STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 09/25/2024

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
D 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted an annual and follow-up survey from 09/24/24 to 09/25/24.	D 000		
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 a controlled substance for 1 of 10 residents sampled who received anti-anxiety medication (Resident # 5). The findings are: 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. Review of Resident # 5's current FL2 dated 03/14/24 revealed:	D 392		

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D 392	Continued From page 1	D 392		

-Diagnoses included schizophrenia.
-There was an order for alprazolam (a medication to treat anxiety) 0.25mg, one tablet three times daily.

Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 0.25mg, one tablet three times daily at 8:00am, 2:00pm and 8:00pm.
-Alprazolam 0.25mg, one tablet was documented as administered to Resident #5 three times daily from 09/01/24 to 09/23/24 and on 09/24/24 at 8:00am and 2:00pm.

Review of Resident #5's alprazolam 0.25mg controlled substance count sheets (CSCS) revealed:
-There was a CSCS for Resident #5's alprazolam 0.25mg dated 08/30/24.
-There was documentation alprazolam 0.25mg, one tablet was administered to Resident #5 three times daily from 08/30/24 to 09/12/24.
-There were no CSCS for Resident #5's alprazolam 0.25mg after 09/12/24.

Observation of a medication pass on 09/24/24 at 1:32pm revealed:
-The medication aide (MA) removed one tablet of alprazolam 0.25mg from a cassette for Resident #5.
-There were 12 tablets remaining in the medication cassette.
-The MA documented in the eMAR she administered alprazolam 0.25mg, one tablet to Resident #5.
-There was no CSCS for Resident #5's alprazolam 0.25mg in the CSCS logbook.

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D 392	Continued From page 2 Interview with a MA on 09/24/24 at 1:32pm revealed: -She administered alprazolam 0.25mg, one table to Resident #5 that morning but did not realize there was no CSCS. -She did not know why there was not a CSCS in the logbook for Resident #5's alprazolam 0.25mg. -She thought the CSCS may have been completed the previous evening and a new count sheet had not been placed in the logbook. Interview with a second MA on 09/25/24 at 1:57pm revealed: -She last worked second shift on 09/23/24. -She administered Resident #5's alprazolam 0.25mg, one tablet that evening, on 09/23/24. -She documented she administered alprazolam 0.25mg, one tablet to Resident #5 in the eMAR but did not realize she did not sign a CSCS. -Often the same MA worked both the first and second shift and therefore did not review CSCS and controlled medications with another MA at the end of the shift. -She reviewed controlled substances on hand and the CSCS with the MA that took over the cart during a shift change when that occurred. -She last reviewed controlled substances and CSCSs on hand with another MA on 09/20/24. -She accidentally skipped reviewing the top drawer of one of the medication carts, and that was where Resident #5's alprazolam 0.25mg was stored. -She tried to review the controlled substances on hand with the CSCS during her shift but did not always get to it. Interview with the Health and Wellness Director (HWD) on 09/25/24 at 2:04pm revealed: -She was not aware there was no CSCS for Resident #5's alprazolam 0.25mg.	D 392		

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D 392	Continued From page 3 -She tried to review the controlled substances on hand with the CSCS with the MA daily, Monday through Friday, but had not done it in the last two weeks. -Resident #5's alprazolam 0.25mg CSCS came with the medication, but the sheet was not placed in the CSCS logbook. -MAs were responsible for comparing controlled substances on hand with the CSCSs at least every other day and when an MA took over the medication cart from another MA. Interview with the Administrator on 09/25/24 at 2:22pm revealed: -She was not aware there was no CSCS for Resident #5's alprazolam 0.25mg. -She expected the MAs to compare controlled substances on hand with the CSCS as they administered controlled medications, at the end of each shift and when an MA replaced another MA on the medication cart. Based on observations, record reviews and interviews it was determined Resident #5 was not interviewable.	D 392		