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 |
|---|---|---|---|
| | HAL013843 | A. BUILDING _____ B. WING _____ | R-C 06/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE COUNTRY HOME | 2808 COUNTRY HOME ROAD CONCORD, NC 28025 |

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| (D 000) | Initial Comments<br><br>The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted a follow up survey and complaint investigations on May 29, 2019-May 30, 2019. | (D 000) | | |
| (D 074) | 10A NCAC 13F .0308(a)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0308 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure the walls, floor and fixtures in 3 of 5 common bath/shower areas, on the top hall, the geriatric shower room on the bottom hall, and 7 of 9 resident rooms and bathrooms (Rooms #2, #3, #4, #6, #14, #16 and #20) were kept clean and in good repair, as evidenced by stains and smears on the shower room floors, mold and mildew buildup around the baseboards, black mold and build-up in the inside of the shower and on the tile and toilet, feces on a toilet seat; and 6 of 9 resident refrigerators were moldy and dirty on the interior, (Rooms #2, #10, #11, #16, #18 and #20) and the light fixtures plastic covers throughout both halls were split, jagged and cracked.<br><br>The findings are:<br><br>Observation of the common geriatric shower | (D 074) | | |

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JUL 29 2019
ADULT CARE LICENSURE SECTION
RALEIGH

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chetha Scott — TITLE: Admin — (X6) DATE: 7/29/19
Chetha Scott
STATE FORM 6899 — LUYW12 — If continuation sheet 1 of 60
Nina Barkley Nina Barkley — RCD _____ — 7/29/19

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| {D 074} | Continued From page 1<br>room on the bottom hall on 05/29/19 at 8:15 am revealed:<br>-There was a bathtub in the center of the room with pink tiling enclosing the tub.<br>-The tiling on the right side of the tub was broken and had jagged edges the entire length of the siding.<br>-On the right side wall, there was a row of 5 tiles detached from the wall and were protruding from the wall approximately 1.5 inches.<br>-The 4th tile above the flooring on the right side wall was cracked with a jagged corner piece.<br>-The 5th and 6th tile above the flooring on the right side of the tub were protruding from the wall.<br>-On the left side of the tub, on the ledge, the tile was cracked, as well as the base of the floor.<br>-The shower floor had black ground in dirt and the floor of the shower room had brown and black ground in staining.<br>-The base of the shower had some mold buildup near the tiling.<br>-The bath tub had an accumulation of dirt and some brown staining on the inside porcelain basin.<br><br>Observation during the facility tour on 05/29/19 at 8:20am revealed:<br>-The floor plan divided the facility into two long halls identified by staff as the top hall and the bottom hall.<br>-Three common shower rooms were located on the top hall, and there were two shower rooms located on the bottom hall.<br>-The resident rooms were located on both the top and bottom halls.<br><br>Observation during the initial tour on 05/29/19 from 8:20am through 9:45am revealed:<br>-Room 2 had a strong urine odor.<br>-The urinal was sitting on the dresser in the | {D 074} | D074- Tiling Repaired Made<br>D074- Tiles reattach to wall<br>D074- 4th Tile Replaced<br>D074- 5th & 6th Tile Replaced<br>D074- Tile Replaced<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean | 6/15/19<br>6/15/19<br>6/15/19<br>6/15/19<br>6/15/19<br>5/30/19<br>5/30/19<br>5/30/19 |

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| {D 074} | Continued From page 2<br>bedroom.<br>-The urinal was empty, but there was black buildup inside the urinal covering all sides.<br>-There was an opened plastic food container with dried food on the closet shelf.<br>-The toilet base and the flooring had black buildup, and around the toilet bowl the floor was stained with ground in brown and black areas.<br>-In Room 3 there was mold around the baseboard of the bedroom.<br>-There was an electrical outlet with a television plugged into the outlet without a face plate over the socket.<br>-The air conditioning unit was dusty on the exterior cover and appeared to have a buildup of dirt in the interior.<br>-Room 4's bathroom sink had ground in dirt that was not recent and scum build up around the faucets.<br>-Under the bathroom sink was a plastic container with dirt and brown build up in the container.<br>-There were feces stains on the underside of the toilet seat.<br>-The walls of the bathroom had several brown and black streaks and stains.<br>-In Room 6 there was a puddle of coffee on the floor from breakfast and used food containers and utensils on the tray beside the chair and the dresser top.<br>-The bathroom had dust and dirt accumulation in the corners, the toilet bowl cover and the porcelain had brown staining.<br>-The base of the toilet had black buildup and urine pooled in the corners.<br>-In Room 14, there was dirt in the corners of the bathroom, black buildup around the base of the toilet, and the flooring near the walls.<br>-The floor of the bedroom had ground in dirt, and dirt and dust under the beds.<br>-In Room 15, the bedroom walls were stained in | {D 074} | D074 Hskp Immediately remove urinal, dried food removed<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean<br>D074 New Face Plate Installed<br>D074 A/C Unit Cleaned Exterior Interior<br>D074 Hskp Immediately clean RM4<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately removed<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean<br>D074 Hskp Immediately clean | 5/29/19<br>5/29/19<br>5/29/19<br>6/2/19<br>6/2/19<br>5/29/19<br>5/29/19<br>5/29/19<br>5/29/19<br>5/29/19<br>5/29/19<br>5/29/19<br>5/29/19 |

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| {D 074} | Continued From page 3<br>faded grey black coloring.<br>-The air conditioning unit was dirty on the cover and dust was seen in the interior of the unit.<br>-In Room 20, there was significant dust on the appliances and furniture, and the window ledge was dirty.<br>-The air conditioning unit was stained on the cover with brown spots and an accumulation of dust and build up could be seen in the interior.<br>-The personal refrigerators in Rooms #2, #10, #11, #16, #18 and #20 were moldy on the inside of the door and on the bottom of the unit.<br>-There was dirt build up on the side walls of the interior unit and dirt and dust around the exterior unit.<br><br>Observation of the bottom hall overhead plastic light covers on 05/29/19 at 9:50am revealed:<br>-The overhead light fixtures consisted of a rectangular lighting unit attached to the ceiling and composed of two long fluorescent bulbs with a plastic cover encasing the bulbs.<br>-Outside Rooms 4 and 5 in the hall the overhead plastic light cover was cracked and missing a large piece of the plastic, and a portion of the plastic was hanging down about 2 inches.<br>-On the bottom hall near the kitchen area there were two overhead plastic light covers that were cracked and missing small plastic pieces from several areas.<br><br>Interview with the Maintenance staff person at the facility on 05/29/19 at 9:55am revealed:<br>-He provided the day to day maintenance tasks for the facility; painting, changing light bulbs, stopped toilets.<br>-He walked through the facility several times a week and prepared a list of tasks that needed to be completed.<br>-He had been painting the hall walls and door | {D 074} | D074 A/C Unit Cleaned Exterior Interior<br>D074 Hskp Immediately clean<br>D074 A/C Unit Cleaned Exterior Interior<br>D074 Hskp Immediately clean<br>D074 A/C Unit Cleaned Exterior Interior<br>D074 Light Fixtures replaceds as needed | 6/2/19<br>5/29/19<br>6/2/19<br>5/29/19<br>6/2/19<br>6/30/19 |

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| {D 074} | Continued From page 4<br>frames of resident's rooms, changing light bulbs and cleaning the gutters.<br>-He sent pictures of areas he thought needed attention, taken on his phone, to the owner.<br>-He sent a picture of the jagged tiles in the geriatric shower room at the last survey in March 2019.<br>-The owner responded with directives or sends the Corporate Maintenance Supervisor to the facility to assist him.<br>-Jobs requiring more than general maintenance were handled by the Corporate Maintenance Supervisor.<br>-They have replaced the flooring in the bathroom at the top of the hall.<br>-He was working on replacing the the other bathroom floors.<br>-The Maintenance Supervisor ordered the supplies for repairs.<br>-The tiling for the geriatric shower room on the bottom floor had been ordered but had not arrived at the facility yet.<br>-The plastic covers for the hall light fixtures had been ordered.<br>-The Supervisor has had a difficult time locating covers that fit the existing fixtures<br>-The Administrator and the Corporate Maintenance Supervisor were his direct supervisors.<br><br>Interview with the housekeeper on 05/29/19 at 10:14am revealed:<br>-She had been hired as a housekeeper/personal care aide (PCA) 2 months ago.<br>-She was trained by the other fulltime housekeeper.<br>-She reported to the Administrator as her supervisor.<br>-She worked Monday through Friday from 9:00am-2:00pm. | {D 074} | | |

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| {D 074} | Continued From page 5<br>-She had a Housekeepers Checklist she was to follow in cleaning.<br>-She and the other housekeeper divided the facility and each cleaned half. She generally had the upper hall, including the bathrooms and the bedrooms.<br>-The Administrator walked the halls during the day and supervised their work.<br>-The daily tasks included emptying trash, dusting tables and furniture , wipe window sills, sweep and mop floors.<br>-She did not dust or clean if the resident's possessions are on the furniture or on the floor.<br>-She did not move or clean under any clutter.<br>-She was told when she trained not to touch the resident's possessions-even to move them to clean.<br>-She mopped the bathrooms, hallways and common areas every day.<br>-She cleaned the bedroom floors every other day.<br>-The PCAs did light housekeeping on the weekends.<br>-The cleaning supplies were kept in the closet on the bottom hall and could be accessed by the staff when housekeepers were not in the building.<br><br>Interview with the Corporate Maintenance Supervisor on 05/29/19 at 10:30am revealed:<br>-He was the Maintenance Supervisor for 3 different properties.<br>-He received directives from the owner as to the priorities of maintenance jobs he performed.<br>-He did not remember if he was given a list of the areas cited on the last survey or a general list of repairs.<br>-The tiles for the geriatric shower bathtub were in the back shed.<br>-He was supposed to work on the tiling today.<br>-He was unable to find plastic covers for the lighting fixtures in the hallways. | {D 074} | | |

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| {D 074} | Continued From page 6<br>-The industry was moving to LED (light emitting diode) lighting with smaller bulbs and smaller fixtures.<br>-He could not find a store or online site that carried the brand of cover he needed to repair the existing light fixtures.<br><br>Interview with the Administrator on 05/29/19 at 11:15am revealed:<br>-She was "trying to get a little bit of everything done".<br>-She purchased new furniture for the common living area.<br>-The maintenance staff had painted the hall walls, the frames of the resident's bedroom doors and the outdoor areas.<br>-She hired a second housekeeper to assist with the housekeeping tasks in the facility.<br>-She walked the halls in the facility several times a day and observed the appearance of the residents and the general appearance of the community.<br>-She also spot checked the bedrooms behind the housekeepers randomly.<br>-She was the direct supervisor of the housekeepers.<br>-The housekeeping staff worked Monday through Friday from 9:00am to 2:00pm.<br>-The second and third shift PCA staff and the PCAs on the weekend were to perform light housekeeping tasks to maintain the cleanliness of the facility.<br>-The housekeepers and the PCAs have a checklist of housekeeping duties to perform each day in the facility.<br>-The tasks on the Housekeeping List were to to be checked off and signed daily by the housekeepers and PCAs, with the Administrators signature below theirs. | {D 074} | | |

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| {D 074} | Continued From page 7<br><br>Observation of the common shower room on the top hall near the end of the hall on 05/30/19 at 10:30am revealed:<br>-There was a bathtub and sink in the common bathroom.<br>-The bathtub had brown discoloration along the inside bottom of the porcelain.<br>-The faucet fixtures had a white dried scum on the handles.<br>-There was mold to the right of the faucet fixtures at the base of the wall tile and porcelain tub ledge.<br>-There were brown stains on the tile wall where the soap holder was attached to the tile.<br><br>Observation of a metal sink on the top hall, on the right side of the hall, on 05/30/19 at 10:33am revealed the entire bowl of the sink was filled with a white putty like material that had hardened.<br><br>Observation of the third common shower room on the top hall on the left side near the smoking area on 05/30/19 at 12:10pm revealed:<br>-The shower curtain had areas of white and brown staining on the outside of the curtain.<br>-The bottom left corner of the shower had broken tiles and mold buildup.<br>-The sink was dirty and had white scum build up in the bowl.<br><br>Observation of the top hall overhead light fixtures on 05/30/19 at 12:15pm revealed:<br>-The overhead light fixtures consisted of a rectangular lighting unit attached to the ceiling and composed of two long fluorescent bulbs with a plastic cover encasing the bulbs.<br>-Near the foyer the two overhead plastic light covers were cracked and missing small plastic pieces from several areas.<br>-There was another plastic light cover on the top | {D 074} | | |

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| {D 074} | Continued From page 8<br>hall that had the plastic broken, cracked down the middle and missing pieces of the plastic.<br><br>Interview with the Owner and the Administrator on 05/30/19 at 4:05pm revealed:<br>-The Administrator was disappointed in the housekeeping performance.<br>-She did not know the bathrooms and bedrooms were not getting cleaned as they should.<br>-She had not gone behind the housekeepers and checked their jobs more thoroughly.<br>-She thought the additional housekeeper would ensure the housekeeping tasks were completed. | {D 074} | **PLAN OF CORRECTION TAG D074**<br>Administrator immediately put a cleaning schedule in effective for HSKP.<br>*Administrator will walk the Facility each am-noon-evening.<br>*Administrtaor will walk the Faciltiy with HSKP at the end of the day<br>*When Administrator in not available or in Facility RCD will walk the Facility. | 6/30/19 |
| D 076 | 10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(3) have furniture clean and in good repair;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews the facility failed to assure 5 dressers, and 1 nightstand were in good repair in 3 of 7 resident rooms (Rooms #14, #17, and in the upper hall across from the common bathroom and shower).<br><br>The findings are:<br><br>Observations during the initial tour of the facility on 05/29/19 at 8:25am revealed:<br>-In Room #14, there were two twin beds, two nightstands and two dressers.<br>-There was a dresser with three drawers in the middle of the room. | D 076 | | |

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| D 076 | Continued From page 9<br><br>-The middle drawer was hanging to the right side and the right side drawer handle was missing.<br>-The bottom drawer was missing the front drawer panel and the drawer was unable to slide in or out of the dresser.<br><br>Observation during the initial tour on 05/29/19 at 9:10am revealed:<br>-In Room #17 there were two twin beds, two dressers and a nightstand.<br>-The dresser against the wall next to the bathroom had two drawers.<br>-The top drawer front panel had broken from the drawer and was hanging off to the right side.<br>-The drawer pull was not attached to the top drawer panel and was hanging to the side.<br>-The drawer pull was missing from the bottom drawer panel.<br>-The edges of both the drawers were worn and revealed the underlying particle board beneath the wood veneer.<br><br>Interview with the housekeeper on 05/29/19 at 9:30am revealed:<br>-She had been hired 2 months ago and was trained by the other first shift housekeeper.<br>-The Administrator was her direct supervisor.<br>-She cleaned the top hall bedrooms and bathrooms.<br>-She emptied trash, dusted tables and dressers, swept and mopped floors and dusted window sills.<br>-She worked 9:00am-2:00pm Monday through Friday.<br>-She had been trained not to move the residents possessions or straighten any of the furniture-"the residents don't like us to touch their stuff".<br>-She had not reported any damaged furniture to the Administrator.<br>-She was never told to report damaged furniture | D 076 | D076 RM14 Middle Drawer R side handle replace repaired front drawer<br><br>D076 Replacing Night Stand | 6/30/19<br><br>6/10/19 |

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| D 076 | Continued From page 10<br>to anyone.<br><br>Interview with the Maintenance staff person on 05/29/19 at 9:55am revealed:<br>-He provided the day to day maintenance tasks for the facility, painting; changing light bulbs, stopped toilets.<br>-He would walk through the facility several times a week and prepare a list of tasks that needed to be completed.<br>-The Corporate Maintenance supervisor was called in for larger projects.<br>-The Administrator and the Corporate maintenance were his direct supervisors.<br>-He had not been instructed to inventory furniture and report to his supervisors.<br>-He did not know who was responsible for repairing broken furniture.<br>-If the staff brought this to his attention, he would have followed up with his supervisors.<br><br>Interview with the Administrator on 05/29/19 at 11:15am revealed:<br>-She walked the halls in the facility several times a day.<br>-She also spot checked the bedrooms behind the housekeepers.<br>-She was "trying to get a little bit of everything done".<br>-She did not know there were several dressers and a nightstand in disrepair.<br>-She expected the staff to report to her if there was furniture in the resident's rooms that needed repair.<br>-She was disappointed the staff did not let her know about the dressers and nightstand.<br>-She did not remember telling the staff directly to report resident's furniture that needed repair - she " just expected they would". | D 076 | | |

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| D 076 | Continued From page 11<br><br>Interview with the first shift personal care assistant (PCA) on 05/30/19 at 9:10am revealed:<br>-Her duties were to "get everyone up and moving in the morning", assist the residents with bathing, make the beds and direct the residents to the dining room for meals.<br>-If she is requested to perform a duty that was not her responsibility, she could choose to assist.<br>-She did not know some of the furniture was in disrepair.<br>-She had not been told to report furniture that was in poor condition to her supervisor.<br>-She would report to the medication aide (MA), the Activities Director (AD) or the Administrator when there was a problem she could not address on her own.<br><br>Observation of the Resident's room on the upper hallway across from the common shower room on 05/30/19 at 2:37pm revealed:<br>-There was a nightstand next to the bed against the window side of the room.<br>-The nightstand had two drawers.<br>-The top drawer was slightly open and slanted to the right side.<br>-The left side upper corner of the top drawer had a 2.5 inch gouge removing the corner of the drawer and leaving a jagged edge exposing the particle board underneath.<br><br>Interview with the second shift PCA on 05/30/19 at 3:37pm revealed:<br>-When she arrived for her shift, the first shift PCAs would give a verbal report or she looked in the Nurses office to see who needed a shower.<br>-She provided personal care and did laundry if needed.<br>-She directed residents to the dining room for their evening meal.<br>-Since there were no housekeepers on second | D 076 | **PLAN OF CORRECTION FOR TAG D076**<br>Staff Inservice on 6/8/19 to report all badly furnishings to Administrator or RCD Administrator or RCD will report to Owners for repairs or replacements | 6/30/19 |

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| D 076 | Continued From page 12<br>shift, the PCAs were supposed to do light housekeeping.<br>-She did not observe any furniture in disrepair.<br>-She only worked part time.<br>-She was not told to report furniture repair to her supervisor or the Administrator. | D 076 | | |
| D 087 | 10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:<br>(1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following:<br>(A) at least one pillow with clean pillow case;<br>(B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and<br>(C) clean bedspread and other clean coverings as needed;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to maintain clean top and bottom bed sheets and pillowcases in 3 of 7 resident bedrooms (Rooms #10, #16 and #18).<br><br>The findings are: | D 087 | | |

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| D 087 | Continued From page 13<br><br>Observation during the initial tour on 05/29/19 at 9:05am revealed:<br>-The resident in Room #10, occupying the twin bed against the wall furthest from the door, was not in his room.<br>-The blanket on his bed was loosely thrown over the mattress.<br>-His bed had no bottom fitted sheet, top sheet or pillowcase.<br>-His pillow was a faded gray.<br>-There were no sheets in his laundry basket.<br>-There was no documentation this was his shower day.<br><br>Observation on 05/30/19 from 2:45pm -3:00pm revealed:<br>-Resident in Room #16 was not in his room.<br>-The twin bed against the window side of the room was disheveled with a blanket rolled up on the side of the bed.<br>-There was no fitted sheet or top sheet on the bed.<br>-Resident in Room #18 was not in his room.<br>-The bed against the window side of the room was not made and a blanket strewn across the end of the bed.<br>-The bed did not have a top sheet or a pillowcase.<br>-There was no documentation residents in Room #16 or Room #18 were scheduled for a shower.<br><br>Interview with a resident on 05/29/19 at 9:55am revealed:<br>-The staff made the bed if the residents requested assistance.<br>-Some residents stayed in bed all day so the staff could not change them often.<br>-He was not sure how often the linens were changed.<br>-"It probably was every week." | D 087 | D087 PCA immediately made bed and change sheets<br><br>D087 PCA immediately made bed and change sheets<br><br>D087 RCD immediately updated Shower List | 5/29/19<br><br>5/29/19<br><br>5/29/19 |

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| D 087 | Continued From page 14<br><br>Interview with the Resident Care Director (RCD) on 05/29/19 at 3:30pm revealed:<br>-She had recently assumed the responsibility of the medication aides (MAs) and PCAs.<br>-The PCAs were to sign the Personal Care Logs at the end of the day to verify their personal care tasks were completed.<br>-The logs were kept in a binder in the Nurses office<br>-The PCAs were to change the linen when the resident received their scheduled shower .<br>-Showers were scheduled for each resident 2 to 3 times a week.<br>-The Personal Care Logs should indicate the resident's shower day with a box to initial when the shower was administered.<br>-The PCAs were initialing every day in the boxes indicated for showers.<br>-They did not understand how to document on the Personal Care Log.<br><br>Interview with the first shift personal care assistant (PCA) on 05/30/19 at 9:10am revealed:<br>-She was responsible to assist with showers and making beds as needed, getting everyone "up and moving in the morning" and making sure everyone gets to the dining room for meals.<br>-The residents were mostly independent, "they can do for themselves."<br>-There was a list of tasks on the Personal Care Log the PCAs were responsible for each shift.<br>-If a resident needed assistance with tasks she was not responsible for, such as emptying trash, "it is my choice to assist."<br><br>Interview with the Administrator on 05/30/19 at 9:35am revealed:<br>-One of the responsibilities of the PCAs was to make the resident's beds and change their linens. | D 087 | | |

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| D 087 | Continued From page 15<br>-The bed linens were to be changed on the residents shower days and as needed.<br>-There is a task list for the PCAs to check off after each shift.<br>-Some of the residents like to make their own beds and do their own linens.<br>-It was the responsibility of the PCAs to follow up and make sure the residents have completed the task.<br>-The PCAs direct supervisor was the RCD.<br>-She did not know some beds did not have the proper bed linens and pillowcases.<br><br>Review of the Personal Care Logs revealed:<br>-The PCA activities were bathing, personal hygiene, toileting , dressing, ambulation, shampoo and shave, medication and transfers.<br>-The logs did not indicate when the residents were scheduled to receive their showers.<br>-The logs did not indicate when the linens were changed.<br>-No documentation was presented showing the shower schedule or the bed linen change.<br><br>Review of the PCA checklist revealed:<br>-There was a PCA checklist to be completed each day and turned into the supervisor 30 minutes before the end of the shift.<br>-The staff person completing the duties and the Administrator were to sign the sheet.<br>-From 05/01/19 through 05/29/19, the Administrator had not signed the PCA checklist.<br>-Making the residents' beds and changing the linens on shower day was not on the list | D 087 | **PLAN OF CORRECTION FOR TAG D087**<br>RCD will review PCA flow sheets x3 weekly to ensure residents showers, bed changing are being done as schedule per Rule requirement Administartor will follow up with RCD weekly. | 6/30/19 |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration | D 367 | | |

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| D 367 | Continued From page 16<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(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).<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to assure the medication administration records were accurate for 2 of 5 sampled residents (Resident #1 & #3) in relation to orders for a medication for dry eyes to be administered four times a day (#1), and in relation to orders for a medication for shortness of breath (#3).<br><br>The findings are: | D 367 | | |

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| D 367 | Continued From page 17<br>1. Review of Resident #'1's current FL2 dated 01/17/19 revealed:<br>-Diagnoses included angina, chronic obstructive pulmonary disease (COPD), a history of stroke and thrombocytopenia.<br>-Medications included Refresh Tears Lubricant eye drops 0.5%, instill 2 drops into the right eye four times a day.<br><br>Observation of medications on hand on 05/29/19 at 3:15pm revealed:<br>-There was a 15ml bottle of Refresh Tears Lubricant eye drops, with the plastic seal unbroken, in a medicine bottle on the medication cart.<br>-The medicine bottle had a computer-generated pharmacy label with Resident #1's name and directions for Refresh Tears eye drops.<br>-There was a handwritten entry, 05/10/19, on the medicine bottle container.<br>-There were no other bottles of eye drops for Resident #1 on the medication cart.<br><br>Interview with the first shift medication aide (MA) on 05/29/19 at 3:20pm revealed:<br>-She had administered Resident #1's medications during her shift.<br>-She had administered the Refresh eye drops to Resident #1 at 8:00am and 12:00pm.<br>-She did not know who had placed the handwritten date of 05/10/19 on the medication bottle containing the Refresh eye drops.<br>-She thought the date was written to indicate when the Refresh eye drop bottle was opened.<br>-There was no other Refresh eye drop bottles for Resident #1 on the medication cart.<br><br>Review of Resident #1's May 2019 Medication Administration Record (MAR), from 05/01/19 through 05/29/19 revealed: | D 367 | D 367 RCD will check cart Daily to ensure all Medication is given as schedule Med Tech will be re-inservice by corp RN | 6/1/19 |

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| D 367 | Continued From page 18<br>-There was an entry for Refresh Tears 0.5% eye drops, instill 2 drops into the right eye 4 times daily, at 8:00am, 12:00pm, 4:00pm and 8:00pm.<br>-There was documentation the eye drops had been administered from 05/01/19 through 05/29/19, at 8:00am, 12:00pm, 4:00pm and 8:00pm.<br><br>Interview with the Resident Care Director (RCD) on 05/29/19 at 3:30pm revealed:<br>-She had recently assumed the clinical and staffing responsibilities as supervisor at the facility.<br>-Her responsibilities included reviewing the MARs for "holes" (medications not signed as administered by the MA), as needed medications (PRNs) administered and PRNs not used for several months, controlled substance records and random cart audits.<br>-She was the liaison between the facility and the physicians.<br>-A medication was only signed as administered if it had been given to the resident and the resident had taken the medication.<br>-If a resident refused a medication, the MA documented the reason on the back of the MAR, initialed and circled the MAR on the date and time of administration.<br>-An 'FYI' form was sent to the primary care physician (PCP) if a resident refused a medication regularly- about 4 or 5 times.<br>-There was no current policy on refusals, however she "would not let it go beyond 7 consecutive days of refusals before notifying the physician".<br>-The FYI's are signed by the PCP and filed in the resident's record.<br><br>Review of Resident #1's record revealed no documentation the PCP had been notified of the | D 367 | | |

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| D 367 | Continued From page 19<br>resident's refusals of Refresh eye drops 4 times a day.<br><br>Interview with the first shift MA on 05/30/19 at 9:50am revealed:<br>-The date on the medication bottle containing the Refresh eye drops was written by the former Resident Care Director (RCD).<br>-The RCD entered 05/10/19 as the date the Refresh eye drop bottle was put on the cart.<br>-Resident #1 often refused the eye drops, so the MA re-approached him later in the day and administered the eye drops then.<br>-She signed the Refresh eye drops as administered on the MARs because she re-approached him later in the day and expected to administer the eye drops.<br>-When a resident refused a medication, she documented the refusal on the back of the MAR with the time, date, medication, dosage, reason and signature.<br>-She did not document a refusal for Resident #1's eye drops since she thought he would allow her to administer them later.<br>-She signed that she had administered the Refresh eye drops because she thought he would take them later.<br>-She knew this was not accurate documentation.<br><br>Interview with the Administrator on 05/30/19 at10:00am revealed:<br>-She had administered Refresh eye drops to Resident #1 "several times since 05/10/19".<br>-The first shift MA labeled the medicine bottle that contained the Refresh eye drops with the date 05/10/19 when she put the bottle on the medication cart.<br>-There was another bottle on the medication cart at the time she administered the medications.<br>-"I am a stickler for medications and I know I | D 367 | | |

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| D 367 | Continued From page 20<br>gave those eye drops " to Resident #1.<br>-She always gave the residents the medications as listed on their MARs when she passed medications.<br>-If a resident refused medications she expected the MAs to document on the reverse side of the MARs and notify the physician.<br>-She did not know some of the MAs were not following the proper procedure for medication documentation.<br>-She did not know Resident #1 was refusing his Refresh eye drops.<br><br>Telephone interview with the second shift MA on 05/30/19 at 11:05am revealed:<br>-The handwritten date on the medication bottle was the date the medication was put on the cart and ready to be administered.<br>-The handwritten date was labeled by the MAs.<br>-Resident #1 frequently refused his Refresh eye drops.<br>-She documented the refusals in the 'Care Notes' book.<br><br>Review of the Progress Notes binder provided by the RCD on 05/30/19 revealed:<br>-There were no entries for Resident #1 refusing the administration of the Refresh eye drops.<br>-There was no further documentation provided regarding medication refusals for Resident #1.<br><br>Interview with Resident #1 on 05/30/19 at 3:45pm revealed:<br>-He knew he was prescribed Refresh eye drops for dry eyes.<br>-His eyes were itchy and burning at times, with some redness.<br>-The MAs did not bring him the Refresh eye drops 4 times a day.<br>-He did not remember the last time the MAs | D 367 | | |

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| D 367 | Continued From page 21<br>administered the Refresh eye drops.<br>-If he requested the Refresh eye drops the MAs administered them.<br><br>Interview with the second shift MA on 05/30/19 at 3:55pm revealed:<br>-She administered Resident #1's evening medications.<br>-She should have administered Resident #1's Refresh eye drops in the evenings, at 4:00pm and 8:00pm.<br>-She had been "used to what medications he usually takes" and was not always referring to the MARs.<br>-She thought she had been administering all the medications on Resident #1's MAR, and signed accordingly at the end of her shift.<br>-She did not remember administering Refresh eye drops for Resident #1 at 4:00pm and 8:00pm recently.<br>2. Review of Resident #3's current FL2 dated 03/28/19 revealed:<br>-A diagnosis of schizophrenia-chronic.<br>-She was intermittently disoriented.<br>-An order for albuterol-ipratropium 0.5mg-3mg (2.5mg base)/3ml take 3ml inhalation every 4 hours.<br><br>Review of Resident #3's Resident Register revealed an admission date of 03/28/19.<br><br>Review of a clarification of orders dated 03/28/19 revealed an order for albuterol-ipratropium 3ml 1 vial via nebulizer four times a day.<br><br>Review of Resident #3's March 2019 Medication Administration Record (MAR) revealed:<br>-There was a handwritten entry for albuterol-ipratropium 3ml 1 vial via nebulizer four times a day scheduled for administration at | D 367 | | |

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| D 367 | Continued From page 22<br>8:00am; 12:00pm; 4:00pm and 8:00pm.<br>-The albuterol-ipratropium 3ml was documented as administered beginning 03/28/19 at 8:00pm to 03/31/19 at 8:00pm.<br>-Thirteen vials of albuterol-ipratropium 3ml was documented as administered from 03/28/19 to 03/31/19.<br><br>Review of clarification of orders dated 4/10/19 from a hospital discharge revealed:<br>-An order to discontinue albuterol-ipratropium 3ml 1 vial via nebulizer four times a day as needed.<br>-An order to continue albuterol-ipratropium 3ml 1 vial via nebulizer four times a day.<br><br>Review of a hospital discharge summary dated 04/30/19 for Resident #3 revealed:<br>-Resident #3 was hospitalized from 04/23/19 to 04/30/19.<br>-Discharge diagnoses included hypercapnic respiratory failure; community acquired pneumonia; acute respiratory failure; anxiety; depression; emphysema; chronic obstructive pulmonary disorder (COPD) and schizophrenia.<br>-Resident #3's oxygen level was in the 70's when she arrived at the hospital on 04/23/19 and she was admitted to the Intensive Care Unit (ICU).<br><br>Review of Resident #3's April 2019 Medication Administration Record (MAR) revealed:<br>-There was a handwritten entry for albuterol-ipratropium 3ml 1 vial via nebulizer four times a day scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-The albuterol-ipratropium 3ml was documented as administered four times daily beginning on 04/01/19 at 8:00am to 04/08/19 at 12:00pm.<br>-The albuterol-ipratropium 3ml was documented as not administered on 04/08/19 at 4:00pm to 04/10/19 at 12:00pm due to Resident #3 being | D 367 | | |

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| D 367 | Continued From page 23<br>out of the facility in the hospital.<br>-The albuterol-ipratropium 3ml was documented as administered on 04/10/19 at 4:00pm to 04/22/19 and 8:00pm.<br>-The albuterol-ipratropium 3ml was documented as not administered on 4/23/19 at 8:00am to 04/30/19 at 12:00pm due to Resident#3 being out of the facility in the hospital.<br>-The albuterol-ipratropium 3ml was documented as administered on 04/30/19 at 4:00pm and 8:00pm.<br>-Eighty-two vials of albuterol-ipratropium 3ml were documented as administered.<br><br>Review of Resident #3's hospital discharge summary dated 05/23/19 revealed Resident #3 was hospitalized from 05/20/19 to 05/23/19 in the Intensive Care Unit due to chronic obstructive pulmonary disease (COPD) exacerbation.<br><br>Review of Resident #3's May 2019 Medication Administration Record (MAR) revealed:<br>-There was a computer-generated entry for albuterol-ipratropium 3ml 1 vial via handheld nebulizer every 4 hours scheduled for administration at 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.<br>-There was a handwritten entry that noted "Rewrote".<br>-There was a handwritten entry for albuterol-ipratropium 3ml 1 vial via nebulizer four times a day scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.<br>-The albuterol-ipratropium 3ml was documented as administered on 05/01/19 at 8:00am to 05/19/19 at 8:00pm.<br>-The albuterol-ipratropium 3ml was documented as not administered from 05/20/19 at 8:00am to 05/23/19 at 8:00pm due to Resident #3 being out of the facility in the hospital. | D 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 367 | Continued From page 24<br>-The albuterol-ipratropium 3ml was documented as administered on 05/24/19 at 8:00am to 05/29/19 at 8:00pm.<br>-One hundred vials of albuterol-ipratropium were documented as administered.<br><br>Observations of medications on the medication cart on 05/29/19 at 3:15pm revealed:<br>-There was a zip lock bag with 10 vials of albuterol-ipratropium 3ml stored in the bag.<br>-The label noted albuterol-ipratropium 3ml one vial via nebulizer every 4 hours with a dispense date of 03/28/19.<br><br>Observations of medications on the medication cart on 05/30/19 at 3:10pm revealed:<br>-There was a zip lock bag with 10 vials of albuterol-ipratropium 3ml stored in the bag.<br>-The label noted albuterol-ipratropium 3ml one vial via nebulizer every 4 hours with a dispense date of 03/28/19.<br><br>Interview with Resident #3 on 05/30/19 at 11:45am revealed:<br>-She was not feeling well.<br>-She was short of breath because she had just come back inside from smoking.<br>-She experienced shortness of breath frequently even during times when she had not smoked.<br>-She had been in the intensive care unit at the hospital the week prior due to breathing issues and pneumonia.<br>-She had also been in the hospital in April 2019 due to COPD and pneumonia.<br>-She depended on the staff to administer her medications.<br>-She thought all her medications were being administered as ordered.<br>-She had received nebulizer treatments in the past and she had noted improvement in breathing | D 367 | | |

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| D 367 | Continued From page 25<br>after receiving the treatments.<br>-She had not received any nebulizer treatments at the facility since the week before she was in the ICU at the hospital.<br><br>Telephone interview with the facility contracted pharmacy on 05/30/19 at 11:30am revealed:<br>-On 03/28/19 the pharmacy had received a physician's order for albuterol-ipratropium 0.5mg-3mg (2.5mg base)/3ml take 3ml inhalation every 4 hours.<br>-Sixty vials (10-day supply) of albuterol-ipratropium 0.5mg-3mg (2.5mg base) was dispensed on 03/28/19<br>-On 04/30/19, a discharge summary was received that noted to discontinue the albuterol-ipratropium 0.5mg-3mg (2.5mg base)/3ml take 3 ml inhalation every 4 hours as needed.<br>-The discharge summary received 04/30/19 noted an order to start albuterol-ipratropium 0.5mg-3mg (2.5mg base)/3ml take 3ml four times a day.<br>-The facility had not requested the medication be refilled since 03/28/19.<br><br>Review of Resident #3's March, April, and May 2019 Medication Administration Records compared to the number of vials dispensed from the facility contracted pharmacy revealed:<br>-One hundred and ninety-five vials had been documented as administered.<br>-Sixty vials had been dispensed on 03/28/19<br><br>Telephone interview with Resident #3's primary care doctor on 05/30/19 at 2:29pm revealed:<br>-The albuterol-ipratropium 3ml was prescribed to treat symptoms of COPD.<br>-The medication helped to reduce the frequency and intensity of COPD exacerbations.<br>-He was not aware that Resident #3 was not | D 367 | | |

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| D 367 | Continued From page 26<br>receiving the medication.<br>-There were no significant risks to the resident if she did not receive the medication.<br>-Resident #3 may experience some shortness of breath without the medication but since she was a smoker it would be hard to say if the shortness of breath would be due to lack of the medication or from smoking.<br>-He did not think Resident #3 missing the medication caused, contributed to or was a factor in Resident #3's hospitalization in April 2019 and May 2019.<br>-Resident #3 was at risk for hospitalizations due to COPD because COPD symptoms were hard to manage especially since she was a smoker.<br><br>Telephone interview with the facility's corporate nurse on 05/30/19 at 2:52pm revealed:<br>-He conducted audits at the facility about once or twice a month.<br>-Audits consisted of him choosing a sample of 5-6 residents to review.<br>-He would compare medication orders with the MAR and medications available on the cart.<br>-If there were any issues identified he would address with staff and correct.<br>-He was unable to recall if he had included Resident #3 in one of the audits he had conducted at the facility.<br>-Resident #3 had not been at the facility long so he may not have reviewed her yet for medications.<br>-He did not know of any issues with Resident #3 receiving her medications as ordered.<br><br>Interview with a first shift medication aide on 05/30/19 at 3:10pm revealed:<br>-She administered the albuterol-ipratropium 3ml to Resident #3 as ordered.<br>-Sometimes Resident #3 would sit in the | D 367 | | |

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| D 367 | Continued From page 27<br>medication room while receiving the albuterol-ipratropium 3ml treatment in her nebulizer and sometimes she would sit in her room while receiving the treatment.<br>-Resident #3 did not come to the facility with a nebulizer machine.<br>-Resident #3 received a nebulizer machine after being hospitalized in April 2019.<br>-She was not sure why Resident #3 had albuterol-ipratropium 3ml that had been dispensed on 3/28/19 on the medication cart.<br>-She thought maybe the most recent refill of Resident #3's albuterol-ipratropium 3ml had been placed in the bag labeled 03/28/19 and the bag with the most recent dispense date had been accidentally discarded.<br><br>Interview with a second shift medication aide on 05/30/19 at 3:15pm revealed:<br>-She usually administered the albuterol-ipratropium 3ml to Resident #3 twice during her shift at 4:00pm and 8:00pm.<br>-Sometimes the first shift medication aide would administer the 4:00pm dose of albuterol-ipratropium 3ml before she left the facility.<br>-She did not know why Resident #3 still had albuterol-ipratropium 3ml that was dispensed on 03/28/19.<br>-She had administered Resident #3's medications as ordered.<br><br>Joint interview with the facility owner, administrator and RCD on 05/30/19 at 3:30pm revealed:<br>-They did not know Resident #3 was not receiving the albuterol-ipratropium 3ml as ordered.<br>-They expected residents to receive medications as ordered by the doctor.<br>-They would ensure Resident #3 received the | D 367 | **PLAN OF CORRECTION FOR TAG D 367**<br>RCD will check Med Cart Daily to ensure all Medication signed for were given.<br>RCD will report to Administrator any Meds signed for not given<br>RCD will inform MD/Pharmacy of Med Error<br>Med Aide will be re-inservice by Corp RN | 6/1/19 |

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| D 367 | Continued From page 28<br>albuterol-ipratropium 3ml as ordered. | D 367 | | |
| D 392 | 10A NCAC 13F .1008(a) Controlled Substances<br><br>10A NCAC 13F .1008 Controlled Substances<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 2 of 2 residents sampled (Residents #4, and #5) who were prescribed controlled substances.<br><br>The findings are:<br><br>Review of the facility's Controlled Substance policy revealed:<br>-"Facility Resident Care Director (RCD) maintain original copy of Narc (narcotics) sheet from pharmacy."<br>-"RCD prepare facility Narc sheet and attach original to it once it is zero out."<br>-"The RCD will have medication aides (MA) sign for the amount Controlled Substance he/she receive, the card number, and date."<br>-"Form is designed for on-coming MA to sign off as well as off going MA." | D 392 | D 392 RCD immediately counted all Narcs. | 5/30/19 |

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| D 392 | Continued From page 29<br><br>1. Review of Resident #4's current FL2 dated 02/25/19 revealed diagnoses included chronic lower back pain, depression, delusional disorder, reflux, peptic ulcer disease, hypertension, and hyperlipidemia.<br><br>Review of Resident #4's physician's orders revealed:<br>-There was a physician's order dated 03/01/19 for hydrocodone 7.5mg with acetaminophen 325mg (a narcotic used to treat severe pain) one tablet twice daily (quantity of sixty tablets).<br>-There was a physician's order dated 04/01/19 for hydrocodone 7.5mg with acetaminophen 325mg one tablet twice daily (quantity of sixty tablets).<br>-There was a physician's order dated 05/01/19 for hydrocodone 7.5mg with acetaminophen 325mg one tablet twice daily (quantity of sixty tablets).<br><br>Interview with Resident #4 on 05/30/19 at 11:00am revealed:<br>-She had chronic back pain.<br>-She had scheduled pain medication that helped to relieve her pain, but her back would continue to hurt.<br>-She did not know if she had not been given her pain medication every time it was scheduled.<br><br>Attempted telephone interview with Resident #4's responsible party on 05/30/19 at 11:15am was unsuccessful.<br><br>Telephone interview on 05/29/19 at 8:30am with a Pharmacist at the contracted pharmacy revealed:<br>-The pharmacy provided CSCS along with controlled substances dispensed to Resident #4.<br>-On 03/01/19, the pharmacy dispensed sixty hydrocodone 7.5mg with acetaminophen 325mg tablets labeled one tablet twice daily and delivered them on 03/11/19. | D 392 | | |

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| D 392 | Continued From page 30<br><br>-On 04/10/19 the pharmacy dispensed sixty hydrocodone 7.5mg/acetaminophen 325mg tablets labeled one tablet twice daily and delivered them on 04/10/19.<br>-On 04/24/19 the facility contacted them related to thirty tablets missing of the sixty tablets for Resident #4 that was dispensed on 04/10/19.<br>-She had instructed the RCD to contact the police and to file a report for the missing thirty tablets.<br>-She informed the RCD the resident's physician would need to send another prescription for thirty tablets.<br>-On 04/24/19 the pharmacy dispensed thirty hydrocodone 7.5mg/acetaminophen 325mg tablets labeled one tablet twice daily and delivered them on 04/24/19.<br>-On 05/08/19 the pharmacy dispensed thirty hydrocodone 7.5mg/acetaminophen 325mg tablets labeled one tablet twice daily and delivered them on 05/08/19.<br><br>Review of Resident #4's March Controlled Substance Count Sheets (CSCS) revealed:<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 03/01/19 at 8:00am to 03/09/19 at 8:00pm for eighteen tablets.<br>-Eighteen tablets of hydrocodone 7.5mg/acetaminophen 325mg were signed out from 03/01/19 at 8:00am to 03/09/19 at 8:00pm.<br>-There was no CSCS documentation on 03/10/19 at 8:00am to 03/11/19 at 8:00am for three tablets of hydrocodone 7.5mg/acetaminophen 325mg.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 03/11/19 at 8:00pm to 03/25/19 at 8:00am for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg/acetaminophen 325mg were signed out | D 392 | | |

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| D 392 | Continued From page 31<br>from 03/11/19 at 8:00pm to 03/25/19 at 8:00am.<br><br>Review of Resident #4's April Controlled Substance Count Sheets (CSCS) revealed:<br>-There was a CSCS handwritten by the facility for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 03/26/19 at 8:00pm to 04/09/19 at 8:00pm for thirty tablets.<br>-Nineteen tablets of hydrocodone 7.5mg/acetaminophen 325mg had been signed out from 03/26/19 at 8:00am to 04/09/19 at 8:00pm.<br>-There was no CSCS documentation on 03/29/19 at 8:00pm to 03/31/19 at 8:00pm for twelve tablets of hydrocodone 7.5mg/acetaminophen 325mg.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 04/10/19 at 9:00pm to 04/11/19 at 8:00am for thirty tablets.<br>-Two tablets of hydrocodone 7.5mg/acetaminophen 325mg had been signed out from 04/10/19 at 9:00pm to 04/11/19 at 8:00am and one tablet on 04/10/19 at 8:00am had not been signed out.<br>-There was CSCS documentation for 04/11/19 at 9:00pm and 04/11/19 at 8:00am with twenty-eight doses of hydrocodone 7.5mg/acetaminophen 325mg remaining and the remainder of the page was left blank.<br>-There was a CSCS handwritten by the facility for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 04/11/19 at 8:00pm to 04/22/19 at 8:00pm for twenty-seven tablets.<br>-Twenty-three tablets of hydrocodone 7.5mg/acetaminophen 325mg had been signed out with four tablets remaining and the remainder of the page was left blank.<br>-There was a CSCS handwritten by the facility for hydrocodone 7.5mg/acetaminophen 325mg take | D 392 | | |

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| D 392 | Continued From page 32<br><br>one tablet twice daily dated 04/29/19 at 8:00am to 05/08/19 at 8:00pm for twenty tablets.<br>-Twenty tablets of hydrocodone 7.5mg/acetaminophen 325mg had been signed out from 04/29/19 at 8:00am to 05/08/19 at 8:00pm.<br><br>Review of Resident #4's May Controlled Substance Count Sheets (CSCS) revealed:<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 05/09/19 at 8:00am to 05/23/19 at 8:00pm for thirty tablets.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg/acetaminophen 325mg take one tablet twice daily dated 05/25/19 at 8:00am to 05/30/19 at 8:00am for twenty tablets.<br>-There was no documentation for two tablets of hydrocodone 7.5mg/acetaminophen 325mg administered on 05/24/19 at 8:00am and 8:00pm.<br><br>Review of Resident #4's March 2019 CSCS for hydrocodone 7.5mg with acetaminophen 325mg compared to the March 2019 Medication Administration Record (MAR) revealed:<br>-Hydrocodone 7.5mg/acetaminophen 325mg was documented as signed out forty-eight times on the CSCS for March 2019 and sixty times on the March 2019 MAR.<br>-There were entries on 03/26/19 at 8:00pm to 03/30/19 at 8:00am ten doses of hydrocodone 7.5mg/acetaminophen 325mg were documented as not given because the resident was out of the facility on the MAR.<br>-The March CSCS did not have documentation for twelve doses of hydrocodone 7.5mg/acetaminophen 325mg from 03/26/19 to 03/31/19. | D 392 | | |

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| D 392 | Continued From page 33<br><br>Review of Resident #4's April 2019 CSCS for hydrocodone 7.5mg with acetaminophen 325mg compared to the April 2019 Medication Administration Record (MAR) revealed:<br>-Hydrocodone 7.5mg with acetaminophen 325mg was documented as signed out forty-seven times on the CSCS for April 2019 and documented as administered fifty times on the MAR.<br>-There were entries on 04/23/19 at 8:00pm to 04/28/19 at 8:00am ten doses of hydrocodone 7.5mg/acetaminophen 325mg were documented as not given because the resident was out of the facility.<br>-The April CSCS did not have documentation for thirteen doses of hydrocodone 7.5mg/acetaminophen 325mg from 04/23/19 to 04/28/19.<br><br>Observation on 05/30/19 at 11:00am of Resident #4's medications on hand for administration revealed there were nineteen hydrocodone 7.5 mg with 325mg acetaminophen on hand matching the amount remaining on the CSCS.<br><br>Review of Resident #4's CSCS from 03/01/19 to 05/23/19 compared to the number of tablets dispensed from the facility contracted pharmacy revealed:<br>-Two hundred hydrocodone 7.5mg/acetaminophen 325mg tablets had been dispensed and one hundred and forty-one hydrocodone 7.5mg/acetaminophen 325mg tablets had been documented on the CSCS.<br>-Fifty-nine tablets of hydrocodone 7.5mg/acetaminophen 325mg tablets were not counted on the CSCS.<br><br>Interview with a first shift medication aide (MA) on 05/29/19 at 1:00pm revealed:<br>-Every time she had administered Resident #4's | D 392 | | |

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| D 392 | Continued From page 34<br><br>hydrocodone 7.5mg/acetaminophen 325mg she had documented the ongoing count on the CSCS.<br>-She did not know why Resident #4's CSCS did not match her MAR.<br>-There were incidents that Resident #4's hydrocodone 7.5mg/acetaminophen 325mg had gone missing.<br>-During shift change the controlled substances were counted by her and the oncoming MA.<br>-When the count was off she had reported it to the RCD.<br>-The count would be reviewed, and corrections were made by the RCD.<br>-She did not know exactly how many times the count was incorrect.<br>-The controlled substances were delivered to the facility in a tote that was kept in the medication room.<br>-The medication cart was restocked by the RCD the morning after medications had been delivered.<br>-A CSCS was delivered with the controlled substances to document an ongoing count of the tablets as she had administered them.<br>-If the CSCS was missing she had handwritten a new one and counted the number of tablets left on the cart for the resident with another MA or the RCD.<br>-When the CSCS count of hydrocodone 7.5mg/acetaminophen 325mg reached zero for the count the CSCS she gave it to the RCD.<br>-She did not know if the RCD had not audited the CSCS with the number of tablets of hydrocodone 7.5mg/acetaminophen 325mg on hand in March, April, and May.<br><br>Interview with the second shift MA on 05/30/19 at 3:45pm revealed:<br>-She did not know why the CSCS for hydrocodone 7.5mg/acetaminophen 325mg | D 392 | | |

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| D 392 | Continued From page 35<br>tablets did not match the MAR.<br>-There was an incident when an entire card of thirty hydrocodone 7.5mg/acetaminophen 325mg had gone missing.<br>-She had reported the missing hydrocodone 7.5mg/acetaminophen 325mg tablets to the RCD.<br>-She had counted all controlled substances for Resident #4 during shift change with the oncoming MA.<br>-When the count was incorrect for the hydrocodone 7.5mg/acetaminophen 325mg tablets she had reported it to the RCD.<br>-Sometimes the CSCS for the hydrocodone 7.5mg/acetaminophen 325mg were missing and she reported it to the RCD.<br>-The RCD would create a handwritten CSCS for hydrocodone 7.5mg/acetaminophen 325mg tablets.<br>-The RCD had not audited the number of hydrocodone 7.5mg/acetaminophen 325mg tablets on medication carts.<br><br>Refer to interview with the RCD on 05/29/19 at 2:00pm.<br><br>Refer to interview with the Administrator on 05/29/19 at 2:30pm.<br><br>2. Review of Resident #5's current FL2 dated 03/21/19 revealed diagnoses included acute renal failure, metabolic encephalopathy, diabetes, and hypertension.<br><br>Review of Resident #5's physician's orders revealed:<br>-There was a physician's order dated 03/01/19 for hydrocodone 7.5mg with ibuprofen 200mg (a narcotic used to treat severe pain) one tablet three times daily (quantity of ninety tablets).<br>-There was a physician's order dated 04/03/19 for | D 392 | | |

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| D 392 | Continued From page 36<br><br>hydrocodone 7.5mg with ibuprofen 200mg one tablet three times daily (quantity of ninety tablets).<br>-There was a physician order dated 04/23/19 to hold hydrocodone 7.5mg with ibuprofen 200mg and restart it on 04/25/19.<br>-There was a physician's order dated 04/25/19 for hydrocodone 7.5mg with ibuprofen 200mg one tablet three times daily (quantity of ninety tablets).<br>-There was a physician's order dated 05/24/19 for hydrocodone 7.5mg with ibuprofen 200mg one tablet three times daily (quantity of ninety tablets).<br><br>Interview with Resident #5 on 05/30/19 at 10:00am revealed:<br>-He had pain in his legs all the time.<br>-He was supposed to get pain medication for the pain but did not know if he was being adminsitered the pain medication as ordered.<br>-He could not say he went without it.<br>-He did not know if he had gotten his pain medication because it was not effective in relieving his pain.<br><br>Telephone interview on 05/29/19 at 8:30am with a Pharmacist at the contracted pharmacy revealed:<br>-The pharmacy provided CSCS along with controlled substances dispensed to Resident #5.<br>-On 03/01/19, the pharmacy dispensed ninety hydrocodone 7.5mg with ibuprofen 200mg tablets labeled one tablet three times daily and delivered them on 03/01/19.<br>-On 04/03/19, the pharmacy dispensed ninety hydrocodone 7.5mg with ibuprofen 200mg tablets labeled one tablet three times daily and delivered them on 03/01/19.<br>-On 04/24/19 the facility contacted them related to thirty tablets of hydrocodone 7.5mg/ibuprofen 200mg missing of the ninety tablets for Resident #4 that was dispensed on 04/03/19.<br>-She had instructed the RCD to contact the police | D 392 | | |

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| D 392 | Continued From page 37<br>and filing a report for the missing thirty tablets.<br>-She informed the RCD the resident's physician would need to send another prescription for thirty tablets.<br>-On 04/25/19, the pharmacy dispensed ninety hydrocodone 7.5mg with ibuprofen 200mg tablets labeled one tablet three times daily and delivered them on 04/25/19.<br>-On 05/24/19, the pharmacy dispensed ninety hydrocodone 7.5mg with ibuprofen 200mg tablets labeled one tablet three times daily and delivered them on 05/24/19.<br><br>Review of Resident #5's March Controlled Substance Count Sheets (CSCS) revealed:<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 03/01/19 at 8:00am to 03/04/19 at 8:00pm for ten tablets.<br>-Ten tablets of hydrocodone 7.5mg with ibuprofen 200mg were signed out from 03/01/19 at 8:00am to 03/04/19 at 8:00pm.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 03/04/19 at 8:00am to 03/13/19 at 8:00pm for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg with ibuprofen 200mg were signed out from 03/04/19 a 8:00am to 03/13/19 at 8:00pm.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 03/13/19 at 8:00am to 03/23/19 at 8:00pm for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg/ibuprofen 200mg were signed out from 03/13/19 a 8:00am to 03/23/19 at 8:00pm.<br>-There was a CSCS generated by the contracted | D 392 | | |

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| D 392 | Continued From page 38<br><br>pharmacy for hydrocodone 7.5mg/ibuprofen 200mg take one tablet three times daily dated 03/24/19 at 8:00am to 04/02/19 at 1:00pm for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg/ibuprofen 200mg were signed out from 03/24/19 a 8:00am to 04/02/19 at 1:00pm.<br>-One tablet of hydrocodone 7.5mg/ibuprofen 200mg was documented as wasted on 03/28/19.<br><br>Review of Resident #5's April Controlled Substance Count Sheets (CSCS) revealed:<br>-There was no CSCS provided with documentation of controlled substances for 04/02/19 at 8:00pm to 04/13/19 at 2:00pm for hydrocodone 7.5mg with ibuprofen 200mg thirty tablets.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 04/13/19 at 8:00pm to 04/23/19 at 2:00pm for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg with ibuprofen 200mg were signed out from 04/13/19 at 8:00pm to 04/23/19 at 2:00pm.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 04/26/19 at 8:00am to 05/05/19 at 8:00pm for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg with ibuprofen 200mg were signed out from 04/26/19 at 8:00pm to 05/05/19 at 8:00pm.<br><br>Review of Resident #5's May Controlled Substance Count Sheets (CSCS) revealed:<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 05/06/19 at 8:00am to 05/15/19 at 8:00pm for | D 392 | | |

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| D 392 | Continued From page 39<br>thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg with ibuprofen 200mg were signed out from 05/06/19 at 8:00am to 05/15/19 at 8:00pm.<br>-There was no CSCS sheet for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated for 05/16/19 at 8:00am to 05/25/19 at 8pm for thirty tablets.<br>-Thirty tablets of hydrocodone 7.5mg with ibuprofen 200mg had not been signed out from 05/16/19 at 8:00am to 05/25/19 at 8:00pm.<br>-There was a CSCS generated by the contracted pharmacy for hydrocodone 7.5mg with ibuprofen 200mg take one tablet three times daily dated 05/26/19 at 8:00am to 05/30/19 at 8:00pm for twenty-one tablets.<br>-Thirteen tablets of hydrocodone 7.5mg with ibuprofen 200mg had been signed out from 05/26/19 at 8:00am to 05/30/19 at 8:0pm leaving eight tablets for a balance on hand.<br><br>Observation on 05/30/19 at 11:00am of Resident #5's medications on hand for administration revealed there were eight tablets of hydrocodone 7.5 mg with 200mg ibuprofen on hand matching the amount remaining on the CSCS.<br><br>Review of Resident #5's March 2019 CSCS for hydrocodone 7.5 mg with 200mg ibuprofen compared to the March 2019 Medication Administration Record (MAR) revealed:<br>-Hydrocodone 7.5 mg with 200mg ibuprofen was documented as signed out ninety-five times on the CSCS for March 2019 and ninety-three times on the March 2019 MAR.<br>-There was documentation on the March MAR on 03/19/19 at 8:00am Resident #5 had refused his medications.<br>-There was documentation on the March CSCS for two hydrocodone 7.5 mg with 200mg | D 392 | | |

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| D 392 | Continued From page 40<br>ibuprofen tablets wasted on 03/19/19 at 8:00am and 03/28/19 at 8:00pm.<br><br>Review of Resident #5's April 2019 CSCS for hydrocodone 7.5 mg with 200mg compared to the April 2019 Medication Administration Record (MAR) revealed:<br>-Hydrocodone 7.5 mg with 200mg ibuprofen was documented as signed out fifty times on the CSCS for April 2019 and eighty-three times on the April 2019 MAR.<br>-There was no CSCS provided with documentation of controlled substances for 04/02/19 at 8:00pm to 04/13/19 at 2:00pm for thirty-three tablets.<br>-Resident #5's hydrocodone 7.5 mg with 200mg was on hold from 04/23/19 at 8:00pm to 04/25/19 at 2:00pm requiring 7 doses to be not given.<br><br>Review of Resident #5's May 2019 CSCS for hydrocodone 7.5 mg with 200mg compared to the May 2019 Medication Administration Record (MAR) revealed:<br>-Hydrocodone 7.5 mg with 200mg ibuprofen was documented as signed out fifty-eight on the CSCS for May 2019 and eighty-three times on the May 2019 MAR.<br>-There was no CSCS provided with documentation of controlled substances for 05/16/19 at 8:00am to 05/25/19 at 8:00pm for thirty hydrocodone 7.5 mg with ibuprofen 200mg tablets.<br><br>Review of Resident #5's CSCS for hydrocodone 7.5 mg with 200mg tablet from 03/01/19 to 05/24/19 compared to the number of hydrocodone 7.5 mg with 200mg tablets dispensed from the facility contracted pharmacy revealed:<br>-Three hundred and sixty hydrocodone | D 392 | | |

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| D 392 | Continued From page 41<br>7.5mg/acetaminophen 325mg tablets had been dispensed and two hundred and eleven hydrocodone 7.5 mg with ibuprofen 200mg tablets had been documented on the CSCS.<br>-One hundred and forty-nine hydrocodone 7.5mg with ibuprofen 200mg tablets were not counted on the CSCS.<br><br>Interview with a first shift medication aide (MA) on 05/29/19 at 1:00pm revealed:<br>-Every time she had administered Resident #5's hydrocodone 7.5mg with ibuprofen 200mg she had documented the ongoing count on the CSCS.<br>-She did not know why Resident #5's CSCS were missing.<br>-There were incidents that Resident #5's hydrocodone 7.5mg with ibuprofen 200mg had gone missing.<br>-During shift change the controlled substances were counted by her and the oncoming MA.<br>-When the count was off she had reported it to the RCD.<br>-The count would be reviewed, and corrections were made by the RCD.<br>-She did not know exactly how many times the count was incorrect.<br>-The controlled substances were delivered to the facility in a tote that was kept in the medication room.<br>-The medication cart was restocked by the RCD the morning after medications had been delivered.<br>-A CSCS was delivered with the controlled substances to document an ongoing count of the tablets as she had administered them.<br>-When the CSCS count of hydrocodone 7.5mg with ibuprofen 200mg reached zero for the count the CSCS she gave it to the RCD.<br>-She did not know if the RCD had not audited the CSCS with the number of tablets of hydrocodone | D 392 | | |

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| D 392 | Continued From page 42<br>7.5mg with ibuprofen 200mg on hand in March, April, and May.<br><br>Interview with the second shift MA on 05/30/19 at 3:45pm revealed:<br>-She did not know why the Resident #5's CSCS for hydrocodone 7.5mg with ibuprofen 200mg tablets did not match the MAR.<br>-There was an incident when an entire card of thirty hydrocodone 7.5mg with ibuprofen 200mg for Resident #5 had gone missing.<br>-She had reported the missing hydrocodone 7.5mg with ibuprofen 200mg tablets to the RCD.<br>-She had counted all controlled substances for Resident #5 during shift change with the oncoming MA.<br>-When the count was incorrect for the hydrocodone 7.5mg with ibuprofen 200mg tablets she had reported it to the RCD.<br>-Sometimes the CSCS for the hydrocodone 7.5mg with ibuprofen 200mg tablets were missing and she reported it to the RCD.<br>-The RCD had not audited the number of hydrocodone 7.5mg with ibuprofen 200mg tablets on medication carts.<br><br>Refer to interview with the RCD on 05/29/19 at 2:00pm.<br><br>Refer to interview with the Administrator on 05/29/19 at 2:30pm._____<br>Interview with the RCD on 05/29/19 at 2:00pm revealed:<br>-She had recently taken on the role of RCD.<br>-She was in the process of auditing all the CSCS and MARs for accuracy.<br>-She was aware there had been missing controlled substances.<br>-The Administrator and the Corporate Nurse were | D 392 | | |

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| D 392 | Continued From page 43<br>in the process of assisting her with auditing and reconciliation of all the controlled substance documentation.<br><br>Interview with the Administrator on 05/29/19 at 2:15pm revealed:<br>-She knew controlled substances had been reported missing.<br>-She had reported one of MAs to the HCPR when she refused a drug screening and quit.<br>-She had not audited the records for accuracy.<br>-She had been preoccupied with rehiring staff after the investigation of the staff involved in the incident of missing controlled substance had quit.<br>-The RCD and the MAs were responsible to assure accuracy of the controlled substance accounting, including auditing CSCS compared to MARs for accurate documentation.<br>-She had recently hired a new RCD, who had started a couple of weeks ago.<br>-The new RCD and the Corporate Nurse were currently auditing the CSCS and MARs.<br>-She did not have a system in place at this time to ensure accuracy of the CSCS and MARs. | D 392 | **PLAN OF CORRECTION FOR TAG D 392 / TAG D 393**<br>**Immediately replace locks**<br>*Pharmacy will fax a list of all Narcs being send to RCD/Administrator<br>*Med Aide on Duty will sign for Narcs and lock tote, and lock it in Double Lock Med Room<br>*RCD will open tote next day any compare list from Pharmacy.<br>*RCD will inform Administrator of any missing NARCS<br>*Administrator will inform Owners, DSS, Police, Pharmacy, Resident, Guardian, and report to HCPR<br>*RCD/Corp RN will do a Narc Audit x3 monthly | 5/30/19 |
| D 393 | 10A NCAC 13F .1008 (b) Controlled Substance<br><br>10A NCAC 13F .1008 Controlled Substance<br><br>(b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. | D 393 | | |

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| D 393 | Continued From page 44<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to properly store excess supply of Schedule II medications under double lock and proper supervision upon receipt of controlled medications for 2 of 2 sampled residents (#4 & #5).<br><br>The findings are:<br><br>Observation of the medication room located in the middle of the resident's lower hallway of the building during the initial tour on 05/29/19 between 8:00 and 9:00am revealed:<br>-The doorway to the entrance of the medication room had been left open allowing staff or residents to enter and exit the room without opening the door.<br>-A gray medication tote was observed sitting on the floor in the room under the counter.<br>-There were two medication carts sitting in the hallway beside on another along the wall.<br>-A resident was standing in the entrance to the medication room.<br>-No staff were present in the medication room and hallway.<br>-The Resident Care Director (RCD) and a medication aide (MA) were sitting in an office located approximately 20 feet down the hallway on the opposite side of the hall.<br><br>Review of the facility's Controlled Substance policy revealed:<br>-"Controlled Substances are kept on Medication cart, locked in separate compartment."<br>-"Medications remain locked at all times, Controlled Substance compartment must be locked with key."<br>-"Only Medication Aide on Duty has key." | D 393 | | |

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| D 393 | Continued From page 45<br><br>1. Review of Resident #4's current FL2 dated 02/25/19 revealed diagnoses included chronic lower back pain, depression, delusional disorder, reflux, peptic ulcer disease, hypertension, and hyperlipidemia.<br><br>Review of Resident #4's physician's orders revealed there was a physician's order dated 05/01/19 for hydrocodone 7.5mg with acetaminophen 325mg (a narcotic used to treat severe pain) one tablet twice daily (quantity of sixty tablets).<br><br>Telephone interview on 05/29/19 at 8:30am with a Pharmacist at the contracted pharmacy revealed:<br>-On 04/10/19 the pharmacy dispensed sixty hydrocodone 7.5mg/acetaminophen 325mg tablets labeled one tablet twice daily and delivered them on 04/10/19.<br>-On 04/24/19 the facility contacted them related to thirty tablets missing of the sixty tablets for Resident #4 that was dispensed on 04/10/19.<br>-She had instructed the RCD to contact the police and filing a report for the missing thirty tablets.<br>-She informed the RCD the resident's physician would need to send another prescription for thirty tablets.<br>-On 04/24/19 the pharmacy dispensed thirty hydrocodone 7.5mg/acetaminophen 325mg tablets labeled one tablet twice daily and delivered them on 04/24/19.<br><br>Interview with Resident #4 on 05/30/19 at 11:00am revealed:<br>-She had chronic back pain.<br>-She had scheduled pain medication that helped to relieve her pain, but her back would continue to hurt.<br>-She did not know if she had not been given her pain medication. | D 393 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL013042 | A. BUILDING: _____ B. WING _____ | R-C 05/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE COUNTRY HOME | 2908 COUNTRY HOME ROAD CONCORD, NC 28025 |

| (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 393 | Continued From page 46<br>-When she had left the facility to go home with her daughter she had been given all her medications to take home.<br>-She did not know how many tablets of hydrocodone/acetaminophen she had been given to take home.<br><br>Attempted telephone interview with Resident #4's responsible party on 05/30/19 at 11:15am was unsuccessful.<br><br>Observation on 05/30/19 at 11:00am of Resident #4's medications on hand for administration revealed there were nineteen hydrocodone 7.5 mg with 325mg acetaminophen on hand matching the amount remaining on the Controlled Substance Count Sheet (CSCS).<br><br>Refer to interview with a first shift medication aide (MA) on 05/29/19 at 1:00pm.<br><br>Refer to interview with the second shift MA on 05/30/19 at 3:45pm.<br><br>Refer to interview with the RCD on 05/29/19 at 2:00pm.<br><br>Refer to interview with the Administrator on 05/29/19 at 2:30pm.<br><br>2. Review of Resident #5's current FL2 dated 03/21/19 revealed diagnoses included acute renal failure, metabolic encephalopathy, diabetes, and hypertension.<br><br>Review of Resident #5's physician's orders revealed:<br>-There was a physician order dated 04/23/19 to hold hydrocodone 7.5mg with ibuprofen 200mg and restart it on 04/25/19. | D 393 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL013042 | A. BUILDING: _____ B. WING _____ | R-C 05/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE COUNTRY HOME | 2908 COUNTRY HOME ROAD CONCORD, NC 28025 |

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|---|---|---|---|---|
| D 393 | Continued From page 47<br>-There was a physician's order dated 04/25/19 for hydrocodone 7.5mg with ibuprofen 200mg one tablet three times daily (quantity of ninety tablets).<br>-There was a physician's order dated 05/24/19 for hydrocodone 7.5mg with ibuprofen 200mg one tablet three times daily (quantity of ninety tablets).<br><br>Telephone interview on 05/29/19 at 8:30am with a Pharmacist at the contracted pharmacy revealed:<br>-On 04/03/19, the pharmacy dispensed ninety hydrocodone 7.5mg with ibuprofen 200mg tablets labeled one tablet three times daily and delivered them on 03/01/19.<br>-On 04/24/19 the facility contacted them related to thirty tablets of hydrocodone 7.5mg/ibuprofen 200mg missing of the ninety tablets for Resident #4 that was dispensed on 04/03/19.<br>-She had instructed the RCD to contact the police and filing a report for the missing thirty tablets.<br>-She informed the RCD the resident's physician would need to send another prescription for thirty tablets.<br>-On 04/25/19, the pharmacy dispensed ninety hydrocodone 7.5mg with ibuprofen 200mg tablets labeled one tablet three times daily and delivered them on 04/25/19.<br><br>Interview with Resident #5 on 05/30/19 at 10:00am revealed:<br>-He had pain in his legs all the time.<br>-He was supposed to get pain medication for the pain.<br>-He did not if he had gotten his pain medication because it wasn't helping to relieve the pain.<br><br>Observation on 05/30/19 at 11:00am of Resident #5's medications on hand for administration revealed there were eight hydrocodone 7.5 mg with 200mg ibuprofen on hand matching the amount remaining on the Controlled Substance | D 393 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL013042 | A. BUILDING: _____ B. WING _____ | R-C 05/30/2019 |

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| THE COUNTRY HOME | 2908 COUNTRY HOME ROAD CONCORD, NC 28025 |

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|---|---|---|---|---|
| D 393 | Continued From page 48<br>Count Sheet (CSCS).<br><br>Refer to interview with a first shift medication aide (MA) on 05/29/19 at 1:00pm.<br><br>Refer to interview with the second shift MA on 05/30/19 at 3:45pm.<br><br>Refer to interview with the RCD on 05/29/19 at 2:00pm.<br><br>Refer to interview with the Administrator on 05/29/19 at 2:30pm.<br><br>_____<br><br>Interview with first shift medication aide (MA) on 05/29/19 at 1:00pm revealed:<br>-All medications delivered on second shift were left in a gray tote from the pharmacy in the medication room.<br>-The door to the medication room had a lock on it.<br>-The medications left by the pharmacy in the gray totes were opened by the RCD the next morning.<br>-Any Controlled Substance including Scheduled II medications remained in the gray tote until the RCD opened the tote and restocked the medication carts.<br><br>Interview with the second shift MA on 05/30/19 at 3:45pm revealed:<br>-Medications delivered from the pharmacy on second shift were stored in the medication room on the floor, under the counter beside the sink.<br>-They remained there in gray totes until the next day when the RCD had arrived to the facility.<br>-The door to the medication room had one lock on it.<br>-There was not an additional lock on the gray | D 393 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL013042 | A. BUILDING: _____ B. WING _____ | R-C 05/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| D 393 | Continued From page 49<br>totes.<br>-Controlled Substances had gone missing from the medication room in April.<br><br>Interview with the RCD on 05/29/19 at 2:00 pm revealed:<br>-Gray medication totes had been delivered by the pharmacy.<br>-The gray medication tote are stored in the medication room until she arrived in the morning.<br>-The medication room had one lock on the door, and this was the only lock securing the medications.<br>-When she arrived in the morning the medications were removed from the gray tote and stored in the medication carts.<br>-She knew medications had gone missing from the facility in April.<br>-The medications that went missing had been secured in a gray tote in the medication room.<br><br>Interview with the Administrator on 05/29/19 at 2:30pm revealed:<br>-She knew the medications delivered from the pharmacy were stored in gray totes in the medication room with one lock on the door.<br>-She knew medications had gone missing from the facility in April.<br>-The medications that went missing from the facility had been left unsupervised in the medication room in April. | D 393 | | |



Reviewed and accepted on 07/31/19 by MA

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 17, 2019

Ms. Georgette Johnson, Managing Member
K & B Adult Care, Licensee
The Country Home
P.O. Box 1803
Shelby, NC 28151

*Email address: chetha.hertiageoaks@yahoo.com*

**Re: Overdue Plan of Correction for Statement of Deficiencies dated May 30, 2019 (LUYW12)**
**Facility: The Country Home**
**Licensure Number: License # HAL-013-042**
**County: Cabarrus**

Dear Ms. Johnson:

A survey was completed May 30, 2019 at The Country Home by staff with the Adult Care Licensure Section and the Cabarrus County Department of Social Services. As a result of the survey, it was determined that the facility was operating in violation of required rules. The summary of findings was cited on the Statement of Deficiencies form, which was transmitted for your information and response on June 14, 2019. The plan of correction was to be returned to this office by July 9, 2019.

On July 11, 2019, I spoke with Chetha Scott concerning the need for the plan of correction to be returned to this office for approval. As of today, the plan of correction has not been received. I am requesting that you submit the plan of correction immediately to this office.

This letter is also to inform you that failure to submit an acceptable plan of correction does not prevent a revisit to the rule areas cited to determine compliance.

You may contact me at (919) 630-8036 if you have questions.

Sincerely,
Mary E Agena

Mary E. Agena, BSN, RB, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

cc: Georgette Johnson, Managing Member,harrisjohnson6656@yahoo.com
Tammy Barc, Supervisor Cabarrus County DSS
Heather Bingham, Team Supervisor, West 2 Region Office, Adult Care Licensure Section

Raleigh Facility File