STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: _____ B. WING _____	R 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 000	Initial Comments The Adult Care Licensure Section and the Orange County Department of Social Services conducted an annual and follow-up survey on April 9-11, 2019.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by storage of oxygen tanks in an unsafe manner in three residents' rooms. The findings are: Observation of resident room #119 on 04/09/19 at 10:23 am revealed: -There were two approximately 25 inch oxygen tanks and one 11 1/2 inch oxygen tank on the floor behind a cardboard box containing twelve 11 1/2 inch oxygen tanks. -There were three oxygen tank regulator keys available for use. -There was an oxygen concentrator with oxygen tubing attached. -There were no oxygen tank holders in the	D 079		

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D 079	Continued From page 1	D 079		

resident room.
-There was no oxygen in use; there was no caution sign on the resident room door.

Interview with the resident in room #119 on 04/10/19 at 10:00 am revealed:
-He had resided at the facility for a little over a year and had used oxygen since his admission.
-The oxygen tanks were delivered directly to his room and were placed on the floor by the oxygen company.
-He purchased his on demand oxygen regulator to use with his small portable oxygen tanks because he did not need the oxygen at all times
-He called the oxygen company himself and ordered the oxygen tanks.
-He ordered twelve small tanks approximately every month whenever he called for replacement tanks.
-The empty oxygen tanks always remained in his room.
-He provided the cardboard box to place the small oxygen tanks into for storage.
-He used the oxygen concentrator when he was in the room only.

Observation of resident room #117 on 04/09/19 at 10:25 am revealed:
-There were five approximately 28 inch oxygen tanks on the floor standing beside the kitchenette cabinet area.
-There was an oxygen tank in an oxygen tank holder with wheels.
-There was an oxygen concentrator with oxygen tubing attached.
-There was no oxygen in use caution sign on the resident room door.

Interview with the resident in room #117 on 04/10/19 at 10:06 am revealed:

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D 079	Continued From page 2	D 079		

-He had used oxygen since his hospitalization in January 2019.
-The local durable medical supply delivered the oxygen tanks when he returned to the facility after the hospitalization.
-The oxygen company delivery person placed the oxygen tanks on the floor beside the kitchenette cabinet.
-He did not use the oxygen tanks and used the oxygen concentrator when he was in the room only.
-The oxygen company had provided the single oxygen tank holder with wheels, but he had not used it.

Observation of resident room #103 on 04/10/19 at 10:19 am revealed:
-There was an approximately twenty eight inch oxygen tank in the center of the room near the resident's clothes storage area.
-There was an eight canister holder that held two oxygen tanks covered with folded clothes.
-There were two oxygen concentrators with oxygen tubing attached.
-There was no oxygen in use caution sign on the resident room door.

Interview with the resident in room #103 on 04/11/19 at 11:00 am revealed:
-He had been a resident for two years.
-The oxygen tanks were stored in his room for the past six months, and he did not need oxygen until six months ago.
-The oxygen tanks and canister holder were placed in the area of his room by a staff; he did not recall the staff name.
-The empty oxygen tanks were stored in the canister holder.
-He placed folded clothes on top of the canister holder.

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D 079	Continued From page 3	D 079		

-An oxygen company delivered the oxygen tanks to his room.
-He had not asked staff to remove the tanks but it hampered his available storage space.

Interview with the personal care aide (PCA) on 04/10/19 at 9:35 am revealed:
-She did not assist residents with the oxygen tanks.
-The medication aides (MAs) assisted residents who needed help with their oxygen tanks.
-She notified the MAs if there was a problem with an oxygen tank.

Interview with a day and evening shift MA on 04/10/19 at 3:02 pm revealed:
-The facility had a storage closet for oxygen tanks.
-She knew the residents in room #103, #117, and #119 had oxygen tanks in their rooms.
-The residents on the assisted living side of the facility "handled their own oxygen".
-Each resident was able to store their oxygen tanks in the storage closet.
-The MA responsibilities were to make sure there were not a lot of tanks in the corner, provide the resident with an oxygen canister holder, ensure oxygen tanks were not on the floor, ensure no smoking in the rooms, provide new oxygen tubing, ensure the regulator was set on the correct amount to deliver, provide moisture for residents' noses if needed, and assist with anything the resident requested.
-She did not know there was an unsecured oxygen tank in room #103 and thought the resident was using the canister holder.
-She knew there were oxygen tanks in resident room #117 but had not moved them to the oxygen storage closet or provided a canister holder.
-She knew there were oxygen tanks in resident

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D 079	Continued From page 4	D 079		

room #119 but she thought they were secured in the cardboard box.
-The empty oxygen tanks were supposed to be picked up by the durable medical supply company.
-She did not know who was responsible for calling the durable medical supply company to pick up empty oxygen tanks.
-She did not know that the oxygen was stored incorrectly.

Interview with the resident care coordinator (RCC) on 04/10/19 at 5:00 pm revealed:
-She did rounds once a day and also still worked as a MA.
-She worked as a MA on the assisted living side on 04/09/19.
-All oxygen tanks were supposed to be stored in a crate off of the floor.
-She noticed on 04/09/19 the oxygen tanks were stored in an unsafe manner in resident rooms #103, 117, and #119.
-She called the durable medical supply company to pick up the tanks on 04/09/19 and had called previously at the end of March 2019.
-The oxygen tanks in the facility oxygen storage closet were from residents who had expired or were discharged from the facility.
-The durable medical supply company told her they would pick up the empty tanks on 04/04/19 but the tanks were not picked up.
-The empty oxygen tanks were still at the facility despite the phone calls.
-She was told about the empty oxygen tanks stored incorrectly on 04/10/19 by a MA.
-She instructed the MA to call the durable medical supply companies to come and pick up the empty oxygen tanks on 04/10/19.
-The oxygen tanks in the storage closet were from different durable medical supply companies.

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D 079	Continued From page 5 Attempted interviews with two durable medical supply companies on 04/11/19 at 12:20 pm and 04/11/19 at 12:29 pm were unsuccessful. Interview with the Administrator on 04/11/19 at 1:20 pm revealed: -He made rounds daily through the facility but he did not make rounds into each resident room daily. -He did not know about the oxygen tanks stored in an unsafe manner in resident rooms #103, #117, and #119. -He expected all staff to notify him or the RCC if there was an oxygen tank stored in an unsafe manner. -He or the RCC would call the durable medical supply company to arrange a pick-up of the empty or unused oxygen tanks. -He had discussed this issue in the staff meeting held February 2019. -All staff who entered resident rooms were responsible for ensuring oxygen tanks were stored safely.	D 079		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure food preparation and storage areas, walk-in	D 282		

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D 282	Continued From page 6 refrigerator, and the gas stove and oven were clean and free of contamination. The findings are: Observations of the food preparation table and counter on 04/10/19 at 8:36 am revealed: -The bottom shelf of the table had stains and crumbs scattered throughout the shelf. -The bottom shelf of the table near the meat preparation area had crumbs and dust scattered along the edges of the shelf. -There were stored boxed condiments, gloves, kitchen towels and food items on the lower shelf of the counter. -There were crumbs and food debris all along both shelves. Observation of the gas stove and oven on 04/10/18 at 8:39 am revealed -There was a thick layer of grease and dirt on and around the ten knobs used to control the stove burners and oven. -The black material attached to the base of the wall of the stove underneath the knobs was peeling away. -There were streaks of brownish stains running down the gas oven doors. -There were brownish spots speckled over both gas oven doors. -There were crumbs, food debris and brownish stains on the inner gas oven doors. -There were crumbs, food debris and brownish stains inside each oven. Observation of a plastic storage rack on 04/10/19 at 8:50 am revealed: -There were four plastic shelves that had grooves. -There was crumbs, and other food debris	D 282		

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D 282	Continued From page 7 collected at each corner of the plastic shelves. Observation of the metal storage rack beside the food preparation counters on 04/10/19 at 8:50 am revealed: -There were four shelves. -The shelves stored dishes such as bowls, and plates as well as sheet pans. -There was a dusty residue on each shelf. -The bottom shelf was covered with aluminum foil which had a brownish liquid collected on portions of the aluminum foil. Observation of the dry food storage area on 04/10/19 at 8:51 am revealed: -The five metal storage racks had four shelves. -The shelves had a dusty residue of varying thickness. Observation of the large canned food storage rack on 04/10/19 at 8:53 am revealed: -There were several large cans of food stored on the rack. -There were crumbs and dust in the grooves of the storage rack. Observation of the walk-in refrigerator on 04/10/18 at 8:56 am revealed: -There were four green and silver metal racks in the walk-in refrigerator. -There were spots on each shelf with rust stains along the full length of the shelf. Review of the kitchen cleaning checklist on 04/10/19 revealed there was documentation of the completion of the cleaning on 02/18/19, 02/27/19, 02/28/19, and 03/01/19, which included the tables, floors, sinks/basins, walls, drains, containers, trash cans, and stove/hood.	D 282		

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D 282	Continued From page 8 Interview with the dietary aide (DA) on 04/10/19 at 8:25 am revealed:. -He and the other dietary aide were responsible for the day to day kitchen operations at this time. -There was a cleaning schedule for the kitchen area kept in a notebook. -He did not look at it daily and he knew the cleaning checklist without referring to it daily. -There was no one to review the kitchen cleaning checklist; he knew the cleaning to be completed. -The entire dietary staff was responsible for maintaining a clean kitchen. -He and the other DA switched duties, which included cooking or cleaning and serving. -When he cooked he was responsible for cleaning the food preparation areas and the DA was responsible for cleaning the dining room, the dishes, beverage preparation area and the floors. -He was aware of the build-up of grease and dirt on the stove and oven knobs. -He knew how to clean the knobs in order to remove the build-up of grease and dirt and just had not had a moment to clean the knobs. -He had metal cleaning pads to use to remove the grease and dirt from the knobs. -The area around the stove and oven knobs had been peeling for a while, he did not recall when it started. -The entire stove and oven was three years old. -The stove was wiped down daily with a wet cloth and the oven was cleaned when there was time with oven cleaner. -The oven doors were wiped down but he did not recall the last time the oven or oven doors were deep cleaned. -He knew about the crumbs and food debris on the lower shelves of the food preparation tables. -When there was adequate staffing, there was time to address these areas of the kitchen. -He did have cleanser to clean the shelves but he	D 282		

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D 282	Continued From page 9	D 282		

did not clean them because they were short staffed.
-The food preparation tables were cleaned daily with the dish and pan cleaner.
-The lower shelves of the counter were usually wiped down daily when there was adequate staffing.
-He knew about the rust stains on the metal storage rack shelve in the walk-in refrigerator.
-He thought the rust stains were caused when items such as boxes, cans, containers were ran against the shelves causing the paint on the metal racks to be removed leaving the metal exposed to the moisture in the walk-in refrigerator.
-The green and silver metal racks in the walk-in refrigerator were there when he started working at the facility six years ago.
-He had reported it to the Administrator; he did not know the specific date.
-The plastic storage rack and the metal storage rack in the middle of the kitchen were cleaned three weeks ago by using the pressure washer to clean them.
-He did not know the metal racks that stored dry goods were covered with dust.
-He had never cleaned the metal racks in the dry good storage area, because it was always fully covered with food.
-He had not cleaned the storage rack for canned goods and did not know it had crumbs and dust in the grooves.

Interview with another DA on 04/11/19 at 11:34 am revealed:
-He had worked at the facility for one year and during that time there had been changes with the staffing in the kitchen.
-They had been without a dietary manager for over a month.

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D 282	Continued From page 10 -He was a cook and dietary aide. -He cleaned the areas of the kitchen that needed to be cleaned daily according to the kitchen cleaning checklist. -He had noticed the crumbs and food debris on the lower shelves of the food preparation tables and food preparation counters. -He had missed cleaning the lower shelves when he wiped down the tops of the tables and the counters. -He thought the oven was just old equipment and that was the reason it was stained and peeling. -He had not cleaned the oven during his employment at the facility. -The plastic and metal storage racks were cleaned twice a week. -He had cleaned the dry goods storage racks a couple of months ago, but he had not cleaned the large canned food storage rack. -He and the other cook had spoken with the Administrator about the rust developing on the metal storage racks in the walk-in refrigerator about one and half to two months ago. -They were told by the Administrator a work order would be placed for the metal racks in the walk-in refrigerator. -There were supplies to clean the kitchen with such as cloths, degreaser, and detergents. Interview with the Administrator on 04/11/19 at 9:05 am revealed: -He supervised the dietary staff. -He was responsible for dietary services, the staff and for making sure the staff followed the cleaning schedule. -The dietary staff had a cleaning schedule to follow. -He thought the staff followed the cleaning schedule. -He did not review the kitchen cleaning checklist.	D 282		

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D 282	Continued From page 11 -He made "rounds" daily in the kitchen and looked at the floors, countertops, and food preparation areas like the stove table tops. -He did not always look inside the refrigerator when he made rounds. -He did not know the metal racks in the walk-in refrigerator had rust stains but he would place a work order for more storage racks. -He did not know about the debris and residue on any of the metal and plastic racks but he expected the racks to be cleaned weekly. -He did not know about the dusty residue on the metal racks in the dry goods storage area, but he expected the metal racks to be cleaned weekly. -He did not notice the crumbs and food debris on the lower shelves of the food preparation tables and the food preparation counters, but he expected the food preparation areas to be wiped down daily. -He did not know the gas stove and oven knobs were covered with a greasy residue and stained, but he expected the knobs to be cleaned daily. -He did not know the area behind the knobs was peeling but would place a work order to have the stove looked at by maintenance. -He expected the oven to be cleaned weekly and as needed.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 12 and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#3) related to five omitted doses of a medication used for the treatment of heart failure. The findings are: Review of Resident #3's current FL-2 dated 05/30/18 revealed: -Diagnoses included hypertension, atrial fibrillation with rapid ventricular, and congestive heart failure (CHF). -There was a medication order for furosemide 40 mg (used to treat CHF and hypertension) daily. Review of Resident #3's subsequent physician orders revealed: -There was an order dated 01/02/19 to discontinue all current furosemide orders and start furosemide 80 mg daily. -There was an order dated 03/02/19 for furosemide 80 mg twice daily for three days and then resume furosemide 80 mg daily on 03/06/19. Review of Resident #3's February 2019 electronic	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: _____ B. WING _____	R 04/11/2019

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D 358	Continued From page 13	D 358		

mediation administration record (eMAR) revealed
-There was an entry for furosemide 80 mg daily, scheduled at 9:00 am.
-There was documentation of administration from 02/01/19 to 02/28/19 at 9:00am.

Review of Resident #3's March 2019 eMAR revealed:
-There was an entry for furosemide 80 mg daily scheduled at 9:00 am.
-There was documentation of administration from 03/01/19 to 03/03/19 at 9:00 am and from 03/12/19 to 03/31/19 at 9:00 am.
-There was an entry for furosemide 80 mg twice daily for three days then resume once daily on 03/06/19 scheduled at 9:00 am and 5:00 pm.
-There was documentation of administration on 03/03/19 at 5 pm, and from 03/04/19 to 03/06/19 at 9:00 am and 5:00 pm.
-There was no documentation of administration from 03/07/19 to 03/11/19 at 9:00 am.

Review of Resident #3's April 2019 eMAR revealed there was documentation of administration of furosemide 80 mg from 04/01/19 to 04/09/19 at 9:00 am.

Observation of medication on hand on 04/11/19 at 10:30 am revealed there was one packet of furosemide 80 mg tablets with a dispensed date of 04/05/19 and 25 of thirty tablets remaining in the packet.

Interview with Resident #3 on 04/10/19 at 4:48 pm revealed:
-She had a good memory but she did not remember the specific medication given to her in March 2019.
-She did not recall the physician telling her about any adjustments to a medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: _____ B. WING _____	R 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

(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 358	Continued From page 14 Interview with Resident #3's physician's medical assistant on 04/11/19 at 10:49 am revealed: -There was documentation of Resident #3 going to the emergency room on 03/01/19 due to shortness of breath and chest heaviness. -Resident #3 was not admitted to the hospital and returned to the facility on 03/02/19. -Resident #3 was seen by the physician on 03/06/19 and there was documentation of a medication order written on 03/06/19 for furosemide 80 mg daily. -She did not know how the order was sent to the pharmacy, it could have been left at the facility or transmitted electronically. -The order written on 03/06/19 for furosemide was a continuance of the dose already ordered for Resident #3. -She was not able to locate documentation of the facility notifying the physician about any missed doses from 03/07/19 to 03/11/19. -There was no documentation of a hold or discontinued order in the computer system -She was told by the physician on 04/11/19 that the possible results of not receiving furosemide for five days was worsening edema. Interview with a pharmacy technician at the facility's contracted pharmacy on 04/10/19 at 5:35 pm and 04/11/19 at 9:54 am revealed: -The pharmacy placed medication orders into the computer system for the facility. -There was an order for furosemide 80 mg daily dated 01/02/19. -There was an order for furosemide 80 mg twice daily for three days and then resume daily dose dated 03/02/19. -There were no discontinue orders for furosemide in the computer system for March 2019. -The order placed into the system on 01/30/19 for	D 358		

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D 358	Continued From page 15	D 358		

furosemide had eleven refills.
-There were thirty tablets of furosemide dispensed on 02/13/19, six tablets of furosemide 80 mg were dispensed on 03/03/19, and thirty tablets of furosemide 80 mg were dispensed on 03/12/19 from the 01/30/19 order.
-The order for furosemide appeared as discontinued on 03/12/19 but there was no discontinue order from the physician.
-She did not know why the furosemide was discontinued in the computer system on 03/12/19.
-The staff was able to enter a medication order manually and change the times a medication was delivered.
-There was no reason in the computer system for Resident #3's omitted doses from 03/07/19 to 03/11/19, because the order was keyed into the computer system and on the eMAR.
-The order for furosemide 80 mg daily was on Resident #3's profile before the order change and it should appear after the order change.
-There had been instances where staff had changed scheduled time of administration and the order then appeared as discontinued on the pharmacy computer system.
-The staff may have removed an order to prevent the furosemide from appearing twice on the eMAR.

Attempted interview on 04/11/19 at 11:01 am with a medication aide (MA) who worked day shift 03/07/19 was unsuccessful.

Interview with a MA on 04/11/19 at 11:45 am revealed:
-She worked day shift from 03/08/19 to 03/10/19.
-There was a new system for eMAR and the facility started using it at the end of February 2019.
-The only reason she knew for a medication not

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D 358	Continued From page 16	D 358		

being given was because the medication was not available to administer.
-The medication appeared on the screen but if the medication was not available a note was entered by the Resident Care Coordinator (RCC).
-When a medication was not available to administer, the RCC was told and the medication was re-ordered from the pharmacy.
-The medication was delivered the same day if the request was made by 12:00 pm.
-The MAs were not able to enter medication orders, remove duplicate orders or change the times for administration in the eMAR system.
-The RCC was able to enter medication orders, remove duplicate orders or change the times for administration in the eMAR system.
-She did not know why Resident #3 did not receive furosemide from 03/08/19 to 03/10/19.

Interview with another MA on 04/11/19 at 12:00 pm revealed:
-She worked day shift on 03/11/19.
-She worked on both the assisted living and memory care side of the facility.
-The only reason she was able to think of for Resident #3 not receiving furosemide on 03/11/19 was there was none available for administration.
-She was not able to recall if Resident #3 had furosemide available on 03/11/19.
-The MAs were not able to make changes to a medication order in the eMAR system.

Interview with the RCC on 04/11/19 at 1:00 pm revealed:
-Resident #3 did not receive furosemide for five days in March 2019.
-There were two possible reasons for the omission of dose in March 2019: one reason was the medication did not show on the computer screen to be administered after the increased

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D 358	Continued From page 17	D 358		

dose and the other reason was the order for furosemide was entered incorrectly on the pharmacy side.
-She had reached out to the software creator for help solving this issue.
-The furosemide did not appear on the eMAR dash board as a missed dose for those days.
-The pharmacy received orders and placed the orders into the eMAR system.
-She reviewed the new orders that were populated into the eMAR system and she kept a copy of the order to assist with determining if an order was missed by the pharmacy.
-She did not have a process for reviewing the eMAR at the end of the month to determine any errors.
-There were reports that could be pulled to determine if there were any missed doses or errors but she had not pulled the reports before.
-Resident #3's physician was notified about the five missed doses of furosemide on 04/10/19.

Interview with the Administrator on 04/11/19 at 1:20 pm revealed:
-The RCC was responsible for ensuring medications were administered accurately.
-He expected the medications to be administered as ordered and to follow through with every physician order.
-If there was a question about a medication, he expected the MA or RCC to reach out to the physician to ask questions.
-He did not know Resident #3 had missed five doses until 04/10/19.