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PRINTED: 07/10/2021
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
	fcl001172	A. BUILDING: _____ B. WING _____	06/30/2021

RECEIVED
AUG 16 2021
ADULT CARE LICENSURE SECTION
RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW CARE	806 LAKESIDE AVENUE BURLINGTON, NC 27217

(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 the conducted an annual survey on 06/30/21.	C 000	RECEIVED AUG 25 2021 ADULT CARE LICENSURE SECTION RALEIGH	
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's FL2 dated 07/17/20	C 342	See Attached Document	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicolla V. Rogers — TITLE: Administrator — (X6) DATE: 8/9/2021

Reviewed and Acknowledged on 08/30/21 by MA

Mary R. Agena

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C 342	Continued From page 1 revealed: -Diagnoses included schizophrenia and anemia. -There was a physician order for oxycodone/APAP 5/325mg one tablet every four hours as needed for pain. Review of Resident #2's physician order dated 04/14/21 revealed oxycodone/APAP 5/325mg one tablet every four hours as needed for pain. Review of Resident #2's April, May, and June 2021 Medication Administration Records (MAR) revealed: -There was an entry for oxycodone/APAP 5/325mg one tablet every four hours as needed for pain. -The was no documentation the oxycodone/APAP 5/325mg was administered 04/01/03/01/21 to 06/30/21. Observation of Resident #2's available oxycodone/APAP 5/325mg on 06/30/21 at 12:00pm revealed there were no oxycodone/APAP 5/325mg available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/30/21 at 12:30pm revealed: -They provided the MARs for the facility. -The only order they had for Resident #2's oxycodone 5/325mg was on Resident #2's FL2 date 07/17/20. -The order for Resident #2's oxycodone 5/325mg was entered into Resident #2's pharmacy profile and the oxycodone 5/325mg was not dispensed. -On 07/21/21 there was a communication note in the Resident #2's pharmacy profile indicating the pharmacy spoke to the facility's Administrator. -The Administrator informed the pharmacy	C 342		

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C 342	Continued From page 2 Resident #2 did not have any oxycodone/APAP 5/325mg available for administration and Resident #2 was not complaining of pain requiring the oxycodone 5/325mg. -The pharmacy informed the Administrator in order for the oxycodone/APAP 5/325mg to be removed from Resident #2's pharmacy profile and MAR the pharmacy needed an order to discontinue the oxycodone/APAP 5/325mg. -The pharmacy's protocol was to reach out to the prescribing physician to obtain an order to discontinue the oxycodone/APAP 5/325mg but for some reason he did not know why this did not happen and the order remained on the MAR. -No one from the facility reached out to the pharmacy after receiving the monthly MARs to follow up on getting the order to be removed from the MARs from July 2020 to June 2021. Interview with Resident #2 on 06/30/21 at 1:20pm revealed: -She was not having any pain. -She did not remember taking any oxycodone for pain. Interview with the Supervisor in Charge (SIC) on 06/30/21 at 12:05pm revealed: -She could not remember the last time she reviewed Resident #2's MARs comparing them with Resident #2's physician orders. -She did not check Resident #2's medication on hand and make sure they were available according to the MAR. -Resident #2 did not have oxycodone/APAP 5/325mg in the medication cabinet since Resident #2 was admitted to the facility. -She takes responsibility for not taking the time to make sure Resident #2's MAR was correct. Telephone interview with the Administrator on	C 342		

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C 342	Continued From page 3 06/30/21 at 2:45pm revealed: -She had not been able to review Resident #2's MARs over the past year. -She depended on the SICs to make sure Resident #2's MARs were correct and orders that required an order to discontinue medications were obtained from the doctor.	C 342		
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: Based on observations, record reviews, and interviews, the facility failed to ensure a retrievable record of controlled substances was maintained and reconciled accurately for 1 of 3 sampled residents (Resident #2) related to the administration of an anti-anxiety medication. The findings are: Review of Resident #2's current FL2 dated 07/17/20 revealed: -Diagnoses included schizophrenia, intellectual disability, and anemia. -An order for lorazepam 0.5mg one tablet once daily as needed for anxiety. Review of Resident #2's physician orders dated 04/14/21 revealed an order for lorazepam 0.5mg	C 367		

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C 367	Continued From page 4 one tablet once daily as needed for anxiety. Review of Resident #2's February 2021 MAR revealed: -There was an entry for lorazepam 0.5mg once daily as needed for anxiety. -There was documentation lorazepam 0.5mg one tablet was administered on 02/21/21. Review of Resident #2's February 2021 controlled substance count sheets (CSCS) revealed: -There was a printed pharmacy label for lorazepam 0.5mg attached to the top left side of the CSCS. -There was documentation for a total of 30 tablets dispensed on 02/09/21. -There was documentation lorazepam 0.5mg one tablet was given on 02/21/21 and the amount that remained was 29 tablets. Review of Resident #2's March, April, May, and June 2021 medication administration MARs revealed: -There was an entry for lorazepam 0.5mg one tablet once daily as needed for anxiety. -There was no documentation lorazepam 0.5mg was administered once daily from 03/01/21 through 06/30/21. Observation of Resident #2's lorazepam 0.5mg on hand at the facility 06/30/21 at 11:58am revealed lorazepam was dispensed on 02/09/21 for 30 tablets with 28 lorazepam tablets remaining. Telephone interview with the facility's contracted pharmacy on 06/30/21 at 12:30pm revealed: -Resident #2's lorazepam 0.5mg was dispensed on 02/09/21 and 30 tablets were delivered the same day (02/09/21).	C 367		

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C 367	Continued From page 5 -The pharmacy sent a CSCS rubbered around the bubble packed supply of lorazepam for documentation and accuracy purposes. -If staff wasted or disposed a tablet of lorazepam, they were expected to document the tablet on the CSCS, and the best practice would be to had another witness document the wasted tablet. Interview with the Supervisor in Charge (SIC) on 06/30/21 at 12:05pm revealed: -She did not know Resident #2 was missing lorazepam 0.5mg one tablet. -She did not count Resident #2's lorazepam 0.5mg with the other SICs when she started her shifts. -She had not administered Resident #2 any lorazepam, so she did not notice any tablets missing. Telephone interview with the second shift SIC on 06/30/21 at 2:17pm revealed: -It was his fault the lorazepam tablet was missing and not documented on the CSCS. -He remembered accidently crushing one of the lorazepam tablets when he attempted to push it through the back side of the package. -He did not subtract the wasted lorazepam from the amount given on the CSCS or have another SIC witness it. -The SICs did count Resident #2's controlled substances during shift changes because they never thought of doing it to account for the lorazepam. Telephone interview with the Administrator on 06/30/21 at 2:45pm revealed: -The facility did not have a system of monitoring the CSCS or MARs. -The SICs could have caught the missed	C 367		

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C 367	Continued From page 6 documentation of the wasted tablet if they counted controlled substances every shift. -She trusted SIC to do her job and complete the necessary documentation when administering medications.	C 367		

Review on Resident #2's February 2021 controlled substance count sheets (CSCS) revealed:

1. There was a printed pharmacy label for lorazepam 0.5mg attached to the top left side of the CSCS.
2. There was documentation for a total of 30 tablets dispensed on 02/09/21.
3. There was documentation lorazepam 035mg one tablet was given on 02/21/21 and amount that remained was 29 tablets.

Review of Resident #2's March, April, May and June 2021 medication administration MAR'S revealed:

1. There was an entry for lorazepam 0.5mg one tablet once daily as needed for anxiety.
2. There was no documentation lorazepam 0.5mg was administrated once daily from 03/01/2021 through 06/30/2021.
3. Observation of Resident #2's lorazepam 0.5mg on hand at the facility 06/30/21 at 11:58 am revealed lorazepam was dispensed on 02/09/21 for 30 tablets with 28 lorazepam tablets remaining.
4. Telephone interview with the facility's contracted pharmacy on 06/30/21 @ 12:30pm revealed:
    a. Resident #2's lorazepam 0.5mg was dispensed on 02/09/21 and 30 tablets were delivered the same day (02/09/21).
    b. The pharmacy sent a CSCS rubbered around the bubble packed supply of lorazepam for documentation and accuracy purposes.
    c. If staff wasted or disposed a tablet of lorazepam, they were expected to document the tablet on the CSCS, and the best practice would be to have another witness document the wasted tablet.

Interview with the Supervisor in Charge (SIC) on 06/30/21 at 12:05 pm revealed:

1. She did not know Resident #2 was missing lorazepam 0.5mg one tablet
2. She did not count Resident #2's lorazepam 0.5mg with the other SIC'S when she started her shifts.
3. She had not administered Resident #2 any lorazepam, so she did not notice any tablets missing.

Telephone interview with the second shift SIC on 036/30/21 at 2:17 pm revealed:

a. It was his fault the lorazepam table was missing and not documented on the CSCS
b. He remembered accidently crushing one of the lorazepam tablets when he attempted to push it through the back side of the package
c. He did not subtract the wasted lorazepam from the amount given on the CSCS or have another SIC witness it
d. The SIC'S did count Resident #2 controlled substances during shift changes because they never thought of doing it to account for the lorazepam

Telephone interview with the Administrator on 06/30/21 at 2:45 pm revealed:

a. The facility did not have a system of monitoring the CSCS or MARs
b. The SIC'S could have caught the missed documentation of the wasted tablet if they counted controlled substances every shift.
c. The trusted SIC to do her job and complete the necessary documentation when administering medications.

Systematic Change to Prevent the Out of Compliance Issues: The Administrator will go over the protocol for documenting and counting all "Control Substances"; before the end of each shift change; both staff will review the CSCS sheet, to make sure there is accurate amount of medication left and the count is correct. Each staff will be trained, and we review the policy on control substance and follow all protocol as directed. If there are any staff that maybe having issues with documentation/count or understanding how retrieval of medication is performed, the Director will contact the pharmacy/nurse to have all staff retrained.

Timetable for Implementation of the Corrective Action: The Director of Lakeview will have all staff retrained by August 30, 2021. The Director will complete and in-house training by July 30, 2021

Reference to the out of Compliance issues: Deficiencies Description-10A NCAC 13G.1004(j) Medication Administration

Comment: This Rule is not met as evidence by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (Resident #2).

The findings are: Review of Resident #2's FL2 dated 07/17/20 revealed:

a. Diagnoses included schizophrenia and anemia. There was physician order for Oxycodone/APAP 5/325 mg one tablet every four hours as needed for pain:
    1. Review of Resident's #2's physician order dated 04/14/21 revealed oxycodone/APAP 5/325 mg one tablet every four hours as needed for pain.
    2. Review of Resident #2's April, May, and June 2021 Medication Administration Records (MAR) revealed:
    3. There was an entry for oxycodone/APAP 5/325 mg was administered 04/01/03/01/21 to 06/30/21.
    4. Observation of Resident #2's available oxycodone/APAP 5/325mg on 06/30/21 at 12:00 pm revealed there were no oxycodone/APAP 05/325mg available for administration.

b. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/30/21 at 12:30 revealed:
    1. They provided the MARs for the facility
    2. The only order they had for Resident #2's oxycodone 5/325mg was on Resident #2's FL2 date 07/17/20.
    3. The order for Resident #2's oxycodone 5/325 mg was entered into Resident #2's pharmacy profile and the oxycodone 5/325 mg was not dispensed.
    4. On 07/21/21 there was a communication note in the Resident #2's pharmacy profile indicating the pharmacy spoke to the facility's administrator.
    5. The Administrator informed the pharmacy that Resident #2 did not have any oxycodone/APAP 5/325 available for administration and Resident #2 was not complaining of pain requiring the oxycodone/APAP 5/325mg to be removed from Resident #2's pharmacy profile and MAR the pharmacy needed an order to discontinue the oxycodone/APAP 5/325mg but for some reason he did not know why this did not happen and the order remained on the MAR.
    6. No one from the facility reached out to the pharmacy after receiving the monthly MARs to follow up on getting the order to be removed from the MARs from July 2020 to June 2021.

c. Interview with Resident #2 on 06/30/21 at 1:20 pm revealed:
    a. She was not having any paid
    b. She did not remember taking any oxycodone for pain

d. The Interview with the Supervisor in Charge (SIC) on 06/30/2021 at 12:05pm revealed:
    a. She could not remember the last time she reviewed Resident #2's MARs comparing them with Resident #2's physician orders.

b. She did not check Resident #2's medication on hand and make sure they were available according to the MAR.
c. Resident #2 did not have oxycodone/APAP 5/325mg in the medication cabinet since Resident #2 was admitted to the facility.
d. She takes responsibility for not taking the time to make sure Resident #2's MAR was correct.
e. 06/30/21 at 2:45 pm revealed:
    i. She had not been able to review Resident's #2's MAR over the past year.
    ii. She depended on the SIC's to make sure Resident #2's MAR were correct and orders that required an order to discontinue medications were obtained from the doctor.

Systematic Change to Prevent the Out of Compliance Issues: The Director will review the MAR's once a month and compare the physician orders to the MAR to make sure that all the information is correct, and the director will inform the pharmacist to any changes to any DC orders so that it will not be printed on the MAR; also any DC orders will be reflected on the MAR, the director will appropriately document on the MAR which medication is DC, the date to ensure accurate documentation.

Timetable for Implementation of the Corrective Action: The director will review the MAR immediately and make any necessary changes to the MAR as needed. The director will verify all orders with their physician and send any correspondence to the pharmacist as needed. The director will meet with all staff and go over rules for documenting/checking orders on the MAR, this will be done by July 9, 2021. The director will contact the physician and pharmacist to review any order changes and make sure that the MAR will reflect it. This will be done by July 9, 2021.

Reference to the out of Compliance issues: Deficiencies Description-10A NCAC 13G.1008(a) Controlled Substances

Comment: This rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a retrievable record of controlled substances was maintained and reconciled accurately for 1 of 3 sampled residents (Resident #2) related to the administration of an anti-anxiety medication.

The findings are: Review of Resident #2's current FL@ dated 07/17/20 revealed:

1. Diagnosis included schizophrenia, intellectual disability, and anemia.
2. An order for lorazepam 0.5mg one tablet once daily as needed for anxiety.
3. Review of Resident #2's physician orders dated 04/14/21 revealed on order for Lorazepam 0.5mg one tablet daily as needed for anxiety.

Review of Resident's #2's February 2021 MAR revealed.

a. There was an entry for lorazepam 0.5mg once daily as needed for anxiety
b. There was documentation lorazepam 05.mg one tablet was administered on 02/21/2021.