STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted from 11/11/2023 to 11/15/2023. Event ID # CDGU11. The following intake was investigated NC00209408. One of the two allegations resulted in a deficiency.	F 000		
F 755 SS=D	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 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	F 755		11/15/23

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

Electronically Signed | 11/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 1 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, staff interview, pharmacy director interview, physician assistant interview, and resident interview the facility failed to provide medications upon admission for 18 hours for 1 (Resident #1) of 3 residents reviewed for provision of medication upon admission. Findings included: Resident #1 had cumulative diagnoses some of which included Type 2 diabetes, Hypertension, Bipolar disorder, congestive heart failure, anxiety disorder, status post orthopedic surgery, and post-traumatic stress disorder. Documentation in the electronic medical record of Physician orders listed as entered on 10/30/2023 by Nurse #2 at 12:57 PM for Resident #1 included the following medications: - Novolin (Insulin) 70/30 Flex Pen Subcutaneous Suspension Pen 60 units of insulin to be injected subcutaneously every morning for Type 2 diabetes. 15 units of insulin were to be injected subcutaneously if Resident #1 was not eating breakfast. - Novolin (Insulin) 70/30 Flex Pen Subcutaneous Suspension Pen 30 units of insulin were to be injected subcutaneously every evening for Diabetes Mellitus. - Aspirin in the form of an 81-milligram (mg) tablet taken by mouth once daily as supplement. - Atorvastatin Calcium in the form of an 80-mg	F 755	F-755 (1). How corrective action will be accomplished for resident(s) found to have been affected: On 11/11/23, the Pharmacy delivery hours to the facility were changed to earlier times. The Pharmacy also changed our facility to be a first facility on the run to have the medications delivered. (2). How the corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents. (3). What measures will be put into place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 11/11/23, we instructed the Pharmacy to change our delivery times to 10:00am and 5:00pm and made the facility the first run on each delivery. (4). Indicated how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:	

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F 755	Continued From page 2 tablet taken by mouth at bedtime for coronary artery disease. - Empagliflozin in the form of a 10 mg tablet taken by mouth once a day for Diabetes Mellitus. - Prasugrel HCL in the form of a 10 mg tablet taken by mouth one time a day as supplement. - Carvedilol in the form of a 3.125-mg tablet twice daily for Hypertension. - Sertraline HCL in the form of two 100 mg tablets taken by mouth one time a day for bipolar disorder. - Buspirone HCL in the form of a 7.5 mg tablet to be taken by mouth one time a day for bipolar disorder. - Icosapent Ethyl in the form of a 2-gram capsule to be taken by mouth two times daily for coronary artery disease. - Lamotrigine in the form of a 200 mg tablet to be taken by mouth two times a day coronary artery disease. - Pregabalin in the form of a 100 mg capsule to be taken by mouth two times a day for pain. - Ranolazine extended release in the form of a 1000 mg tablet to be taken by mouth two times a day for Hypertension. - Probiotic Acidophilius in the form of a capsule to be taken by mouth three times a day as supplement.	F 755	The monitoring of pharmacy delivery times will be done by the Director of Nursing or designee to ensure the accuracy of the new schedule times are being adhered to and that the medications are being delivered timely; this monitoring will be daily for 3 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report any findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 755	Continued From page 3	F 755		

- Alprazolam in the form of a 0.5 mg table to be taken by mouth every 24 hours as needed for anxiety.

- Nitroglycerin Sublingual in the form of a 0.4 mg tablet to be taken sublingually every 5 minutes as needed for chest pain. Repeated every 5 minutes up to 3 0.4 mg tablets maximum.

- Levofloxacin in the form of a 500 mg tablet to be administered by mouth one time a day for 10 days for amputation.

- Metronidazole in the form of a 500 mg tablet to be administered by mouth two times a day for 14 days for antiinfection.

- Oxycodone HCL in the form of a 5 mg tablet to be administered by mouth every 6 hours as needed for pain.

Documentation in an admission summary dated 10/30/2023 written by Nurse #1 indicated Resident #1 arrived at the facility at approximately 2:00 PM.

Nurse #1 was interviewed on 11/11/2023 at 5:03 PM. Nurse #1 revealed that another nurse entered the medications from the hospital discharge summary for Resident #1 to the electronic medical record system for transmission to the pharmacy on 10/30/2023. Nurse #1 additionally revealed she did not contact the physician or the pharmacy regarding the medications for Resident #1 because she assumed the medications for Resident #1 were already verified by the physician and would come in on the night shift. Nurse #1 confirmed she worked from 7:00 AM to 11:00 PM on 10/30/2023

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F 755	Continued From page 4	F 755		

and the medications for Resident #1 did not come in on that shift from the pharmacy.

Nurse #2 was interviewed on 11/11/2023 at 3:53 PM. Nurse #2 revealed she entered the physician orders for medications from the hospital discharge summary into the electronic medical record system for Resident #1. Nurse #2 stated a second nurse was to confirm the physician orders with the facility physician and then have the orders sent to the pharmacy.

Review of the Medication Administration Record (MAR) for October 2023 revealed Resident #1 did not receive any medications on 10/30/2023 after his arrival at 2:00 PM.

Nurse #3 was interviewed on 11/11/2023 at 6:28 PM. Nurse #3 confirmed she worked from 11:00 PM on 10/30/2023 to 7:00 AM on 10/31/2023. Nurse #3 conveyed the following information regarding the medication orders for Resident #1. Nurse #3 was informed at the start of her nursing shift on 10/30/2023 Resident #1 was admitted to the facility that afternoon and did not have any medications in the facility yet. Nurse #3 looked in the electronic record system and compared the discharge summary from the hospital to orders that were entered into the electronic medical record system. Nurse #3 found no discrepancies except for the lack of information on allergies. Nurse #3 completed the allergy information and submitted the orders to the pharmacy.

Review of the MAR for October 2023 revealed Resident #1 received his ordered dose of Aspirin as the only medication received at 9:00 AM on 10/31/2023.

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F 755	Continued From page 5	F 755		

The Physician Assistant (PA #1) for Resident #1 was interviewed on 11/13/2023 at 1:29 PM. PA #1 stated was made aware on the morning of 10/31/2023 that Resident #1 did not have his medications delivered from the pharmacy at that time as she was reviewing his chart as a new admission. PA #1 stated her specific concern was that insulin was not available for Resident #1. PA #1 revealed she went with Nurse #4 to check the blood sugar of Resident #1 and find insulin by any means necessary if insulin was required. PA #1 revealed she called the pharmacy to order the medications for Resident #1 to be sent as soon as possible.

Nurse #4 was interviewed on 11/13/2023 at 12:25 PM, who worked the 7:00 Am to 3:00 PM shift on 10/31/2023. Nurse #4 stated that on the morning of 10/31/2023 Resident #1 still did not have his medications to include insulin. Nurse #4 stated she went to PA #1, who was in the building, and notified her of the lack of medications for Resident #1. Nurse #4 explained she went with PA #1 to check the blood sugar of Resident #1 and it was within normal limits, not requiring insulin administration. Nurse #4 revealed Resident #1 did not require pain medication on the morning of 10/31/2023.

Documentation in electronic medication administration notes for Resident #1 on 10/31/2023 revealed the evening dose of Novolin insulin to be administered at 5:00 PM stated, "Medication not available from pharmacy."

Documentation on the MAR for 10/31/2023 revealed Resident #1 received his evening medication ordered doses of Atorvastatin,

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F 755	Continued From page 6	F 755		

Buspirone, Carvedilol, Icosapent Ethyl, Lamotrigine, Pregabalin, Ranolazine extended release, and Oxycodone.

An interview was conducted with Nurse #6 on 11/13/2023 at 2:28 PM. Nurse #6 confirmed she was working on the 7:00 AM to 3:00 PM shift on 11/01/2023 and was assigned to the medication cart on the hall Resident #1 resided. Nurse #6 confirmed the morning medications were available for Resident #1 to include his morning dose of insulin.

An interview with the Director of Nursing was conducted on 11/11/2023 at 3:04 PM. The facility policy, as explained by the DON, was for a nurse to enter the physician orders into the MAR and once on the MAR, the orders were to be transmitted to the pharmacy. The DON revealed that the facility received two deliveries of medications from the pharmacy, one at approximately 2:00 PM and another at approximately 9:00 PM. The DON further revealed that the pharmacy was a new pharmacy for the facility and the facility had no back up medications onsite in an automated medication dispensing system.

An interview was conducted with the Pharmacy Director for the facility pharmacy on 11/11/2023 at 3:19 PM. The Pharmacy Director was able to convey the following information from the pharmacy records. The first facsimile from the facility regarding the medications for Resident #1 was received by the pharmacy at 5:42 PM on 10/30/2023, after the closing time of 5:30 PM for the pharmacy. At 11:30 PM on 10/30/2023 the facility pharmacy received a lot of physician orders for Resident #1. The orders for Resident

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F 755	Continued From page 7 #1 were processed when the pharmacy reopened on 10/31/2023. The first delivery of medications was sent with the driver at 1:19 PM on 10/31/2023. The driver delivered the medications for Resident #1 at 8:44 PM on 10/31/2023 to the facility and the medications were signed for by Nurse #3 at that time. The Pharmacy Director had no explanation for why the pharmacy driver delivered the medications for Resident #1 outside of the expected delivery times contracted by the facility. The Pharmacy Director explained that it was the expectation of the pharmacy that if medications were needed after the close of business of the pharmacy, the backup pharmacy needed to be called by the facility so that medications were obtained by morning for the resident. The Pharmacy Director confirmed the facility did not currently have an automated medication dispensing machine that contained insulin as a backup for needed medications. Documentation on a Brief Interview for Mental Status dated 10/31/2023 revealed Resident #1 was screened as cognitively intact. Resident #1 was interviewed on 11/11/2023 at 4:13 PM. Resident #1 stated it was a stressful and frustrating 2 days when he was first admitted to the facility as he did not understand why his medications were not available to him. Resident #1 stated he "did not suffer anything health wise" from not having his medications available to him but reiterated it was stressful worrying about not having his insulin, blood thinners, antibiotics, and pain medication after surgery. Resident #1 stated he was able to "tolerate" the pain while he waited for his medication to arrive at the facility.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		11/15/23

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F 760	Continued From page 8 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Physician Assistant interview, Pharmacy Director interview, Surgical Physician interview and resident interview the facility failed to provide antibiotic, diabetic, hypertension, antiepileptic, and pain medication as ordered resulting in significant errors by omission of high alert medications for one (Resident #1) of one resident reviewed for significant medication errors. Antibiotic medications were delayed after admission to the facility due to a transcription error for Resident #1. Diabetic, hypertension, antiepileptic, and pain medication were omitted initially upon admission due to a delay obtaining required medications from the pharmacy for Resident #1. Findings included: 1.Documentation on a hospital discharge summary dated 10/30/2023 revealed Resident #1 was to be discharged to the facility post operation for an amputation. The problem list on the discharge summary revealed Resident #1 had a diabetic infection of his left foot. The surgical wound was cultured and grew out bacteria. The plan was to continue at least 4 weeks of the antibiotics Levaquin and Flagyl when Resident #1 discharged to the facility as discussed with the infectious disease specialist. Documentation on the same hospital discharge summary revealed physician orders for Levaquin in the form of a 500- milligram (mg) tablet administered by mouth	F 760	F-760 (1). How corrective action will be accomplished for resident(s) found to have been affected: In-services were provided for the nurses, an Insulin E-Kit was ordered, and an earlier pharmacy delivery time was put into place on 11/11/23. (2). How the corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All new admissions have the potential to be affected by this non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents. (3). What measures will be put into place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 11/11/23 the Regional Nurse in-serviced the Director of Nursing, Nurse manager and staff nurses on the process of verifying new admission or re-admission orders with the MD/PA/NP immediately upon admission, place the orders into Point Click Care and	

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F 760	Continued From page 9 every day and Flagyl in the form of a 500 mg tablet to be administered by mouth twice a day. Resident #1 was admitted to the facility on 10/30/2023 with cumulative diagnoses some of which included diabetes mellitus, status post amputation of left great toe and left forefoot, and diabetic left foot infection. Documentation in the electronic medical record system revealed Nurse #2 entered an order on 10/30/203 for Resident #1 to receive Levaquin in the form of a 500 mg tablet by mouth one time daily for 10 days with a start date of 11/9/2023. Documentation on the Medication Administration Record (MAR) for November of 2023 revealed the first day the antibiotic Levaquin was administered to Resident #1 was 11/9/2023, 10 days from 10/30/2023. Documentation in the electronic medical record system revealed Nurse #2 entered an order on 10/30/2023 for Resident #1 to receive Flagyl in the form of a 500 mg tablet by mouth two times a day for 14 days with a start date of 11/13/2023. At the time of the survey the documentation on the MAR for November 2023 revealed the first day the antibiotic Flagyl was to be administered to Resident #1 was 9:00 PM on 11/13/2023, 14 days from 10/30/2023. An interview was conducted with Nurse #2 on 11/13/2023 at 1:01 PM. Nurse #2 indicated she thought she was putting in the orders for the antibiotic medication Levaquin and Flagyl to be started immediately upon admission of Resident #1 on 10/30/2023. Nurse #2 confirmed she made	F 760	immediately order the medications. Then utilizing our emergency backup kit for immediate dispensing of medications needed. On 11/11/23, the Regional Nurse in-serviced the Director of Nursing, Nurse manger and nursing staff that the Pharmacy closes at 5:00pm and to call the backup pharmacy for new admission orders as well as any new medications ordered after 5:00pm. On 11/11/23, the Regional Nurse called the Director of Pharmacy and ordered an Insulin E-kit for the facility. The Insulin E-Kit was received by the facility. (4). Indicated how the facility plans to monitor its performance to make sure the solutions are achieved and sustained: The monitoring will be done by the Director of Nursing or designee for each new or re-admission admission. The Director of Nursing or designee will review upon admission all new medications orders in PCC to include start dates, stop dates, and transcription accuracy. This monitoring will be done with each new admission for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of	

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an error and put the wrong start dates for the antibiotics for Resident #1.

An interview was conducted with the Physician Assistant (PA #1) on 11/13/2023 at 1:29 PM. PA #1 confirmed she saw Resident #1 on the morning of 10/31/2023 and reviewed his chart as a new admission. PA #1 confirmed the antibiotics Levaquin and Flagyl, according to the hospital discharge summary, were supposed to continue to be administered when he arrived at the facility. PA #1 noted Resident #1 was on intravenous antibiotics in the hospital but was to switch to administration by mouth at the facility. PA #1 confirmed the antibiotics Levaquin and Flagyl should have been started immediately upon admission because that was what the order was for. PA #1 revealed delaying the provision of antibiotics could have a potential effect or outcome on the healing process and the infection in the left foot of Resident #1 but, he had not shown any signs of a systemic change since admission.

Documentation on a Brief Interview for Mental Status dated 10/31/2023 revealed Resident #1 was screened as cognitively intact.

Resident #1 was interviewed on 11/11/2023 at 4:13 PM. Resident #1 indicated he "did not suffer anything health wise" from not having his antibiotics available to him but revealed it was stressful worrying about not having his antibiotics after surgery.

The Surgical Physician who performed the amputation procedure on the left foot of Resident #1 was interviewed on 11/15/2023 at 9:08 AM. The Surgical Physician revealed the following

this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

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F 760	Continued From page 11	F 760		

information. The Surgical Physician saw Resident #1 during a follow up appointment on 11/14/2023. The open wound looked good, was very much improved, and did not show signs of infection. It was not an ideal situation regarding Resident #1 not continuing with his antibiotics when he was first admitted to the facility but, more importantly the facility provided good wound care with the wound VAC (vacuum-assisted closure). Resident #1 was always at a higher risk for infection because he had diabetes and had always had uncontrolled blood glucose levels.

2. Resident #1 had cumulative diagnoses some of which included Type 2 diabetes, Hypertension, Bipolar disorder, congestive heart failure, anxiety disorder, status post orthopedic surgery, and post-traumatic stress disorder.

Documentation in the electronic medical record of Physician orders listed as entered on 10/30/2023 by Nurse #2 at 12:57 PM for Resident #1 included some of the following medications.

Novolin (Insulin) 70/30 Flex Pen Subcutaneous Suspension Pen 60 units of insulin to be injected subcutaneously every morning for Type 2 diabetes. 15 units of insulin were to be injected subcutaneously if Resident #1 was not eating breakfast.

Novolin (Insulin) 70/30 Flex Pen Subcutaneous Suspension Pen 30 units of insulin were to be injected subcutaneously every evening for Diabetes Mellitus.

Empagliflozin in the form of a 10 mg tablet taken by mouth once a day for Diabetes Mellitus.

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	345316	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

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Carvedilol in the form of a 3.125-mg tablet twice daily for Hypertension.

Lamotrigine in the form of a 200 mg tablet to be taken by mouth two times a day for coronary artery disease. (Lamotrigine is a medication that requires periodic monitoring of levels of the medication in the blood.)

Pregabalin in the form of a 100 mg capsule to be taken by mouth two times a day for pain.

Ranolazine extended release in the form of a 1000 mg tablet to be taken by mouth two times a day for Hypertension.

Documentation in an admission summary dated 10/30/2023 written by Nurse #1 indicated Resident #1 arrived at the facility at approximately 2:00 PM.

Nurse #1 was interviewed on 11/11/2023 at 5:03 PM. Nurse #1 confirmed she worked from 7:00 AM to 11:00 PM on 10/30/2023 and the medications for Resident #1 did not come in on that shift from the pharmacy.

Nurse #2 was interviewed on 11/11/2023 at 3:53 PM. Nurse #2 revealed she entered the physician orders for medications from the hospital discharge summary into the electronic medical record system for Resident #1. Nurse #2 stated a second nurse was to confirm the physician orders with the facility physician and then have the orders sent to the pharmacy.

Review of the Medication Administration Record (MAR) for October 2023 revealed Resident #1 did not receive any medications on 10/30/2023 after

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his arrival at 2:00 PM to include his Novolin insulin, Carvedilol, Lamotrigine, Pregabalin, and Ranolazine.

Nurse #3 was interviewed on 11/11/2023 at 6:28 PM. Nurse #3 confirmed she worked from 11:00 PM on 10/30/2023 to 7:00 AM on 10/31/2023. Nurse #3 conveyed the following information regarding the medication orders for Resident #1. Nurse #3 was informed at the start of her nursing shift on 10/30/2023 Resident #1 was admitted to the facility that afternoon and did not have any medications in the facility yet. Nurse #3 looked in the electronic record system and compared the discharge summary from the hospital to orders that were entered into the electronic medical record system. Nurse #3 found no discrepancies except for the lack of information on allergies. Nurse #3 completed the allergy information and submitted the orders to the pharmacy.

Review of the MAR for October 2023 revealed Resident #1 did not receive his ordered 7:30 AM dose of Novolin insulin nor his 9:00 AM ordered doses of Empagliflozin, Carvedilol, Lamotrigine, Pregabalin, and Ranolazine on 10/31/2023.

The Physician Assistant (PA #1) for Resident #1 was interviewed on 11/13/2023 at 1:29 PM. PA #1 stated was made aware on the morning of 10/31/2023 that Resident #1 did not have his medications delivered from the pharmacy at that time as she was reviewing his chart as a new admission. PA #1 stated her specific concern was that insulin was not available for Resident #1. PA #1 revealed she went with Nurse #4 to check the blood sugar of Resident #1 and find insulin by any means necessary if insulin was required. PA #1 revealed she called the pharmacy to order the

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medications for Resident #1 to be sent as soon as possible.

Nurse #4 was interviewed on 11/13/2023 at 12:25 PM, who worked the 7:00 Am to 3:00 PM shift on 10/31/2023. Nurse #4 stated that on the morning of 10/31/2023 Resident #1 still did not have his medications to include insulin. Nurse #4 stated she went to PA #1, who was in the building, and notified her of the lack of medications for Resident #1. Nurse #4 explained she went with PA #1 to check the blood sugar of Resident #1 and it was within normal limits, not requiring insulin administration. Nurse #4 revealed Resident #1 did not require pain medication on the morning of 10/31/2023.

Documentation in electronic medication administration notes for Resident #1 on 10/31/2023 revealed the evening dose of Novolin insulin to be administered at 5:00 PM stated, "Medication not available from pharmacy."

Documentation on the MAR for 10/31/2023 revealed Resident #1 received his evening medication ordered doses of Carvedilol, Lamotrigine, Pregabalin, and Ranolazine extended release.

An interview was conducted with the Pharmacy Director for the facility pharmacy on 11/11/2023 at 3:19 PM. The Pharmacy Director was able to convey the following information from the pharmacy records. The first facsimile from the facility regarding the medications for Resident #1 was received by the pharmacy at 5:42 PM on 10/30/2023, after the closing time of 5:30 PM for the pharmacy. At 11:30 PM on 10/30/2023 the

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facility pharmacy received a lot of physician orders for Resident #1. The orders for Resident #1 were processed when the pharmacy reopened on 10/31/2023. The first delivery of medications was sent with the driver at 1:19 PM on 10/31/2023. The driver delivered the medications for Resident #1 at 8:44 PM on 10/31/2023 to the facility and the medications were signed for by Nurse #3 at that time. The Pharmacy Director had no explanation for why the pharmacy driver delivered the medications for Resident #1 outside of the expected delivery times contracted by the facility. The Pharmacy Director explained that it was the expectation of the pharmacy that if medications were needed after the close of business of the pharmacy, the backup pharmacy needed to be called by the facility so that medications were obtained by morning for the resident. The Pharmacy Director confirmed the facility did not currently have an automated medication dispensing machine that contained significant medications such as insulin as a backup for needed medications.

An interview with the Director of Nursing was conducted on 11/11/2023 at 3:04 PM. The facility policy, as explained by the DON, was for a nurse to enter the physician orders into the MAR and once on the MAR, the orders were to be transmitted to the pharmacy. The DON revealed that the facility received two deliveries of medications from the pharmacy, one at approximately 2:00 PM and another at approximately 9:00 PM. The DON further revealed that the pharmacy was a new pharmacy for the facility and the facility had no back up medications onsite in an automated medication dispensing system. The DON indicated the delivery times from the pharmacy needed to

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change and an automated medication dispensing system for a back-up of medications would need to be obtained from the pharmacy to prevent significant medication errors.

Documentation on a Brief Interview for Mental Status dated 10/31/2023 revealed Resident #1 was screened as cognitively intact.

Resident #1 was interviewed on 11/11/2023 at 4:13 PM. Resident #1 stated it was a stressful and frustrating 2 days when he was first admitted to the facility as he did not understand why his medications were not available to him. Resident #1 stated he "did not suffer anything health wise" from not having his medications available to him but reiterated it was stressful worrying about not having his insulin, heart medications, and pain medication after surgery. Resident #1 stated he was able to "tolerate" the pain while he waited for his medication to arrive at the facility.