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	345420	A. BUILDING _____ B. WING _____	C 01/11/2018

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ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/5/18 to conduct a complaint survey and exited on 1/10/18. Additional information was obtained on 1/11/18. Therefore, the exit date was changed to 1/11/18.	F 000		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 608		2/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/24/2018

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F 608	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interview the facility failed to implement their abuse policies and procedures by notifying the authorities, the state agency, and adult protective services for suspected diversion of narcotics for two (Resident #1, Resident #2) of five residents reviewed for abuse investigations. The findings included: The facility Abuse/Neglect/Misappropriation/Crime policy and procedure stated, "Any and all suspected or witnessed incidents of patient/patient abuse, neglect, theft, and/or exploitation or any reasonable suspicion of a crime against a patient/patient Center brought to the attention of the Center's Administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as staff corrective action." In the policy, theft of a patient's medication was listed as an example of misappropriation of personal property. The procedure for investigation and follow up reporting stated, "The Administrator will immediately (within 2 or 24 hours of the knowledge of the allegation) notify the Adult Protective Services Agency, the local ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office and/or medical examiner) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime." 1. Resident #1 had a diagnosis of a traumatic spine injury and had long term use of scheduled	F 608	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F608 Processes that lead to deficiency: Nurse # 1 was found to have diverted resident #1 and resident # 2 narcotic medication. Drug Diversion was reported to the North Carolina Board of Nursing and Drug Enforcement Agency. Facility failed to implement policy number 703 Abuse/Neglect/Misappropriation/Crime-initial reporting guidelines for theft of a patient□s medication which includes notification to State Agency, Adult Protective Services and authorities, for suspected diversion of resident #1 and resident # 2. Procedure for implementing the acceptable plan of correction for the deficiency cited: Theft of resident #1 and Resident #2 medications reported to State Agency, Authorities, and Adult Protective Services	

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F 608	Continued From page 2 opiate pain medication. Resident #1 was coded on his Comprehensive Admission Minimum Data Set assessment dated 10/30/17 as cognitively intact and receiving scheduled pain medications during the assessment period. Resident #1 had an order initiated on 10/23/17 for one tablet of Hydromorphone HCL 2 mg (milligram) tablet by mouth every 4 hours as needed for pain. Hydromorphone HCL is a controlled substance used to treat moderate to severe pain. The documentation in the Controlled Medication Utilization Record (CMUR) indicated Nurse #1 administered doses of the ordered Hydromorphone HCL to Resident #1 on 10/23/17 at five different administration times. Only one dose of Hydromorphone HCL was indicated as administered on the MAR for 10/23/17. This was a discrepancy between the CMUR and MAR in the number of doses the resident received on 10/23/17. The documentation in the CMUR indicated Nurse #1 administered doses of Hydromorphone HCL to Resident #1 on 10/24/17 at three different administration times. Nurse #1 did not document on the MAR the administration of the controlled medication on 10/24/17. This was a discrepancy between the CMUR and MAR in the number of doses the resident received on 10/24/17. On 10/24/17, at one of the undetermined times of administration, the CMUR indicated Resident #1 was administered two doses of the controlled medication at one administration time by Nurse #1. Nurse #1 did not follow the physician's order	F 608	on 1/7/2018. Education on Policy number 703 Abuse/Neglect/Misappropriation/Crime-initial reporting guidelines given to Administrator and Director of Nursing by Regional Nurse consultant on 1/7/2018. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The administrator will begin morning meeting each day Monday through Friday by asking for any customer service issues, including theft of patients medications. The administrator will refer all allegations of theft of patient medication□s to local law enforcement, Adult Protective Services, and Health Care Personnel Registry within 24 hours of the allegation being made. This will be audited weekly by the Director of Nursing for 3 months. All Audits will be reviewed at the Quarterly Quality Assurance meeting X 1 for any further problem resolution if needed. The Title of person implementing the acceptable plan of correction: Director of Nursing Completion date: February 8, 2018	

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for administration of the medication at that time.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered doses of Hydromorphone HCL to Resident #1 on 10/25/17, two doses at 5:00 PM and two doses at 9:00 PM. Documentation on the CMUR indicated Nurse #1 did not follow the physician's order for administration of the medication. Nurse #1 did not document on the MAR the administration of the four doses of controlled medication on 10/25/17. This was a discrepancy between the CMUR and MAR in the number of doses the resident received on 10/25/17.

Resident #1 had an order initiated on 10/27/17 to receive 1 tablet of Hydromorphone HCL 2 mg tablets by mouth every 4 hours for pain.

On 10/28/17 at 9:00 PM Resident #1 was documented on the CMUR as having been administered the last dose of Hydromorphone HCL 2 mg that had come from the facility pharmacy.

Resident #1 was interviewed on 1/5/18 at 5:24 PM. He stated on 10/28/17 he was informed by his nurse he was running out of his pain medication Hydromorphone HCL. The resident stated he called a family member and asked him to bring to the facility his pain medication Hydromorphone HCL that he had at his home. Resident #1 stated a family member brought 12 pills of Hydromorphone HCL to the facility in a container. Resident #1 revealed the 12 Hydromorphone HCL brought to him from home to the facility were discovered to be missing on 10/30/17. He said he was never given an

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accounting for the loss of the medication by the facility.

Nurse # 5 wrote a statement dated 12/14/17 that revealed that on 10/28/17, the resident ran out of Hydromorphone HCL and the resident was told he can bring his own medication from home. The resident's family member brought the medication from home. The pill bottle was the resident's original bottle from his pharmacy. Upon receiving the medication, Nurse #5 completed the required documentation for receiving the narcotic per facility policy and counted the medication twice to be 12 pills in the bottle. Nurse #5 then placed the bottle in the narcotic count book located on the middle cart. Nurse #5 stated, "That night, on my shift, I gave the medication as prescribed from the pill bottle. At the end of my shift Saturday night I counted off with the night shift nurse and the count was correct. The next day (10/29/17) I came in at approximately 3:00 PM and counted the middle cart, narcotic counts were correct, the pill bottle had 8 loose pills in it and the required medication had been filled and delivered from our pharmacy for [Resident #1]. When I clocked out Sunday night (10/29/17) the narcotic count, to the best of my knowledge, was correct."

Nurse #5 was interviewed on 1/10/18 at 8:00 PM. Nurse #5 stated that a family member of Resident #1 brought twelve Hydromorphone HCL to the facility at around 6:00 PM on 10/28/17. She stated she counted off the twelve Hydromorphone HCL two times in front of the Resident #1 and then created a narcotic sheet to keep track of the medication use. Nurse #5 stated she worked again at the facility on the 3:00 PM to 11:00 PM shift on 10/29/17. She stated she counted off the remaining medication with Nurse #1 at the end of

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her shift on 10/29/17 and eight Hydromorphone HCL pills were remaining in the pill bottle for Resident #1 at the end of the shift at 11:00 PM on 10/29/17.

Nurse #4 was interviewed on 1/11/18 at 7:30 AM. Nurse #4 confirmed she worked the 11:00 PM to 7:00 AM shift on 10/28-29/17. She stated she did give Resident #1 his scheduled Hydromorphone HCL from the pill bottle in the medication cart brought to the facility with a family member. Nurse #4 stated she only gave Resident #1 the ordered amount of Hydromorphone HCL on her 11:00 PM to 7:00 AM shift on 10/28-29/17. Nurse #4 stated she was unsure who was going to take over the medication cart at 7:00 AM on 10/29/17. She stated Nurse #9 and Nurse #8 both participated in counting the amount of Hydromorphone HCL left for Resident #1 on 10/29/17.

Nurse #8 was interviewed on 1/10/18 at 3:50 PM. Nurse #8 confirmed she was working on the 7:00 AM to 3:00 PM shift on 10/29/17. She stated there was no medication card with Hydromorphone HCL on the medication cart for Resident #1. Nurse #8 stated she asked the physician to write a prescription for Hydromorphone HCL for Resident #1 and then faxed the prescription to the pharmacy. Nurse #8 stated she gave Resident #1 the medication Hydromorphone HCL as ordered from his personal medication pill bottle that was in the cart. Nurse #8 stated she counted off to Nurse #1 at the end of her shift and the pill bottle and associated documentation were on the cart when she turned it over to Nurse #1. Nurse #8 did not recall how many of the Hydromorphone HCL were left in the pill bottle but confirmed she gave

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the resident only the scheduled amount of pain medication on her nursing shift.

Nurse #9 was interviewed on 1/11/18 at 9:20 AM. Nurse #9 confirmed she was working at the facility on the 7:00 AM to 3:00 PM shift on 10/29/17. Nurse #9 stated she remembered the pill bottle Resident #1 had on the medication cart. Nurse #9 confirmed she counted the number of Hydromorphone HCL pills remaining in the pill bottle at 7:00 AM on 10/29/17. Nurse #9 did not recall the exact count of the medication in the pill bottle.

A proof of delivery and shipment summary dated 10/29/17 at 5:57 PM revealed 30 more doses of Hydromorphone HCL were delivered to the facility for the use of Resident #1.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered 9 doses of Hydromorphone HCL to Resident #1 on 10/29-30/17 at five different administration times. Nurse #1 documented on the MAR the administration of the controlled medication on 10/29/17 at 4:00 PM and 8:00 PM. The documentation in the CMUR indicated Nurse #1 had administered the controlled medication at three administration times. This was a discrepancy between the CMUR and MAR in the number of doses the resident received on 10/29/17. Nurse #1 documented on the MAR on 10/30/17 the administration of the controlled medication at 12:00 AM and 4:00 AM. The documentation in the CMUR indicated the controlled medication was given to the resident at 2:00 AM and 6:00 AM, making it unclear when the controlled medication was administered. One 10/29/17 and 10/30/17 Nurse #1 indicated on the

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CMUR Resident #1 was administered two doses of the controlled medication at each administration when he was ordered to receive one dose at each administration. Four of the five administration times indicated an incorrect dose was given. Nurse #1 did not follow the physician's order for administration of the medication at those undetermined administration times on 10/29/17 and 10/30/17.

Nurse #7 was interviewed on 1/10/18 at 11:43 AM. She confirmed she completed a medication count of the narcotics and took over the cart from Nurse #1 on 10/30/17 at 7:00 AM. Nurse #7 stated the resident was in significant pain on the morning of 10/30/17 and was requesting more pain medication. She stated, "I could not give him any more pain medication because the physician denied his request for additional pain medication. I could only give him his pain medication as ordered." Nurse #7 stated she never saw the pill bottle with Resident #1 brought from home. She stated it was not in the medication cart on 10/30/17 and she asked the unit manager to assist her in locating the pill bottle. Nurse #7 stated that the pill bottle and the form used to keep an accurate accounting of the pills were gone. Nurse #7 stated Resident #1 did pay attention to the medication being administered to him.

An "Orders - Administration note" dated 10/30/17 at 7:45 AM stated, "Called MD r/t (relative to) patient requesting/wanting increased amounts of pain medications even when all had been received. MD states that patient is maxed out on pain medications. More would cause reverse effect and increase pain."

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The documentation in the MAR indicated on the evening and night of 10/29/17 Resident #1 had a pain level of 8 on a scale of 1 to 10. The documentation in the MAR indicated on the day of 10/30/17 Resident #1 had a pain level of 4 on a scale of 1 to 10.

A medication report written by Nurse #6 dated 10/31/17 had an incident description that stated, "On 10/24 at 1745 (5:45 PM), 10/25 at 1700 (5:00 PM), 10/25 at 2100 (9:00 PM), 10/29 at 1500 (3:00 PM), 10/29 at 2100 (9:00 PM), 10/29 at 2300 (11:00 PM), 10/30 at 0600 (6:00 AM) the nurse gave a double dose of Dilaudid (Hydromorphone HCL)." The resident was scheduled to have 1 tablet (2 mg) every 4 hours by mouth as needed. The nurse gave 2 tablets (4 mg) at the times listed above. The resident was agitated because "some nurses were giving him 2 pills and some only giving him one."

Resident #1 was interviewed again on 1/8/18 at 11:04 AM. He stated he was very careful to monitor the medications he received. He stated that if he had received 2 doses (4 mg) of Hydromorphone HCL every 4 hours in a 12 hour time period he "would have been a zombie." He stated he remembered being in extreme pain on the Monday it was discovered his pain medication brought from home was missing. He stated on the weekend his personal bottle of Hydromorphone HCL went missing, he did not get 2 doses (4 mg) of Hydromorphone HCL from any of the nurses administering his medication.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered 5 doses of Hydromorphone HCL 2 mg to Resident #1 on 11/21/17. The MAR for

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Resident #1 indicated the resident received 2 doses of Hydromorphone HCL on 11/21/17 from Nurse #1. The documentation in the CMUR indicated Nurse # 1 administered twelve doses of Hydromorphone HCL to Resident #1 on 11/22-23/17 at nine different administration times. Nurse #1 did not document any of the nine administration times for the controlled medication on the MAR. This was a discrepancy between the CMUR and MAR in the number of doses the resident received on 11/22-23/17.

The documentation in the MAR indicated on the evening of 11/22/17 the pain level of Resident #1 was coded as a 7 on a scale of 1 to 10. The documentation in the MAR for the pain level of Resident #1 on the night of 11/22/17 had not been documented by a nurse. The documentation in the MAR indicated on the day of 11/23/17 the pain level of Resident #1 was coded as a 4 on a scale of 1 to 10.

The Director of Nursing (DON) was interviewed on 1/5/18 at 12:00 PM. She stated that on 10/28/17 twelve Hydromorphone HCL were brought from the home of Resident #1 to the facility for his use. The DON revealed the facility allowed residents to bring medications from home for their use and the facility has separate forms to document the receipt and use of the medications. The DON stated the bottle with the twelve Hydromorphone HCL was discovered to be missing on the morning of 10/30/17 along with the documentation created to keep track of the medication. She stated an investigation was started and she determined Resident #1 had been administered all twelve of the medication Hydromorphone HCL from his pill bottle. The DON stated, "The MAR documented 42 doses of

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Hydromorphone HCL had been administered to Resident #1." The DON stated she did not think there was enough evidence without the missing pill bottle and the narcotic sheet to prove there was anything more than a medication error made on the weekend of 10/29-30/17 with regard to Resident #1. The DON did not suspect a diversion of medication on the weekend of 10/29-30/17 and did not report a diversion to any of the authorities.

The DON and Administrator were interviewed on 1/7/18 at 8:56 AM. The DON stated the nursing staff member who took over the medication cart from Nurse #1 on 11/23/17 at 7:00 AM, suspected the narcotic count for administration to Resident #1 was not correct. The DON stated she was notified immediately of the suspected diversion. The DON stated she began an investigation and terminated Nurse #1 because doses of Hydromorphone HCL were unaccounted for. The DON reiterated Nurse #1 was unable to explain the discrepancy between the MAR and the CMUR on 11/22-23/17 for Resident #1. The DON reiterated she was not able to prove a diversion occurred with the missing 12 pills on 10/30/17 because the pill bottle and accompanying documentation were missing. The Administrator stated they had not yet notified law enforcement, adult protective services or the state agency regarding the suspected diversion of medications that occurred on 11/23/17 for Resident #1 per the facility policy.

2. Resident #2 had a diagnoses of rheumatoid arthritis and radiculopathy of the lumbar region causing pain.

Resident #2 was coded on a comprehensive

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Minimum Data Set assessment dated 10/10/17 as cognitively intact with the receipt of Opioid pain medication on an as needed basis during all 7 days of the assessment period.

Resident #2 had an order initiated on 10/3/17 for 1.5 tablets (6 mg) of Hydromorphone HCL 4 mg tablet by mouth every 4 hours as needed for pain.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered doses of 6 mg of Hydromorphone HCL to Resident # 2 on 11/22-23/17 at 3:45 PM, 7:00 PM, 11:00 PM, 1:00 AM, 4:00 AM, and 7:00 AM. Only one dose of Hydromorphone HCL at 6:49 PM on 11/22/17 was documented on the Medication Administration Record (MAR) as administered to Resident #2. This was a discrepancy between the CMUR and MAR in the doses the resident received on 11/22-23/17.

The documentation on the MAR indicated Resident #2 received a one-time ordered dose of Oxycodone-Acetaminophen Tablet 5-325 mg by mouth at 8:00 AM on 11/23/17 for a pain level of 7 on a scale of 1 to 10.

The facility DON provided a statement made by Nurse #1 on 11/27/17. Nurse #1 acknowledged there were discrepancies in the narcotic records and MAR for Resident #2 and could not explain the discrepancies.

Nurse #2 was interviewed on 1/10/18 at 12:30 PM. Nurse #2 stated on 11/23/17 he was orienting another nurse on the medication cart. Nurse #2 noted that Resident #2 had too much Hydromorphone HCL administered on the evening shift (11:00 PM to 7:00 AM shift on

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F 608	Continued From page 12 11/22-23/17) and discrepancies were noted on the MAR. Nurse #2 stated Resident #2 should have been administered 2 doses of Hydromorphone HCL on the 11:00 PM to 7:00 AM shift on 11/22-23/17 leaving two more doses of Hydromorphone HCL left to be administered on the 7:00 AM to 3:00 PM shift. Nurse #2 stated that all of the doses of Hydromorphone HCL had been administered on the night shift leaving Resident #2 without any more Hydromorphone HCL for the morning shift. Nurse #2 stated that Nurse #1 explained the discrepancy by saying she borrowed from one resident to give to another resident. Nurse #2 stated he called his unit manager, who instructed him to call the Director of Nursing. The facility's Director of Nursing (DON) and Administrator were interviewed on 1/7/18 at 8:56 AM. She stated Nurse #2 took over the cart from Nurse #1 on 11/23/17 at 7:00 AM and suspected the narcotic count for administration to Resident #2 was not correct. The DON stated she was notified immediately of the suspected diversion. The DON stated she began an investigation and terminated Nurse #1 because doses of Hydromorphone HCL were unaccounted for. The DON revealed the only notification that was done was to the Board of Nursing and that she had never notified the police of the suspected diversion. The DON notified the Board of Nursing on 11/27/17 of the suspected diversion. The Administrator stated they had not yet notified law enforcement, adult protective services or the state agency regarding the suspected diversion of medications for Resident #2 per the facility policy.	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		2/8/18

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F 609	Continued From page 13 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report allegations of diversion of controlled medications to the proper authorities within the prescribed time frames for 2 (Resident's #1 and #2) of 5 residents reviewed for abuse investigations. Findings included: 1. Resident #1 had an order dated 11/10/17 for	F 609	F609 Processes that lead to deficiency: Nurse # 1 was found to have diverted resident #1 and resident # 2 narcotic medication. Drug Diversion was reported to the North Carolina Board of Nursing and Drug Enforcement Agency. Facility failed to implement policy number 703	

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F 609	Continued From page 14 one tablet of Hydromorphone HCL 2 mg tablet by mouth every 4 hours for pain. The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered 5 doses of Hydromorphone HCL 2 mg to Resident #1 on 11/21/17. The MAR for Resident #1 indicated the resident received 2 doses of Hydromorphone HCL on 11/21/17 from Nurse #1. The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered twelve doses of Hydromorphone HCL to Resident #1 on 11/22-23/17 at nine different administration times. Nurse #1 did not document any of the nine administration times for the controlled medication on the MAR, making it unclear the times and the amount of medication given. The DON and Administrator were interviewed on 1/7/18 at 8:56 AM. The DON stated Nurse #2, who took over the cart from Nurse #1 on 11/23/17 at 7:00 AM, suspected the narcotic count for administration to Resident #1 was not correct. The DON stated she was notified on 10/23/17 by Nurse #2 of the suspected diversion. The DON stated she began an investigation on 10/23/17 and terminated Nurse #1 after evaluating the evidence. The Administrator stated they had not yet notified law enforcement, adult protective services or the state agency regarding the suspected diversion of medications for Resident #1. The state agency was not notified with a report in 24 hours nor with in the 5 day time frame. The DON was interviewed again on 1/10/18 at 9:30 AM. She stated that on 11/23/17 at approximately 9:00 or 10:00 AM she was notified	F 609	Abuse/Neglect/Misappropriation/Crime-initial reporting guidelines for theft of a patient□s medication which includes notification to State Agency, Adult Protective Services and authorities, for suspected diversion of resident #1 and resident # 2. Procedure for implementing the acceptable plan of correction for the deficiency cited: Theft of resident #1 and Resident #2 medications reported to State Agency, Authorities, and Adult Protective Services on 1/7/2018. Education on Policy number 703 Abuse/Neglect/Misappropriation/Crime-initial reporting guidelines given to Administrator and Director of Nursing by Regional Nurse consultant on 1/7/2018. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The administrator will begin morning meeting each day Monday through Friday by asking for any customer service issues, including theft of patients medications. The administrator will refer all allegations of theft of patient medication□s to local law enforcement, Adult Protective Services, and Health Care Personnel Registry within 24 hours of the allegation being made. This will be audited weekly by the Director of Nursing for 3 months. All Audits will be reviewed at the	

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F 609	Continued From page 15 by Nurse #2 of discrepancies with the medication Hydromorphone HCL during the morning medication count. The DON revealed she had access at her home to the electronic medical records and she immediately began an investigation. She stated she called Nurse #1 on the morning of 11/23/17 and told her she was suspended pending the outcome of the investigation. The DON stated she telephoned the Board of Nursing on 11/27/17 and sent information regarding the investigation to the Board of Nursing on 12/2/17. Nurse #2 was interviewed on 1/10/18 at 12:30 PM. Nurse #2 stated on 11/23/17 he was orienting another nurse on the medication cart. Nurse #2 noted that Resident #1 had too much Hydromorphone HCL administered on the evening shift (11:00 PM to 7:00 AM shift on 11/22-23/17) and discrepancies were noted on the MAR. Nurse #2 stated he called his unit manager, who instructed him to call the Director of Nursing. 2. Resident #2 had an order initiated on 10/3/17 for 1.5 tablets (6 mg) of Hydromorphone HCL 4 mg tablet by mouth every 4 hours as needed for pain. The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered ten doses of 6 mg of Dilaudid to Resident # 2 on 11/22-23/17 at 9 different administration times. Only one dose of Dilaudid at 6:49 PM on 11/22/17 was documented on the MAR as administered to Resident #2 by Nurse #1 making it unclear when and how much Dilaudid the resident was administered on 11/22-23/17. The documentation in the CMUR indicated Nurse	F 609	Quarterly Quality Assurance meeting X 1 for any further problem resolution if needed. The Title of person implementing the acceptable plan of correction: Director of Nursing Completion date: February 8, 2018	

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#1 administered doses of 6 mg of Dilaudid to Resident #2 on 11/22-23/17 at 3:45 PM, 7:00 PM, 11:00 PM, 1:00 AM, 4:00 AM, and 7:00 AM.

The facility DON provided a statement made by Nurse #1 on 11/27/17. Nurse #1 acknowledged there were discrepancies in the narcotic records and MAR for Resident #2 and could not explain the discrepancies.

The DON and Administrator were interviewed on 1/7/18 at 8:56 AM. The DON stated Nurse #2, who took over the cart from Nurse #1 on 11/23/17 at 7:00 AM, suspected the narcotic count for administration to Resident #2 was not correct. The DON stated she was notified immediately of the suspected diversion. The DON stated she began an investigation and terminated Nurse #1 after evaluating the evidence. The DON revealed the only notification that was done was to the Board of Nursing and that she had never notified the police of the suspected diversion. The Administrator stated they had not yet notified law enforcement, adult protective services or the state agency regarding the suspected diversion of medications for Resident #2 per the facility policy. The state agency was not notified with a report in 24 hours nor with in the 5 day time frame.

The DON was interviewed again on 1/10/18 at 9:30 AM. She stated that on 11/23/17 at approximately 9:00 or 10:00 AM she was notified by Nurse #2 of discrepancies with the medication Dilaudid during the morning medication count. The DON revealed she had access at her home to the electronic medical records and she immediately began an investigation. She stated she called Nurse #1 on the morning of 11/23/17 and told her she was suspended pending the

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F 609	Continued From page 17 outcome of the investigation. The DON stated she telephoned the Board of Nursing on 11/27/17 and sent information regarding the investigation to the Board of Nursing on 12/2/17. Nurse #2 was interviewed on 1/10/18 at 12:30 PM. Nurse #2 stated on 11/23/17 he was orienting another nurse on the medication cart. Nurse #2 noted that Resident #2 had too much Dilaudid administered on the evening shift (11:00 PM to 7:00 AM shift on 11/22-23/17) and discrepancies were noted on the MAR. Nurse #2 stated he called his unit manager, who instructed him to call the Director of Nursing.	F 609		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		2/8/18

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F 755	Continued From page 18 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to keep an accurate accounting of controlled medications on the Controlled Medication Utilization Record and the Medication Administration Record for 2 (Resident #1 and Resident #2) of 3 residents reviewed for pharmacy services. Findings included: 1. Resident #1 had an order to receive 1 tablet of Hydromorphone HCL 2 mg (milligram) tablets by mouth every 4 hours as needed for pain. Hydromorphone HCL is a controlled medication used to treat moderate to severe pain. The documentation in the Medication Administration Record (MAR) indicated Hydromorphone HCL had been administered to Resident #1 at 3:09 PM on 10/23/17. The documentation in the Controlled Medication Utilization Record (CMUR) revealed Nurse #1 signed out the ordered dose of Hydromorphone HCL for Resident #1 at 4:00 PM on 10/23/17. There was a one-hour difference between the time the medication was said to have been given and the time it was signed out in the Control Record.	F 755	F755 The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. 12/15/17 Regional Nurse consultant initiated audit for resident #1 of # of doses of Dilaudid received from pharmacy versus count on narcotic sheet vs documentation on Electronic Medication Administration Record. On 1/2/18 results of resident # 1 audits revealed documentation issues with narcotic sheets matching Electronic Medication Administration Record s, and Quality Assurance Process Improvement initiated for Documentation of narcotics on narcotic count sheet and on Electronic Medication Administration Record. The procedure for implementing the acceptable plan of correction for the specific deficiency cite; corrected and/or in compliance with the regulatory requirements. Director of nursing and/or Assistant Director of nursing educated all Licensed nurses on correct practice of	

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F 755	Continued From page 19 The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered either 1 or 2 doses of Hydromorphone HCL 2 mg tablets by mouth to Resident #1 on 10/23/17 at 8:00 PM. The documentation of administration was unclear as to how many doses of the controlled medication were given to the resident at that time. The documentation in the CMUR indicated the amount of medication remaining by a decreasing count of the medication. On 10/23/17 at 8:00 PM the numbers twenty six and twenty eight were written in the same column to represent the amount of medication remaining. The two numbers in the same column made it unclear as to the amount of the controlled medication that was remaining at that time. The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered doses of the ordered Hydromorphone HCL to Resident #1 on 10/23/17 at five different administration times. Only one dose of Hydromorphone HCL was indicated as administered on the MAR for 10/23/17 making it unclear as to when Resident #1 received the doses of the controlled medication. The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered doses of Hydromorphone HCL to Resident #1 on 10/24/17 at three different administration times. Nurse #1 did not document on the MAR the administration of the controlled medication on 10/24/17, making it unclear the times of administration. On 10/24/17, at one of the undetermined times of administration, the CMUR indicated Resident #1 was administered two doses of the controlled medication at one	F 755	documenting administration of narcotic medication to include When signing out a scheduled or prn narcotic for a resident you MUST document it on the Narcotic Count Sheet and it MUST be signed out on the Electronic Medication Administration Record. Completed 01/15/2018. All New Licensed nurses will receive education on correct practice of documenting administration of narcotic medication in orientation When signing out a scheduled or prn narcotic for a resident you MUST document it on the Narcotic Count Sheet and it MUST be signed out on the Electronic Medication Administration Record. How the facility plans to monitor and ensure correction is achieved and sustained Director of Nursing or Assistant Director of nursing and/or RN Unit Managers will audit 10% of patients on each unit who receive narcotic medications to verify that Narcotic Count Sheet matches Electronic Medication Administration Record weekly X 4, Bi-Weekly X 2 and Monthly X 1. Results of audits will be reviewed at weekly Quality Assurance Risk Meeting, and at Quarterly Quality Assurance meeting X 1 for further problem resolution if needed The title of the person responsible for implementing the acceptable plan of correction. Director of Nursing. Completion date: February 8, 2018	

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administration time by Nurse #1. Nurse #1 did not follow the physician's order for administration of the medication at that time.

The documentation in the Controlled Medication Utilization Record indicated Nurse # 3 administered one dose of Hydromorphone HCL 2 mg tablets by mouth to Resident # 1 at 8:00 AM on 10/25/17. Nurse #3 documented on the MAR the medication was administered at 10:25 AM on 10/25/17. There was two-hour and twenty-five minute difference between the time the medication was said to have been given and the time it was signed out in the Control Record.

The documentation in the Controlled Medication Utilization Record indicated Nurse # 3 administered one dose of Hydromorphone HCL 2 mg tablets by mouth to Resident # 1 at 1:00 PM on 10/25/17. Nurse #3 documented on the MAR the medication was administered at 2:29 PM on 10/25/17. There was a one-hour and twenty-nine minute time difference between the time the medication was said to have been given and the time it was signed out in the Control Record.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered doses of Hydromorphone HCL to Resident #1 on 10/25/17, two doses at 5:00 PM and two doses at 9:00 PM. Nurse #1 indicated on the CMUR the physician's order was not followed for administration of the medication. Nurse #1 did not document on the MAR the administration of the four doses of controlled medication on 10/25/17, making it unclear the times of administration.

The documentation in the Controlled Medication

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Utilization Record indicated Nurse # 4 gave two doses of Hydromorphone HCL 2 mg tablets to Resident #1 on 10/26/17 at 5:00 AM. The documentation in the CMUR indicated the amount of medication remaining by a decreasing count of the medication. The documentation in the CMUR indicated the amount of medication remaining decreased by one dose and not two doses on 10/26/17 at 5:00 AM. The difference in representation of what was administered and the count of the amount of medication left, made it unclear as to the amount of the controlled medication that was remaining at that time.

The documentation in the Controlled Medication Utilization Record indicated Nurse #2 administered one dose of Hydromorphone HCL 2 mg tablets to Resident #1 on 10/26/17 at 1:00 PM. Nurse #2 did not document on the MAR the administration of the medication to Resident #1 on 10/26/17 at 1:00 PM, making it unclear the time of administration.

Resident #1 had an order initiated on 10/27/17 to receive 1 tablet of Hydromorphone HCL 2 mg tablets by mouth every 4 hours for pain.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered nine doses of Hydromorphone HCL to Resident #1 on 10/29-30/17 at five different administration times. Nurse #1 documented on the MAR the administration of the controlled medication on 10/29/17 at 4:00 PM and 8:00 PM. The documentation in the CMUR for 10/29/17 indicated Nurse #1 had administered the controlled medication at three administration times, making it unclear the times of administration. Nurse #1 documented on the

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MAR on 10/30/17 the administration of the controlled medication at 12:00 AM and 4:00 AM. The documentation in the CMUR for 10/30/17 indicated the controlled medication was given to the resident at 2:00 AM and 6:00 AM, making it unclear when the controlled medication was administered. On 10/29/17 and 10/30/17 Nurse #1 indicated on the CMUR Resident #1 was administered two doses of the controlled medication when he was ordered to receive one dose at each administration. Four of the five administration times indicated an incorrect dose was given. Nurse #1 did not follow the physician's order for administration of the medication at those undetermined administration times on 10/29/17 and 10/30/17.

Resident #1 had an order dated 11/10/17 for one tablet of Hydromorphone HCL 2 mg tablet by mouth every 4 hours for pain.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered 5 doses of Hydromorphone HCL 2 mg to Resident #1 on 11/21/17. The MAR for Resident #1 indicated the resident received 2 doses of Hydromorphone HCL on 11/21/17 from Nurse #1. The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered twelve doses of Hydromorphone HCL to Resident #1 on 11/22-23/17 at nine different administration times. Nurse #1 did not document any of the nine administration times for the controlled medication on the MAR, making it unclear the times and the amount of medication given.

The facility Director of Nursing (DON) provided documentation of statements taken from Nurse

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#1 on 11/14/17. Nurse #1 acknowledged she had made medication errors on the weekend of 10/29-30/17 on the administration of Hydromorphone HCL to Resident #1. The facility DON provided another statement made by Nurse #1 on 11/27/17. Nurse #1 acknowledged there were discrepancies in the narcotic records and MAR for Resident #1 on 11/21-23/17 and could not explain the discrepancies. Nurse #1 did not respond to requests for an interview and no longer was working at the facility at the time of the investigation.

Nurse #2 was interviewed on 1/10/18 at 12:30 PM. Nurse #2 stated he always documented narcotics on the "narc sheet" (CMUR) first and then documented the administration of the medication on the MAR. Nurse #5 stated he evidently had been too busy on 10/26/17 to document on the MAR the administration of the Hydromorphone HCL to Resident #1, but that he probably gave the medication to the resident.

Nurse #3 was interviewed on 1/10/18 at 9:07 PM. Nurse #3 said she did not remember the specific administrations of the controlled medication to Resident #1 on 10/25/17. Nurse #3 stated she thought she removed the controlled medication from the locked box for administration but Resident #1 did not want to take the medication at that time so she "put it back." Nurse #3 stated she probably wrote the wrong times on the "narc sheet" because she went back later to administer the controlled medication after the resident's initial refusal.

Nurse #4 was interviewed on 1/11/18 at 7:30 AM. Nurse #4 stated she had made a mistake in documentation. She stated she never gave

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

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Resident #1 two pills of Hydromorphone HCL at one time. She stated the physician's order was for one pill of Hydromorphone HCL every 4 hours and she followed the physician's order.

The Director of Nursing was interviewed on 1/6/18 at 4:00 PM. She stated that the policy of the facility was to take the medication out of the narcotic box, sign out the medication on the narc sheet (CMUR), give the medication to the resident, and then document on the MAR. She explained that the narcotic would be wasted if the resident did not take the medication and an explanation would be given on the narc sheet. She stated it is a professional standard to document the administration of medications on the MAR.

2. Resident #2 had an order for 1.5 tablets (6 mg) Hydromorphone HCL 4 mg tablets by mouth every 4 hours as needed for pain.

The documentation in the Controlled Medication Utilization Record indicated Nurse #1 administered ten doses of 6 mg of Hydromorphone HCL to Resident # 2 on 11/22-23/17 at 9 different administration times. Only one dose of Hydromorphone HCL at 6:49 PM on 11/22/17 was documented on the MAR as administered to Resident #2 by Nurse #1 making it unclear when and how much Hydromorphone HCL the resident was administered on 11/22-23/17. The documentation in the CMUR indicated Nurse #1 administered doses of 6 mg of Hydromorphone HCL to Resident #2 on 11/22-23/17 at 3:45 PM, 7:00 PM, 11:00 PM, 1:00 AM, 4:00 AM, and 7:00 AM.

The facility DON provided a statement made by

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Nurse #1 on 11/27/17. Nurse #1 acknowledged there were discrepancies in the narcotic records and MAR for Resident #2 and could not explain the discrepancies.

Nurse #1 did not respond to requests for an interview and no longer was working at the facility at the time of the investigation.

The Director of Nursing was interviewed on 1/6/18 at 4:00 PM. She stated that the policy of the facility was to take the medication out of the narcotic box, sign out the medication on the narc sheet (CMUR), give the medication to the resident, and then document on the MAR. She explained that the narcotic would be wasted if the resident did not take the medication and an explanation would be given on the narc sheet. She stated it is a professional standard to document the administration of medications on the MAR.