

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2016
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NAME OF PROVIDER OR SUPPLIER PLEASANT GROVE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 49N 4516 BURLINGTON, NC 27217
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow Up Survey 6/29/16.	D 000		
D 392	<p>10A NCAC 13F .1008(a) Controlled Substances</p> <p>10A NCAC 13F .1008 Controlled Substances (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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a record of controlled substances for (Ativan and Xanax) at the facility.</p> <p>The findings are: 1. Review of Resident #1's June 2016 Medication Administration Record revealed: -Ativan 0.5mg, one by mouth to be given every 12 hours (Ativan is used to treat anxiety.) -This drug was documented as being given appropriately. -No control log was available for this drug.</p> <p>Observation on 6/29/16 at 1:15pm revealed: -There were 17 tablets of Ativan 0.5mg in Resident #1's medicine bottle. -There should have been 14 tablets left according to the dispensing information offered by the pharmacist.</p> <p>Interview with a local pharmacist on 6/29/16 at 1:30pm revealed: -Sixty Ativan 0.5mg tablets were dispensed to</p>	D 392		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 392	<p>Continued From page 1</p> <p>Resident #1's Power of Attorney 6/6/16. -Their pharmacy would not have provided a control log for Resident #1. -The responsibility for providing a control log for that medicine fell to the facility.</p> <p>Interview with the Supervisor in Charge (Staff A) on 6/29/16 at 1:30pm revealed: -Resident #1's POA picked up prescriptions from the pharmacy and brought them in sealed medicine bottles to the facility. -The Supervisor in charge could not provide any further information regrading control log policies regardless of the pharmacy.</p> <p>2. Review of Resident #3's June 2016 Medication Administration record revealed: -Xanax 0.25mg, one by mouth to be given at 8am, 12 pm, and 8pm (Xanax is used to treat anxiety.) -This drug was documented as being given appropriately. - No control log was available for this drug.</p> <p>Observation on 6/29/16 at 1:20pm revealed Resident #3's Xanax 0.25mg was pre-packaged.</p> <p>Interview with the Supervisor in Charge (Staff A) on 6/29/16 at 1:30pm revealed: -She had received the Xanax for Resident #3 but there was no control log with the medicine. -The local pharmacy delivered medicines to the facility around 6pm at least monthly and as needed. -Staff A signed off on delivered medicines and put the medicines in the Administrator's office. -Staff ususally re-ordered medicine when there was a 7 day supply or less of tablets. -Controlled drugs were not delivered the first day of each month so it was difficult to keep a running</p>	D 392		

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D 392	<p>Continued From page 2</p> <p>total.</p> <ul style="list-style-type: none"> -No drug counts were done at the beginning of every shift. -The facility used to have control logs but neither she nor the Administrator had communicated about needing them. -She did not call the pharmacy and request a control log. -She could not remember the last time the facility used control logs. <p>Interview with a local pharmacist on 6/29/16 at 1pm revealed:</p> <ul style="list-style-type: none"> -Forty-five Xanax 0.25mg, one tablet to be given three times a day were dispensed 6/15/16 for Resident #3. -It was the policy of the pharmacy to send control sheets with controlled drugs delivered to the facility. -He could not prove they had been, but he believed the control logs had been sent to the facility. -Even though Resident #3's drugs were pre-packaged, a control log should have been sent. <p>Interview with the Administrator on 6/29/16 at 7:30pm revealed:</p> <ul style="list-style-type: none"> -The local pharmacy used to send control logs with the medicines. -She could not provide a reason why there were no control logs at the facility. -The Administrator would obtain control logs and start using them. 	D 392		