

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2019
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and Caswell County Department of Social Services conducted an annual survey on April 24, 2019.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #1) received healthcare referral and follow-up services for a diabetic resident who needed to see a podiatrist and an eye doctor as requested by the primary care provider (PCP). The findings are: Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease. Review of a PCP visit summary for Resident #1 dated 01/16/19 revealed Resident #1 needed a diabetic foot exam and eye exam. Review of Resident #1's Licensed Health Professional Support evaluation dated 02/04/19 revealed: -There was documentation Resident #1's toenails were very long and need to be trimmed as soon	C 246		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 246	Continued From page 1 as possible. -There was documentation the PCP had requested on 01/16/19 for Resident #1 to have foot care with a podiatrist. -There was documentation Resident #1 was unsure of her last eye exam. -There was documentation the PCP had requested on 01/16/19 for Resident #1 to have an eye exam scheduled. -There was a second notation to "please make sure these appointments were made." Interview with Resident #1 on 04/24/19 at 1:06pm revealed: -She had not been to the eye doctor in several years; she thought she needed to go to the eye doctor for a check-up. -She had not been to the podiatrist since she had moved to the facility. -She had asked several different named staff about going to the podiatrist but no one had made her an appointment. -She needed to go to the podiatrist because her toenails were bothering her. Observation of Resident #1's toenails on 04/24/19 at 1:06pm revealed her toenails extended the length of her toes. Interview with the Medication Aide (MA) on 04/24/19 at 1:17pm revealed: -She usually worked at night; she worked days on the weekend. -She did not know Resident #1's PCP had recommended an appointment for the eye doctor and podiatrist. -The daytime MA was responsible for following up on appointments. -Resident #1 had not asked her about a podiatry appointment or complained about her toenails.	C 246		

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C 246	Continued From page 2 Interview with the Supervisor-in-Charge (SIC) on 04/24/19 at 1:31pm revealed: -The day shift MA was responsible for making appointments and would then contact her to schedule transportation. -Sometimes the MA would contact her and ask her to make the appointment. -She had not scheduled transportation for or made an appointment for Resident #1 for a podiatrist or eye doctor. -She expected the dayshift MA to make an appointment for Resident #1 and was concerned that an appointment had not been made. Telephone interview with the dayshift MA on 04/24/19 at 1:43pm revealed: -The facility staff had made appointments for Resident #1 to see an eye doctor and podiatrist. -She could not remember when the appointments were scheduled. -She thought the appointment had been rescheduled; she did not know the date -She thought the appointments were scheduled for around 04/04/19. -Names of the eye doctor and podiatrist where appointments were made were provided. -She had not made appointments with the named providers. -The PCP made the appointments for Resident #1. Telephone interview with the PCP on 04/24/19 at 2:41pm revealed: -She did not schedule appointments for any of her residents; the facility was responsible for scheduling appointments. -Resident #1 was diabetic and needed to see an eye doctor and a podiatrist. -She wanted Resident #1 to be scheduled to see	C 246		

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C 246	Continued From page 3 an eye doctor and a podiatrist. Telephone interview with the Administrator on 04/24/19 at 3:19pm revealed: -If a resident had an appointment the MA should make the appointment and call the main office to coordinate transportation. -If a resident refused to go to an appointment, they would complete a refusal form and file in the resident's record. -If an appointment was rescheduled, it would be documented in the resident's record. -He was concerned Resident 1's PCP had recommended appointments on 01/16/19 that had not been scheduled.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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 observations, interviews, and record reviews, the facility failed to assure blood pressure checks were completed and documented as ordered for 1 of 3 sampled residents (Resident #1) with an order for blood pressure checks on Monday, Wednesday and Friday. The findings are:	C 249		

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C 249	Continued From page 4 Review of Resident #1's current FL-2 dated 01/16/19 revealed: -Diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease. -There was an order for blood pressure (BP) checks three times a week on Monday, Wednesday and Friday. Review of Resident #1's February 2019, March 2019 and April medication administration record (MAR) revealed there was no entry or documentation of ordered three times a week BP checks. Review of Resident #1's March 2019 MAR revealed there was no documentation of weekly BP checks. Review of Resident #1's April 2019 MAR revealed there was no documentation of weekly BP checks. Review of Resident #1's physician summary dated 03/15/19 revealed: -Resident #1 was seen by the facility primary care provider (PCP). -Resident #1's BP was 123/62. Telephone interview with a representative from the facility's contracted pharmacy on 04/24/19 at 11:32am revealed: -The FL-2 dated 01/16/19 had not been sent to the pharmacy. -If the FL-2 had been sent to the pharmacy the order for BP checks on Monday, Wednesday and Friday would have been added to the MAR.	C 249			

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C 249	Continued From page 5 Telephone interview with the medication aide (MA) on 04/24/19 at 5:22pm revealed: -She did not do BP checks three times a week for Resident #1; it was checked monthly. -She did not see the order for BP checks for Monday, Wednesday and Friday on the FL-2 dated 01/16/19. -She had not checked Resident #1's BP for April 2019. -She did not document the BP on the MAR if it was not an order; the BP's were documented on a separate document. -She did not send Resident #1's FL-2 dated 01/16/19 to the pharmacy; the pharmacy would have put the order on the MAR. -She did not know why she did not send the FL-2 to the pharmacy. Interview with the Supervisor-in-Charge (SIC) on 04/24/19 at 5:47pm revealed: -The day shift MA was responsible for sending the FL-2 to the pharmacy. -She expected the MA to be knowledgeable about the information on the FL-2. -She did not know the FL-2 had not been sent to the pharmacy with orders for BP checks on Monday, Wednesday and Friday. -She expected all orders to be followed. Interview with Resident #1 on 04/24/19 at 5:28 pm revealed: -She had a history of high BP. -She took medication daily for high BP. -No one had taken her BP in a long time. -She did not know how often she was supposed to have her BP checked. Interview with the Administrator on 04/24/19 at 3:19pm revealed:	C 249		

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C 249	Continued From page 6 -The MA was responsible for making sure the PCP orders were followed. -He expected all orders to be followed. -He was concerned Resident #1's BP was not taken as ordered. Attempted second telephone interview with Resident #1's PCP on 04/24/19 at 5:23pm was unsuccessful.	C 249		
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice daily. The findings are: Observation of the refrigerator on 04/24/19 at 8:55am revealed: -There was one opened gallon of milk in the refrigerator that had one-fourth of milk left in the container. -There was an unopened gallon of milk.	C 273		

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C 273	Continued From page 7 -There were no other dairy substitutes. Observation of the lunch meal service on 04/24/19 at 12:00pm revealed the residents were provided with water and tea; milk was not offered. Interview with a resident on 04/24/19 at 12:49pm revealed. -She had not been offered milk in over a week. -She liked milk and would drink milk if it was served or offered. -She had not asked for milk. Interview with a second resident on 04/24/19 at 12:51pm revealed: -She was not offered milk every day; she could not recall the last time she had milk to drink. -She had not asked for milk. -She would drink milk every day; "it is good for your bones." Interview with a third resident on 04/24/19 at 12:53pm revealed: -Staff had given the residents milk to drink three weeks ago but they had not had milk since then. -When they were given milk it was "just a little cup." -She liked milk and would drink it every day if milk was offered. -She had not asked for milk to drink. Interview with a fourth resident on 04/24/19 at 12:59pm revealed: -It had been "ages ago" since they were offered milk to drink in a cup. -She would drink milk every day if it was offered. Interview with a fifth resident on 04/24/19 at 1:06pm revealed: -She seldom had milk to drink.	C 273		

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C 273	Continued From page 8 -The staff did not offer milk to drink. -She liked milk and would drink it every day. Review of the Diet Menu provided by the facility staff revealed the residents were to receive 8 ounces of milk with the breakfast and dinner meal service; milk and ½ sandwich were listed as the evening snack on multiple days reviewed. Interview with a medication aide (MA) on 04/24/19 at 1:17pm revealed: -She did not offer milk to the residents to drink unless they asked for it. -She had not thought to ask the residents if they wanted milk to drink. Interview with the Supervisor in Charge (SIC) on 04/24/19 at 2:22pm revealed: -She expected the MAs to provide milk at the breakfast meal service and to offer milk at the lunch and dinner meal services. -Milk was also offered at snacks. -She had not had any residents complain to her about milk not being offered. Telephone interview with the Administrator on 04/24/19 at 3:19pm revealed he was not sure how often milk was on the menu; he expected staff to follow the menu.	C 273		
C 274	10A NCAC 13G .0904(d)(3)(B) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or	C 274		

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C 274	Continued From page 9 cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure fruit was served twice daily to residents including a serving of citrus juice or fruit. The findings are: Observation of the food supply on 04/24/19 at 8:55am revealed: -There was no canned, fresh, or frozen fruit in the facility. -There was no container of 100% citrus fruit juice in the facility. Interview with a resident on 04/24/19 at 12:49pm revealed: -It had been a long time since she had fruit to eat; they had tangerines at Christmas. -They had orange juice to drink a couple of weeks ago. Interview with a second resident on 04/24/19 at 12:51pm revealed: -It had been a long time since they had fruit to eat. -They always had canned fruit, never fresh fruit to eat. -It had been a long time since she had juice to drink Interview with a third resident on 04/24/19 at	C 274		

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C 274	Continued From page 10 12:53pm revealed: -The medication aide (MA) had brought a banana in "a while back" and fixed them a banana sandwich. -It had been a couple of months since she had any other type of fruit. -They rarely had juice to drink Interview with a fourth resident on 04/24/19 at 12:59pm revealed: -They get canned fruit to eat at times. -The MA had fixed her a banana sandwich about three weeks ago. -She liked fruit and wished it was provided more often. -They had juice sometimes, maybe 2-3 weeks ago. -She loved orange juice and would drink it every day. Interview with a fifth resident on 04/24/19 at 1:06pm revealed: -She could not recall the last time she had fruit to eat, it had been a long time. -They seldom had juice to drink, but she would drink it every day. Review of the Diet Menu provided by the staff for 04/24/19 revealed the residents were to receive orange juice with the breakfast meal service and ½ fresh orange at the dinner meal service. Observation of the lunch meal service on 04/24/19 at 12:00pm revealed peaches were provided to the residents with their lunch. Interview with the MA on 04/24/19 at 1:17pm revealed: -The Supervisor in Charge (SIC) brought two cans of peaches in for the lunch meal service.	C 274		

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C 274	Continued From page 11 -She served mandarin oranges last week. -The SIC bought fruit cocktail and peaches. -The MAs brought fruit to the residents. -The residents had juice to drink last week. Interview with the SIC on 04/24/19 at 2:22pm revealed: -She bought the groceries for the facility. -Last week she bought apples, bananas, and canned fruit. -Last week she bought 10 cans of 100% juice; each can of juice would serve a meal. -No one had told her they did not have fruit or juice available to serve. Telephone interview with the Administrator on 04/24/29 at 3:19pm revealed: -Fruit should be provided daily. -The requirements were listed on the menu, and he expected the staff to follow the menu and provide and document appropriate substitutions.	C 274		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled	C 330		

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C 330	Continued From page 12 residents (#1) related to a bronchodilator. The findings are: Review of Resident #1's current FL-2 dated 01/16/19 revealed: -Diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease. -There was an order for Spiriva handihaler, inhale contents of one capful daily. (Spiriva is used to prevent bronchospasm caused by COPD and reduce flare-ups of serious symptoms.) Review of the Primary Care Provider's (PCP) visit note dated 03/15/19 revealed: -Resident #1 had a decreased Forced vital capacity (FVC) indicating severe restriction (FVC is the largest amount of air that you can forcefully exhale after breathing in as deeply as you can. A lower than normal FVC reading indicates restricted breathing). -Tobacco cessation information was provided. Review of Resident #1's March 2019 MAR revealed: -There was an entry for Spiriva handihaler, inhale one capsule through handihaler daily. -Sprivia was documented as administered daily from 03/01/19-03/31/19. Review of Resident #1's April 2019 MAR revealed: -There was an entry for Spiriva handihaler, inhale one capsule through handihaler daily. -Sprivia was documented as administered daily from 04/01/19-04/24/19.	C 330		

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C 330	Continued From page 13 Observation of Resident #1's medications on hand on 04/24/19 at 11:15am revealed a plastic bag that contained Spiriva handihaler and 15 individually packaged capsules; Resident #1's name was written on the Spiriva handihaler. Telephone interview with a Pharmacist at the facility pharmacy on 04/24/19 at 11:32am revealed: -Resident #1's Spiriva handihaler was dispensed on 03/04/19 with 30 individually foiled packets. -Spiriva handihaler was considered a bulk medication and was only refilled when requested by the facility staff. -There had been no request to reorder Resident #1's Spiriva handihaler. -Thirty capsules would have been enough to administer until 04/04/19. Interview with Resident #1 on 04/24/19 at 1:06pm revealed: -She took Spiriva for her breathing. -She was not administered Spiriva every day. -She did not recall when she had last used the Spiriva handihaler. -She thought her breathing was better when she used the Spiriva handihaler. -She had not asked the MA to use the Spiriva handihaler; "she had not thought about it." Observation of Resident #1 at various times during the survey on 04/24/19 revealed she coughed throughout the day; she coughed so hard at times that she turned red. Interview with a medication aide (MA) on 04/24/19 at 1:17pm revealed: -Resident #1 had not asked to use the Spiriva handihaler when she worked. -Resident #1 had not been wheezing.	C 330		

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 14 -If Resident #1 had been wheezing she would have asked Resident #1 if she wanted to use the Spiriva handihaler. -She did not know the Spiriva handihaler was supposed to be used every day. -She had initialed the MAR for the Spiriva and forgot to circle her initials that she had not administered. -She thought the Spiriva handihaler was as needed, so she had not offered it to Resident #1. -She should have read the MAR closer. Interview with the Supervisor-in-Charge (SIC) on 04/24/19 at 1:31pm revealed: -She expected the MA to use the MAR to administer medications; if a resident did not take a medication the MA should initial, circle and sign the reason why on the back of the MAR. -The MARs were audited every 1-2 months; the MARs were last audited in February 2019. -The SIC compared medications on hand with the MARs when the records were audited. -She expected the medication to be in its original packaging; the Spiriva handihaler should have not been in a plastic bag. -She was concerned the Spiriva handihaler had not been administered as ordered. -Resident #1 could have respiratory problems without her medication. Interview with a second SIC on 04/24/19 at 2:22pm revealed: -She was concerned the Spiriva handihaler had not been administered as ordered. -There was no way they had administered the Spiriva handihaler if there were still medications on hand and it had not been dispensed since 03/04/19. -The MA should not be signing the MAR if Sprivia handihaler had not been administered.	C 330		

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C 330	Continued From page 15 Telephone interview with the PCP on 04/24/19 at 2:41pm revealed: -She would be concerned if Resident #1's Spiriva handihaler was not being administered as ordered. -Resident #1 was a smoker and had COPD and needed to be administered her bronchodilator. -If Resident #1 was not using her Spiriva handihaler her COPD could be exacerbated. Interview with the Administrator on 04/24/19 at 3:19pm revealed: -The MA was responsible for making sure the PCP orders were followed. -He expected all orders to be followed. -He was concerned the order for Spiriva was not being followed. -He expected medications to be administered as ordered. The facility failed to assure medications were administered for 1 of 3 sampled residents (#1) as ordered by the physician which resulted in a bronchodilator not being administered for 36 days who had a recent spirometry test with decreased Forced vital capacity (FVC) indicating severe restriction and severe coughing episodes. Without this medication, this resident was at increased risk of exacerbated COPD. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 8, 2019	C 330		

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C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record in order to accurately reconcile controlled substances for 1 of 2 residents sampled (#1) who had orders for a controlled substance used to treat anxiety and agitation. The findings are: Review of Resident #1's current FL-2 dated 01/16/19 revealed: -Diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease. -There was an order for Lorazepam 1mg twice daily as needed for agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.) Review of Resident #1's April 2019 medication administration record (MAR) revealed: -There was an entry for Lorazepam 1mg tablet take 1 tablet twice daily as needed for agitation. -No Lorazepam was documented as	C 367		

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C 367	Continued From page 17 administered. Review of Resident #1's controlled substance (CS) logs revealed there was no CS log for April 2019 available in the facility. Observation of Resident #1's medications on hand on 04/24/19 at 11:20am revealed: -There were four punch cards of Lorazepam 1mg tablets dispensed by an outside pharmacy. -The instructions were to take 1 tablet twice a day as needed for restlessness and agitation. -There was a punch card dispensed on 04/02/19 with 25 tablets; there were 6 tablets remaining in the punch card. -There was a second punch card dispensed on 04/02/19 with 35 tablets; there were 11 tablets remaining in the punch card. -On 04/02/19 there was a total of 60 tablets dispensed; 17 tablets were available to be administered. -There was a third punch card on 04/18/19 with 25 tablets; there were 25 tablets remaining in the punch card. -There was a fourth punch card dispensed on 04/18/19 with 35 tablets; there were 35 tablets remaining in the punch card. -On 04/18/19 there was a total of 60 tablets dispensed; 60 tablets were available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 04/24/19 at 11:32am revealed: -Sixty tablets of Lorazepam 1 mg were dispensed on 04/02/19. -Sixty tablets of Lorazepam 1 mg were dispensed on 04/18/19. -He was not sure why Lorazepam was dispensed on 04/02/19 and again on 4/18/19.	C 367		

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C 367	Continued From page 18 -Medications that were as needed (PRN) would be filled when requested by the facility. Interview with the Medication Aide (MA) on 04/24/19 at 11:44am revealed: -She did not know where Resident #1's current CS log was located for April 2019. -If she administered Lorazepam to Resident #1 she documented on the MAR and the CS log. -She had not administered Lorazepam to Resident #1 in a long time. (She did not recall a date or time frame). -She had only administered Lorazepam to Resident #1 two-three times since she had been admitted. -When the pharmacy brought out the new cycle of medication, they picked up any unused medication from the previous month. Interview with the Supervisor in Charge (SIC) on 04/24/19 at 12:00pm revealed: -She looked in Resident #1's MARs notebook on 04/24/19 at 12:00pm and only saw a blank CS log for Resident #1's Lorazepam. -There was no CS log documenting the medication administered for April 2019. Interview with Resident #1 on 04/24/19 at 1:06pm revealed: -She took Lorazepam "when she felt nervous." -She did not take Lorazepam every day, only when she asked for it. -She had not asked for Lorazepam in several weeks (she could not recall the date). Telephone interview with the MA on 04/24/19 at 1:43pm revealed: -She accidentally took the CS log when she had picked up other papers off the desk. -When she administered Lorazepam to Resident	C 367		

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C 367	Continued From page 19 #1 she documented it on the CS log. -She had also documented administering Resident #1's Lorazepam on the MAR (she did not recall when she had last documented on the MAR for Lorazepam). -If the count of the CS log was for 29 Lorazepam remaining, then that was how many she counted when she administered the last dose to Resident #1. Review of a CS log for Lorazepam for Resident #1 provided by the MA on 04/24/19 at 1:58pm revealed: -The CS log was dated from the pharmacy for 04/02/19. -The CS log corresponded with the 60 tablets dispensed from the pharmacy on 04/02/19. -The first entry was dated 04/02/19 with an administration time of 12:00pm with a balance of 59. -The last entry was dated 04/24/19 with an administration time of 8:00pm with a balance of 29. -There were two MA's signatures on the CS log; the SIC/MA signed administering Lorazepam seven times; the MA signed administering Lorazepam 24 times. -On 04/16/19, the SIC/MA's first name was signed and the MA's last name was signed for administering Lorazepam at 8:00am. Based on the review of Resident #1's CS log with an ending balance of 29 tablets available for administration, and the actual 17 Lorazepam tablets available for administration, there were 12 Lorazepam 1mg tablets unaccounted for. Interview with the SIC on 04/24/19 at 2:10pm revealed: -When Lorazepam was administered, it should	C 367		

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C 367	Continued From page 20 have been documented on the MAR and the CS log. -She was concerned the CS log provided by the MA did not match the count on hand for Lorazepam. -There was a chance the Lorazepam had been administered and not documented. -She expected the MAs to document on the MAR and on the CS log when Lorazepam was administered. Interview with a second SIC on 04/24/19 at 2:22pm revealed: -There were two SICs for the facility. -She had worked as a MA and administered medication to Resident #1. -She had administered Lorazepam to Resident #1, "but it was probably months ago." -If she administered Lorazepam to Resident #1 she documented on the MAR and on the CS log. -If her initials were not on the MAR, she did not administer Lorazepam to Resident #1. -The SIC did not acknowledge if it was her signature on the CS log provided. -MAR audits had been completed in February 2019 for Resident #1. -MAR audits were scheduled to be completed every 2-3 months. Telephone interview with the Administrator on 04/24/19 at 3:19pm revealed: -He had helped with the MAR audits in February. -He expected the MARs to be complete and match the medication on hand. -He expected staff to document when they administered Lorazepam to Resident #1. -He was concerned the CS log did not match the medication on hand for Resident #1's Lorazepam. _____ The facility failed to provide readily retrievable	C 367		

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C 367	Continued From page 21 records of controlled substances for 1 of 2 residents (#1) and to maintain and accurately document the administration of controlled substances. There were 12 doses of Lorazepam 1mg unaccounted for and there was a discrepancy in the control log for who had actually administered the medication. This failure could result in the diversion of controlled substances and exploitation of residents' resources, which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 8, 2019.	C 367		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to controlled substances and medication administration.	C 912		

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C 912	Continued From page 22 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record in order to accurately reconcile controlled substances for 1 of 2 residents (#1) sampled who had orders for a controlled substance used to treat anxiety and agitation.. [Refer to Tag 367, 10A NCAC 13G .1008 Controlled Substances (a) (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) related to a bronchodilator. [Refer to Tag 330, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	C 912		