 06/15/23 at 11:44am. Refer to interview with the Administrator on 06/15/23 at 12:42pm. 4. Review of Resident #8's current FL2 dated 11/18/22 revealed: -Diagnoses included Type 2 diabetes. -There was an order for insulin lispro 100unit (a rapid acting insulin used to lower elevated blood sugar levels) inject per sliding scale. Review of Resident #8's Primary Care Provider's order (PCP) dated 02/28/23 revealed an order for Novolog 100unit flexpen, inject per sliding scale three times daily before meals. Observation of the medication pass on 06/13/23 at 11:30am revealed: -The MA removed a Novolog flexpen from the medication cart to administer insulin to Resident #8. -The flexpen contained no label indicating the resident's name.	D 352		

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D 352	Continued From page 8 -There was no opened or discard date indicated on the flexpen. -The MA discarded the flexpen. Interview with the MA on 06/13/23 at 11:30am revealed she did not know why the flexpen was not labeled with Resident #8's name. Refer to interview with the MA on 06/13/23 at 12:30pm. Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 06/14/23 at 11:44am. Refer to interview with the RCC on 06/15/23 at 11:44am. Refer to interview with the Administrator on 06/15/23 at 12:42pm. _____ Interview with the MA on 06/13/23 at 12:30pm revealed: -There were two MAs that usually administered insulin to the residents in the facility. -It was the responsibility of the MA to label the insulin pens when they were opened with the date they were opened or the discard date. -She was unsure if she opened the flexpens she used that day (06/13/23). -She usually dated insulin flexpens when she opened them. Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed: -Humalog and Novolog flexpens were to be discarded after 28 days per the manufacturer's recommendations. -She was unsure what the consequences might	D 352		

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D 352	Continued From page 9 be of using a flexpen past the 28 days. Interview with the RCC on 06/15/23 at 11:44am revealed: -The MAs were responsible for labeling insulin flexpens with either the open date or a discard date when they were opened. -The contracted pharmacy did medication cart audits quarterly. -The pharmacy reviewed insulin flexpens in the cart during their audit to ensure they were correctly labeled with a discard date. -She tried to do cart audits weekly but had gotten behind. Interview with the Administrator on 06/15/23 at 12:42pm revealed: -The MAs were responsible for labeling insulin flexpens with either the open date or a discard date when they were opened. -The pharmacy performed medication cart audits quarterly. -The RCC was responsible for completing cart audits monthly, but she was unsure if they were being done.	D 352		
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.	D 358		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 1 of 5 sampled residents (Resident #2) related to a medication used to control elevated blood sugar.

The findings are:

Review the facility's undated Medication Administration policy revealed:
-Staff were to administer medications according to the prescribing practitioner's orders.
-Staff were to document medications administered on the resident's Medication Administration Record (MAR).
-Omissions and refusals of medications and the reason for omissions were to be documented on the MAR.

Review of Resident #2's current FL2 dated 10/17/22 revealed:
-Diagnoses included Type 2 diabetes.
-There was an order to check fingerstick blood sugar (FSBS) three times daily before meals.
-There was an order for Novolog100 unit flexpen (a rapid acting insulin used to lower elevated blood sugar levels) inject per sliding scale: FSBS:0-100 = 0 units, 101-150 = 4 units, 151-200 = 8 units, 201-250 = 12 units, 251-300 = 16 units, 301-350 = 20 units, 351-400 = 24 units, greater than 400 inject 30 units and call the Primary Care Provider (PCP).

Review of a medication change request from the facilities contracted pharmacy dated 03/23/23 revealed Resident #2 had an order to receive Humalog 100unit flexpen (a rapid acting insulin used to lower elevated blood sugar levels) in place of the Novolog 100unit flexpen and to

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D 358	Continued From page 11 continue the same sliding scale. Review of Resident #2's April 2023 Sliding Scale Insulin Medication Administration Record (MAR) revealed: -There was an entry for Novolog insulin inject per sliding scale three times daily to be administered at 7:30am, 12:00pm, and 5:30pm. -On 04/14/23 at 7:30am, the resident's FSBS was 163 and she received 4 units of insulin when the order stated she should have received 8 units. -On 04/23/23 at 12:00 pm, the resident's FSBS was 253 and she received 12 units when the order stated she should have received 16 units. Review of Resident #2's May 2023 Sliding Scale Insulin MAR revealed: -There was an entry for Novolog insulin inject per sliding scale three times daily to be administered at 7:30am, 12:00pm, and 5:30pm. -On 05/04/23 at 5:30pm, the resident's FSBS was 221 and she received 16 units of insulin when the order stated she should have received 12 units. -On 05/10/23 at 5:30pm, the resident's FSBS was 131 and there was no documentation 4 units of insulin were administered as ordered. -On 05/11/23 at 12:00pm, there was no FSBS recorded, and no documentation insulin was administered. -There was no documentation as to a reason why the FSBS and insulin administration was not recorded on 05/11/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/15/23 at 8:38am revealed: -Low blood sugar levels could cause passing out, confusion, dizziness, and weakness. -High blood sugar levels could cause, dry mouth, thirst and potential neurological damage.	D 358		

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D 358	Continued From page 12 Attempted interview with Resident #2's PCP on 06/15/23 at 10:08am was unsuccessful. Interview with the MA on 06/14/23 at 11:15am revealed: -Resident #2 was changed from Novolog to Humalog because of insurance reason. -The MAs charted insulin administration on the Sliding Scale Insulin MAR, an internal document, because it was more legible than trying to document in the small boxes on the MAR. -Resident #2's Sliding Scale Insulin MAR had not been changed to reflect the 03/23/23 change from Novolog to Humalog but Resident #2 was receiving Humalog as ordered. -She thought the errors on the April 2023 and May 2023 Sliding Scale Insulin MAR may have been documentation errors because the MAs were trained to review the sliding scale that was posted for Resident #2 prior to administering her insulin. Interview with Resident Care Coordinator (RCC) on 06/15/23 at 11:44am revealed: -The MAs were responsible to accurately administer insulin according to the PCP's order and to document the FSBS and insulin administration on the resident's Sliding Scale Insulin MAR. -The pharmacy completed MAR audits quarterly. -She was not aware of the errors for Resident #2's sliding scale insulin. Interview with the Administrator on 06/15/23 at 12:42pm revealed: -She expected insulin to be accurately administered and correctly documented. -The RCC was responsible to do MAR audits monthly, but she was unsure if they were being	D 358		

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D 358	Continued From page 13 done.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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 interviews and record reviews, the facility failed to ensure medication administration records (MARs) were complete and accurate for 2 of 5 sampled residents related to a medication used to relieve moderate to severe pain (Resident #1) and a medication used to treat skin infections (Resident #4). The findings are:	D 367		

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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
D 367	Continued From page 14 1. Review of Resident #1's FL2 dated 09/09/22 and 06/14/23 revealed: -Diagnoses included heart failure, generalized weakness, chronic hypoxic respiratory failure, urinary tract infection and cerebrovascular accident with dysphagia. -There was an order for hydromorphone (used to relieve moderate to severe pain) 1mg/ml by mouth sublingual (SL) every four hours as needed. Review of Resident #1's physician orders dated 02/23/23 revealed there was an order for hydromorphone 1mg/ml, SL every four hours as needed. Review of Resident #1's Control Substance Count Sheet (CSCS) for hydromorphone 1mg/ml by mouth SL every four hours as needed revealed: -Hydromorphone 1mg/ml, 60 prefilled individual syringes as needed were dispensed to the facility on 05/24/23. -Hydromorphone as needed was documented as administered on the CSCS by the medication aides (MAs) on 6/08/23 at 8:00pm, on 06/09/23 at 10:00am and on 06/12/23 at 4:00pm. Review of Resident #1's June medication administration record (MAR) on 06/13/23 revealed: -There was an entry for hydromorphone 1mg/ml, SL every four hours as needed. -Hydromorphone 1mg/ml, as needed was documented as administered on 6/02/23, on 06/07/23, and on 06/11/23. Interview with the MA on 06/15/23 at 10:08am revealed:	D 367		

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D 367	Continued From page 15 -She did not know Resident #1's CSCS and MAR dates did not match. -She documented the incorrect dates on the MAR. -There was no documented CSCS of hydromorphone as needed being administered to Resident #1 on 06/02/23 or for 06/07/23. -She did not compare the MAR to the CSCS. -She did not complete MAR and CSCS audits. Attempted telephone interview with a second MA on 06/15/23 at 11:06am was unsuccessful. Telephone interview with a pharmacist with the facilities contracted pharmacy on 06/14/23 at 3:28pm and on 06/15/23 at 8:38am revealed 60 prefilled syringes of hydromorphone as needed were filled on 05/24/23 and delivered to the facility the same day at 7:48pm. Interview with the RCC on 06/15/23 at 11:44am revealed: -She did not know Resident #1's CSCS and MAR dates did not match. -She completed medication cart and MAR audits weekly but had not completed an audit in three weeks. -She and a MA completed CSCS audits but had not completed an audit in three weeks. -The MAs should be completing CSCS audits at least three times weekly but did not know if this was being done. -She stated the Pharmacy came into the facility quarterly to complete medication cart, MAR and CSCS audits. -She expected the MAs to document the correct dates on the MAR and on the CSCS. -She expected the MAs to document on the CSCS and on the MAR when medications were administered.	D 367		

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D 367	Continued From page 16 Interview with the Administer on 06/15/23 at 12:40am revealed: -She did not know Resident #1's CSCS and MAR dates did not match. -She expected the MAs to sign the CSCS and MAR once medication had been administered. -She expected the CSCS to match the MAR. -She expected the MAs to document the correct dates on the MAR and on the CSCS. -She expected the MAs to count all controlled medications when administered and compare them to the CSCS. -She stated the RCC should be auditing the medication carts, MARs and CSCS monthly but did not know if the RCC had been completing audits. -She stated the Pharmacy came into the facility quarterly to complete medication cart, MAR and CSCS audits. 2. Review of Resident #4's current FL2 dated 01/12/23 revealed diagnoses included bipolar disorder, Alzheimer's, and schizoaffective disorder. Review of a physician's order dated 04/18/23 revealed an order for terbinafine 250mg by mouth daily for 14 days. Review of Resident #4's medication administration record (MAR) for April 2023 revealed there was documentation on April 21-30, 2023, terbinafine 250mg was given daily to Resident #4. Review of Resident #4's MAR for May 2023 revealed there was documentation May 01-31, 2023, terbinafine 250mg was given daily to	D 367		

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D 367	Continued From page 17 Resident #4. Interview with Resident #4 on 06/14/23 at 3:10pm revealed: -She had been on an antibiotic last month for skin issues. -She could not remember how long she was on it, but she thought maybe a week or two. Interview with the contracted pharmacy for the facility on 06/15/23 at 8:41am revealed: -Terbinafine 250mg daily for 14 days was dispensed on 04/20/23 for 14 days to the facility. Interview with a medication aide (MA) on 06/15/23 at 10:45am revealed: -The MA, who was on duty, was responsible for blocking out the MAR and writing the medication had been completed. -She did not audit the MAR's but thought it was the resident care coordinator (RCC) who did it monthly. -She was the MA who put the order on the MAR and said she just forgot to block out the dates after it was discontinued. -She knew she had not given terbinafine 250mg daily for the entire month of May 2023 because there were only 14 tablets sent from the pharmacy. Attempted telephone interview with another MA on 06/15/23 at 11:14am was unsuccessful. Interview with the RCC on 06/15/23 at 11:45am revealed: -She was not aware Resident #4's MAR for May 2023 was documented incorrectly for terbinafine 250mg daily. -She was aware Resident #4 had an order for terbinafine 250mg daily for 14 days.	D 367		

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D 367	Continued From page 18 -She was responsible for doing cart audits and comparing each resident's medication to their MAR's, but the last audit was about 3 weeks ago. -The cart audits were done with the RCC and MA, and the MARs were compared to the orders and what was on the medication cart. Interview with the Administrator on 06/15/23 at 12:43pm revealed: -She was not aware Resident #4's MAR for May 2023 was documented incorrectly for terbinafine 250mg daily. -The RCC was responsible for auditing the medication cart. -Cart audits should be done monthly but did not know if the audits were being done monthly. -She expected medication to be signed out on the MAR when it was given. -The MAs should be checking the orders each time medications were given.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 5 of 12 residents sampled who received pain medication (Resident	D 392		

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#1), anti-anxiety medication (Resident #9), a medication to decrease nerve pain (Resident #10 and #11) and a medication to treat seizures and panic disorders (Resident #12).

Findings include:

Review of the facility's undated Medication Policies and Procedures revealed:
-Documentation of controlled substances will be maintained by the facility and will be available for review.
-The record of documentation will be kept in the resident's record under the Medication Administration Record (MAR) or controlled drug sign-out record.

1. Review of Resident #1's FL2 dated 09/09/22 and 06/14/23 revealed:
-Diagnoses included heart failure, generalized weakness, chronic hypoxic respiratory failure, urinary tract infection and cerebrovascular accident with dysphagia.
-There was an order for hydromorphone (used to relieve moderate to severe pain) 1mg/ml by mouth sublingual (SL) every four hours as needed.

Review of Resident #1's physician orders dated 02/23/23 revealed there was an order for hydromorphone 1mg/ml, SL every four hours as needed.

Review of Resident #1's Control Substance Count Sheet (CSCS) for hydromorphone 1mg/ml by mouth SL every four hours as needed revealed:
-Hydromorphone 1mg/ml, 60 prefilled individual syringes as needed were dispensed to the facility

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on 05/24/23.
-Hydromorphone as needed was documented as administered on the CSCS by the medication aides (MAs) on 6/08/23 at 8:00pm, on 06/09/23 at 10:00am and on 06/12/23 at 4:00pm.
-There were 57 out of the 60 syringes remaining, documented on the CSCS sheet.

Review of Resident #1's medication administration record (MAR) on 06/13/23 at 4:48pm revealed there was no documentation that hydromorphone as needed was administered on 6/08/23 at 8:00pm, on 06/09/23 at 10:00am and on 06/12/23 at 4:00pm.

Observation of Resident #1's medications on hand on 06/14/23 at 3:04pm revealed there was a total of 55 prefilled individual syringes remaining of Resident #1's hydromorphone as needed.

Interview with the MA on 06/14/23 at 3:05pm and on 06/15/23 at 10:08am revealed:
-She did know Resident #1 had two syringes of hydromorphone as needed not accounted for.
-She stated the RCC may have been called in overnight to administer Resident #1's hydromorphone as needed and did not document the medication was administered.
-She did not compare the CSCS to the medications on hand.
-She did not complete CSCS, MAR or medication cart audits.

Attempted telephone interview with another MA on 06/15/23 at 11:06am was unsuccessful.

Telephone interview with a pharmacist with the facilities contracted pharmacy on 06/14/23 at 3:28pm and on 06/15/23 at 8:38am revealed:
-Hydromorphone 60 prefilled syringes were filled

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on 05/24/23 and delivered to the facility the same day at 7:48pm.
-Resident #1 could experience increased pain if hydromorphone was not administered when needed.

Interview with the Resident Care Coordinator (RCC) on 06/14/23 at 3:05pm and on 06/15/23 at 11:44am revealed:
-She did know Resident #1 had two syringes of hydromorphone as needed not accounted for.
-She completed medication cart and MAR audits weekly but had not completed an audit in three weeks.
-The MAs should be completing CSCS audits at least three times weekly but did not know if this was being done.
-The Pharmacy came into the facility quarterly to complete medication cart, MAR and CSCS audits.
-She expected the MAs to count all controlled medications when administered and compare them to the CSCS.
-She expected the MAs to document on the CSCS and on the MAR when medications were administered.

Interview with the Administer on 06/15/23 at 12:40am revealed:
-She did know Resident #1 had two syringes of hydromorphone as needed not accounted for.
-She expected the MAs to sign the CSCS and MAR once medication had been administered.
-She expected the CSCS to match the MAR.
-She expected the MAs to count all controlled medications when administered and compare them to the CSCS.
-She stated the RCC should be auditing the medication carts, MARs and CSCS monthly but did not know if the RCC had been completing

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D 392	Continued From page 22 audits. -She stated the Pharmacy came into the facility quarterly to complete medication cart, MAR and CSCS audits. Attempted telephone interview with Resident #1's PCP on 06/15/23 at 12:23pm was unsuccessful. 2. Review of Resident #9's current FL2 dated 03/14/23 revealed: -Diagnoses included schizophrenia. -There was an order for alprazolam 0.25mg (used to treat anxiety), one tablet three times daily. Review of Resident #9's Mental Health Provider's (MHP) note dated 03/03/23 revealed an order for alprazolam 0.25mg, one tablet three times daily for anxiety. Review of Resident #9's Control Substance Count Sheet (CSCS) for alprazolam revealed: -Alprazolam 0.25mg, 42 tablets were dispensed to the facility on 06/09/23. -The medication was dispensed in three cassettes. -Each cassette contained 14 individual boxes and each box contained one tablet. Observation of a medication pass on 06/13/23 at 11:30am for Resident #9 revealed: -The medication aide (MA) removed one tablet of alprazolam 0.25mg from a cassette for Resident #9. -There were 8 tablets remaining in the medication cassette. -The MA signed the CSCS after she removed the medication from the cassette. -The CSCS for Resident #9's alprazolam revealed there were 7 tablets remaining.	D 392		

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Interview with the MA on 06/13/23 at 12:00pm revealed:
-She was unsure why the number of remaining alprazolam 0.25mg tablets for Resident #9 did not match the remaining quantity on the CSCS.
-She thought it may have been signed out on the CSCS as removed from the cassette but was not.

Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed:
-Alprazolam 0.25mg, 42 tablets were delivered to the facility the evening of 06/08/28 for Resident #9.
-A CSCS for alprazolam was sent to the facility with the medication for the facility to account for administration of the controlled substance.
-She did not know Resident #9's history and did not know what the consequences might be if he missed a dose of his alprazolam.

Based on observations, record reviews and interviews it was determined Resident #9 was not interviewable.

Attempted telephone interview with Resident #9's Primary Care Provider (PCP) on 06/14/23 at 11:08am was unsuccessful.

Refer to second interview with the MA on 06/14/23 at 3:39pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/15/23 at 11:44am.

Refer to interview with the Administrator on 06/15/23 at 12:42pm.

3. Review of Resident #10's current FL2 dated 09/29/22 revealed:

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D 392	Continued From page 24 -Diagnoses included seizure disorder and depression. -There was an order for gabapentin 300mg, 1 tablet three times daily. Review of Resident #10's CSCS for gabapentin 300mg revealed: -Gabapentin 300mg, 42 tablets were dispensed to the facility on 06/09/23. -The medication was dispensed in three cassettes. -Each cassette contained 14 individual boxes and each box contained one tablet. Observation of a medication pass on 06/13/23 at 11:30am for Resident #10 revealed: -The MA removed one tablet of gabapentin 300mg from a cassette for Resident #10. -There were no tablets remaining in the medication cassette. -The MA signed the CSCS after she removed the medication from the cassette. -The CSCS for Resident #10's gabapentin revealed there was one tablet remaining. Interview with the MA on 06/13/23 at 12:00pm revealed: -She did not know why the number of remaining gabapentin 300mg tablets for Resident #10 did not match the remaining quantity on the CSCS. -She thought one may have been dropped and another tablet pulled from the cassette and not documented correctly. Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed: -Gabapentin 300mg, 42 capsules were delivered to the facility the evening of 06/08/23 for Resident #10.	D 392		

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-A CSCS for the gabapentin was sent to the facility with the medication for the facility to account for administration of the controlled substance.
-She did not know Resident #10's history and did not know what the consequences might be if she received an additional dose of gabapentin.

Based on observations, record reviews and interviews it was determined Resident #10 was not interviewable.

Attempted telephone interview with Resident #10's Primary Care Provider (PCP) on 06/14/23 at 11:08am was unsuccessful.

Refer to second interview with the MA on 06/14/23 at 3:39pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/15/23 at 11:44am.

Refer to interview with the Administrator on 06/15/23 at 12:42pm.

4. Review of Resident #11's current FL2 dated 04/24/23 revealed:
-Diagnoses included neuropathy (pain from nerve damage).
-There was an order for gabapentin (a medication used to treat neuropathy) 400mg, 1 tablet three times daily.

Review of Resident #11's CSCS for gabapentin 400mg revealed:
-Gabapentin 400mg, 42 tablets were dispensed to the facility on 06/09/23.
-The medication was dispensed in three cassettes.
-Each cassette contained 14 individual boxes and

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D 392	Continued From page 26 each box contained one tablet. Observation of a medication pass on 06/13/23 at 11:30am for Resident #11 revealed: -The MA removed one tablet of gabapentin 400mg from a cassette for Resident #11. -There were seven tablets remaining in the medication cassette. -The MA signed the CSCS after she removed the medication from the cassette. -The CSCS for Resident #11's gabapentin revealed there was 6 tablets remaining. Interview with the MA on 06/13/23 at 12:00pm revealed: -She did not know why the number of remaining gabapentin 400mg tablets for Resident #11 did not match the remaining quantity on the CSCS. -She thought it may have been signed out on the CSCS as removed from the cassette but was not. Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed: -Gabapentin 400mg, 42 capsules were delivered to the facility the evening of 06/08/23 for Resident #11. -A CSCS for the gabapentin was sent to the facility with the medication for the facility to account for administration of the controlled substance. -Gabapentin was prescribed for Resident #11 for neuropathy and if a dose was missed, he may have increased nerve pain. Interview with Resident #11 on 06/15/23 at 10:51am revealed he was not sure what medications he was prescribed but thought staff gave him what was ordered.	D 392		

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Attempted telephone interview with Resident #11's Primary Care Provider (PCP) on 06/14/23 at 11:08am was unsuccessful.

Refer to second interview with the MA on 06/14/23 at 3:39pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/15/23 at 11:44am.

Refer to interview with the Administrator on 06/15/23 at 12:42pm.

5. Review of Resident #12's current FL2 dated 11/21/22 revealed:
-Diagnoses included schizoaffective disorder, anxiety, and tremors.
-There was an order for clonazepam (a medication used to treat panic disorders and seizures) 0.5mg, 1 tablet every 12 hours as needed.

Review of a Mental Health Provider's note for Resident #12 dated 03/03/23 revealed an order for clonazepam 1mg, one tablet three times daily.

Review of Resident #12's CSCS for clonazepam 1mg revealed:
-Clonazepam 1mg, 42 tablets were dispensed to the facility on 06/09/23.
-The medication was dispensed in three cassettes.
-Each cassette contained 14 individual boxes and each box contained one tablet.

Observation of a medication pass on 06/13/23 at 11:30am for Resident #12 revealed:
-The MA removed one tablet of clonazepam 1mg from a cassette for Resident #12.
-There were nine tablets remaining in the

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	HAL049016	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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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medication cassette.
-The MA signed the CSCS after she removed the medication from the cassette.
-The CSCS for Resident #12's clonazepam revealed there was 8 tablets remaining.

Interview with the MA on 06/13/23 at 12:00pm revealed:
-She did not know why the number of remaining clonazepam 1mg tablets for Resident #12 did not match the remaining quantity on the CSCS.
-She thought it may have been signed out on the CSCS as removed from the cassette but was not.

Telephone interview with a Pharmacist with the facilities contracted pharmacy on 06/14/23 at 11:44am revealed:
-Clonazepam 1mg, 42 capsules were delivered to the facility the evening of 06/08/23 for Resident #12.
-A CSCS for the gabapentin was sent to the facility with the medication for the facility to account for administration of the controlled substance.
-Clonazepam was usually prescribed for anxiety or agitation but there was no diagnosis listed for Resident #12's clonazepam so she was unsure of the consequences if he did not receive a dose.

Attempted telephone interview with Resident #12's Primary Care Provider (PCP) on 06/14/23 at 11:08am was unsuccessful.

Refer to second interview with the MA on 06/14/23 at 3:39pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/15/23 at 11:44am.

Refer to interview with the Administrator on

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D 392	Continued From page 29 06/15/23 at 12:42pm. _____ A second interview with the MA on 06/14/23 at 3:39pm revealed: -She often worked both first and second shift. -Medications were not passed on third shift but if a resident needed a medication the Resident Care Coordinator (RCC) lived nearby, and she was a medication aide. -She reviewed controlled substances on hand and the controlled substance count sheets (CSCS) with the MA that took over the cart during a shift change when that occurred. -She did not routinely review the controlled substances on hand with the CSCS when she started and ended her shift and stated she "probably should". -If the count was off, she reviewed the resident's MAR to look for errors and made the RCC aware of any discrepancies. -She had not made the RCC aware the count was off for Resident #9, #10, #11 and #12. -She did not know why she had not reported the count discrepancy to the RCC. Interview with the RCC on 06/15/23 at 11:44am revealed: -There was not always the opportunity for the MA to review the controlled substances count with another MA because the facility did not staff a third shift MA and often the same MA worked both first and second shifts. -There were about three times per week when a MA came in during the day and took over the medication cart, and the controlled substances counts should have been compared with the CSCSs at that time by both MAs. -She tried to do cart audits, including controlled substances, every week or every other week but had gotten behind.	D 392		

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D 392	Continued From page 30 -If the controlled substance count did not match the quantity on the CSCS, she expected the MA to investigate and inform her of the discrepancy. -The facility's contracted pharmacy completed cart audits quarterly and controlled substances were reviewed during their audits. -She expected controlled substances to be documented correctly and for the quantity of medication to match the quantity on the CSCS. Interview with the Administrator on 06/15/23 at 12:42pm revealed: -It was the MA's responsibility to ensure that the controlled substances count matched the count on the CSCS. -The MAs were responsible to do a shift count of the controlled substances to ensure the quantity matched the CSCS but she was unsure if it was being done. -She expected the MA to notify the RCC of any discrepancies between the controlled substances count and the CSCS. -She expected the MA to document on the MAR and the CSCS when the medication was administered. -The RCC was responsible to do cart audits monthly but she was unsure if they were being done.	D 392		