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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 02/06/19-02/08/19 and 02/11/19.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure 3 of 4 staff	D 164		

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sampled (Staff A, B and E) who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin.

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A was hired on 01/22/19.
-There was no documentation of training on the care of the diabetic resident.

Observation on 02/07/19 at 11:57am revealed Staff A checked a resident's FSBS and then administered insulin to the same resident.

Interview with Staff A on 02/07/19 at 11:57am revealed:
-She had worked at the facility about three week as a MA.
-She had been "checked off" by the Resident Care Director (RCD) for medication skills on Friday 02/01/19.
-She performed fingerstick blood sugar (FSBS) checks and administered insulin as needed to residents.
-She did not receive any training on the care of the diabetic resident at the facility, but had received training in the past.

Refer to interview on 02/08/19 at 3:53pm with the Business Office Director (BOD).

Refer to interview on 02/08/19 at 4:20pm with the Administrator.

2. Review of Staff B's, medication aide (MA) personnel record revealed:

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-Staff B was hired on 09/07/17.
-There was no documentation of training on the care of the diabetic resident.

Observation on 02/06/19 at 11:48am during the medication pass observation revealed:
-At 11:48am, Staff B checked a resident's FSBS.
-Staff B removed a plastic bag which contained an insulin pen from the medication cart that was labeled with the resident's name.
-The pharmacy generated label on the plastic bag was labeled with Resident #4 name and directions "Humalog (a rapid acting insulin used to lower blood sugar) KwikPen inject 15 units subcutaneously before breakfast and lunch along with sliding scale insulin (SSI) and inject 20 units subcutaneously before dinner with SSI."
-There were directions on the Humalog KwikPen to administer 15 units with sliding scale at breakfast and lunch and administer 20 units at dinner with sliding scale.
-The SSI order appeared on the electronic medication administration record (eMAR) which was visible on a computer monitor showing for a FSBS result of 351-400, give 10 units of Humalog.
-Staff B used proper technique and primed the insulin pen for 25 units and used aseptic technique to administer the insulin in the lower right abdominal region.
-Staff B asked another staff to transport resident who was in a wheelchair into the dining room area for lunch.
-Staff B documented on the eMAR Humalog 25 units were administered.

Observation in the dining room on 02/06/19 at 11:53am revealed:
-The resident who received the Humalog insulin was not located in the dining room area.

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-The dietary staff informed survey team the resident was taken back to her room.

Interview with Staff B on 02/06/19 at 11:57am revealed:
-Staff B stated "I did not give her enough insulin."
-Staff B had administered 15 additional units of Humalog to the resident.

Interview with Staff B on 02/07/19 at 9:08am revealed:
-She had worked at the facility for a two years as a MA.
-She performed fingerstick blood sugar (FSBS) checks and administered insulin as needed to residents.
-She did not receive any training on the care of the diabetic resident at the facility until 02/07/19.
-The training on 02/07/19 was conducted by a pharmacist.

Review of December 2018 eMAR revealed Staff B had obtained FSBS and administered insulin 2 times.

Review of January 2019 eMAR revealed Staff B had obtained FSBS and administered insulin 1 times.

Review of February 2019 eMAR revealed Staff B had obtained FSBS and administered insulin 2 times.

Refer to interview on 02/08/19 at 3:53pm with the BOD.

Refer to interview with the Administrator on 02/08/19 at 4:20pm.

3. Review of Staff E's, medication aide (MA),

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personnel record revealed:
-Staff E was hired on 09/17/17.
-There was no documentation of training on the care of the diabetic resident.

Review of November 2018 eMAR revealed Staff E had obtained FSBS and administered insulin 1 times.

Review of January 2019 eMAR revealed Staff E had obtained FSBS and administered insulin 3 times

Attempted telephone interview with Staff E on 02/08/19 at 1:08pm and at 3:42pm was unsuccessful.

Refer to interview on 02/08/19 at 3:53pm with the BOD.

Refer to interview with the Administrator on 02/08/19 at 4:20pm.

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Interview on 02/08/19 at 3:53pm with the BOD revealed:
-The facility did provide online training on the care of the diabetic resident.
-The Resident Care Director (RCD) was a nurse and was responsible for the MAs medication skills and the diabetic training.
-She could schedule the online diabetic training if the RCD had informed her when the MAs were ready for the class.
-The diabetic training was online and the pharmacist conducted the class.
-She was not aware the MAs were required to have the diabetic training prior to administering insulin or taking FSBS.
-She thought the training on diabetic care was annually and not prior to administering insulin.

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-She relied on the RCD to complete the MA medication training and the diabetic care training for new MAs.

Interview with the Administrator on 02/08/19 at 4:20pm revealed:
-She did not know the MAs had not received diabetic training prior to administering insulin or obtaining FSBS.
-She knew the training was required prior to administering insulin and obtaining FSBS.
-The BOD was responsible for all the personnel files and knew what training was required.
-The RCD was responsible for new MA training which included the diabetic training class prior to administering insulin and obtaining FSBS.
-Either the BOD or the RCD could schedule the online diabetic training class.
-The facility pharmacy completed all diabetic online class training for all new MAs.

The former RCD was not available for interview on 02/07/19, 02/08/19 or on 02/11/19.

Refer to Tag 358 Medication Administration.

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The facility failed to assure 3 of 4 staff sampled (Staff A, B and E) who administered insulin completed the mandated training on care of diabetic residents resulting in an error with insulin administration of an additional 15 units of Humalog insulin to a diabetic resident with orders for Humalog insulin and SSI. The facility's failure placed the residents at risk in regards to insulin medication error and possibly a hypoglycemic episode which was detrimental to the health and safety of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in

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D 164	Continued From page 6 accordance with G.S. 131D-34 on 02/06/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 28, 2019.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 5 of 7 sampled residents (Residents #8, #5, #6, #2 and #1) related to missed medications including Seroquel and melatonin (Resident #8), potassium chloride, trazodone, divalproex sodium, Lasix, Lotemax, Risperdal, digoxin, diltiazem (Resident #5), divalproex, docusate sodium and carvedilol (Resident #6), albuterol, alendronate, aspirin, calcium carbonate, cholecalciferol, clopidogrel, cyanocobalamin, donezepil, fluticasone nasal spray, furosemide, gabapentin, loperamide, metoprolol tartrate, ocular lubricant and pantoprazole (Resident #2) and simvastatin, sertraline and vitamin D3 (Resident #1) .	D 273		

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The findings are:

1. Review of Resident #8's current FL2 dated 11/28/18 revealed:
-Diagnoses included dementia, major neurocognitive disorder and severe alcohol use disorder in sustained remission.
-Medication orders included melatonin 5mg at bedtime.
-Requested level of care was documented as memory care unit.

a. Review of Resident #8's November 2018 electronic Medication Record Administration (eMAR) revealed:
-There was an order entry for melatonin 5mg (used for insomnia) scheduled for 8:00pm.
-There was documentation melatonin 5mg was not administered as ordered for four consecutive days on 11/22/18, 11/23/18, 11/24/18 and on 11/25/18.
-The reason documented MD (medication pending delivery).

Review of Resident #8's February 2019 eMAR from 02/01/19 to 02/10/19 revealed:
-There was an order entry for melatonin 5mg scheduled for 8:00pm.
-There was documentation melatonin 5mg was not administered as ordered on four consecutive days on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19; the reason documented was MD.
-There was documentation melatonin 5mg was not administered as ordered on 02/01/19, the reason documented was DR (drug refused).
-There was documentation melatonin 5mg was not administered as ordered on 02/09/19 and on 02/10/19, the reason documented was MD.

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Review of Resident #8's record and the eMAR charting notes revealed no documentation Resident #8's primary care physician (PCP) or the psychiatric Nurse Practitioner (NP) had been notified regarding melatonin not being administered as ordered.

Observation of medication on hand for Resident #8 on 02/11/19 at 10:30am revealed there were no melatonin 5mg tablets available for administration on the medication cart.

Telephone interview with the facility's contracted pharmacist on 02/11/19 at 10:15am revealed:
-The pharmacy dispensed Resident #8's melatonin 5mg on 10/24/18 for a quantity of 30 tablets, on 11/28/18 for a quantity of 30 tablets and on 01/03/19 for a quantity of 30 tablets.
-The pharmacy had not received a refill ordered for Resident #8's melatonin 5mg since 01/03/19.
-The melatonin 5mg was an active order for Resident #8.

Interview with a Special Care Unit (SCU) medication aide (MA) on 02/11/19 at 10:30am revealed:
-She did not know why Resident #8's melatonin 5mg was not on the medication cart on 02/11/19.
-Third shift had never mentioned Resident #8 was out of the melatonin 5mg.
-She never administered the melatonin due it was a night time medication.
-"If a resident missed three days of a medication I would call the physician or tell the nurse."

Interview with Resident #8's NP on 02/07/19 at 2:38pm revealed:
-He did not know Resident #8 had missed the melatonin.
-He expected the facility to contact the psychiatric

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team regarding the missed medications.

Telephone interview with Resident #8's psychiatric NP on 02/11/19 at 11:20am revealed:
-She did not know Resident #8 was not administered melatonin 5mg for 4 consecutive days on 11/22/18, 11/23/18, 11/24/18 and on 11/25/18, the reason documented was pending medications delivery.
-She did not know Resident #8 was not administered melatonin 5mg on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19 or on 02/09/19 and on 02/10/19, the reason documented as pending medication delivery.
-She did not know Resident #8's melatonin 5mg was not available for administration as ordered on 02/11/19.
-"If (Resident #8) was not taking his medications as ordered, I could not treat his symptoms or provide the best care."
-The facility staff did not notify her any medications were missed, "I definitely want to know if my patients were missing medications.

Interview with the Administrator on 02/11/19 at 12:30pm revealed:
-She did not know Resident #8 had missed 4 consecutive days of melatonin 5mg 11/22/18, 11/23/18, 11/24/18 and on 11/25/18, the reason documented as pending medication delivery.
-She did not know Resident #8 had missed melatonin 5mg as ordered on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19 or on 02/09/19 and on 02/10/19, the reason documented as pending medication delivery.
-She expected the MAs to notify the PCP or the NP when a resident missed three consecutive days of medications and to document in the eMAR or the resident's record.

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Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am.

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

b. Review of Resident #8's current FL2 dated 11/28/18 revealed medication orders included Seroquel 50mg at bedtime.

Review of Resident #8's hospital discharge summary dated 11/28/19 revealed:
-Resident #8 was admitted to the hospital with the diagnosis of agitation.
-Resident #8 was an involuntary commitment "as he might pose a threat to himself or others."
-There was an order for Resident #8 to have a psychiatric evaluation while in the hospital.
-Home medications at discharge included Seroquel 50mg each night at bedtime.
-Resident #8 returned to the facility SCU on 11/28/19.

Review of Resident #8's November 2018 electronic Medication Record Administration

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(eMAR) revealed:
-There was an order entry for Seroquel 50mg (used for psychosis) scheduled for 8:00pm.
-There was documentation Seroquel 50mg was not administered as ordered for three consecutive days on 11/23/18, 11/24/18 and on 11/25/18.

Review of Resident #8's resident record and the eMAR charting notes revealed no documentation Resident #8's primary care physician (PCP) or the psychiatric Nurse Practitioner (NP) had been notified regarding Seroquel not being administered.

Review of Resident #8's record revealed a signed physician order dated 12/09/18 discontinue Seroquel 50mg at bedtime.

Telephone interview with the facility contract Pharmacist on 02/11/19 at 10:15am revealed:
-The pharmacy had dispensed Resident #8's order for Seroquel 50mg at bedtime on 10/24/18, quantity of 30 tablets, and on 11/28/18 a quantity of 30 tablets.
-The Seroquel 50mg at bedtime was discontinued on 12/09/18.

Interview with Resident #8's Nurse Practitioner on 02/07/19 at 2:38pm revealed:
-The psychiatry team was following Resident #8's psychiatric medications, which included Seroquel.
-He did not know Resident #8 was not administered the Seroquel for three days.
-He would expect the facility to contact the psychiatric team with the missed medications.

Telephone interview with Resident #8's psychiatric NP on 02/11/19 at 11:20am revealed:
-Resident #8 had been prescribed Seroquel 50mg but the order had been discontinued, and a

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new medication had been prescribed.
-"I would want to know if any medications were missed."
-She did not know Resident #8's Seroquel 50mg was not administered for three consecutive nights on 11/23/18, 11/24/18 and on 11/25/18, the reason given as pending medication delivery.

Interview with the Administrator on 02/11/19 at 12:30pm revealed:
-She did not know Seroquel 50mg was not administered to Resident #8 for three consecutive nights on 11/23/18, 11/24/18 and on 11/25/18, the reason given as pending medication delivery.
-She expected the MAs to notify the PCP or the NP when a resident missed three consecutive days of medications and to document in the eMAR or the resident's record.

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

Interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am revealed:
-The MAs were to tell her when a resident missed any medications, "These residents in SCU need all their meds administered due to dementia and behaviors."
-If a medication is missed more than three consecutive days, the physician must be contacted.
-The MAs were to notify the PCP by calling them and documenting the call in the resident's eMAR or the resident's record.
-"There must be a communication problem with the MAs not reporting missed meds to me."
-"Our policy is the physician must be notified if a resident missed three consecutive days of their medications."

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Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am.

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

2. Review of Resident #5's current FL2 dated 11/07/18 revealed diagnoses included dementia, hypertension, cataracts, arrhythmia, and atrial fibrillation.

a. Review of Resident #5's current FL2 dated 11/07/18 revealed a physician's order for potassium chloride 10mEq CR one capsule two times daily (a mineral supplement used to treat or prevent low amounts of potassium in the blood).

Review of Resident #5's physician's orders dated 11/16/18 revealed a medication order for potassium chloride ER 20mEq one tablet daily.

Review of Resident #5's February 2019 electronic Medication Administration Record (eMAR)

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revealed:
-There was documentation Resident #5 was not administered potassium chloride as ordered for 7 of 7 opportunities from 02/01/19 through 02/07/19.
-There was documentation Resident #5 was not administered potassium chloride on 02/01/19, 02/02/19 and 02/03/19 due to "unable to tolerate."
-There was documentation Resident #5 was not administered potassium chloride on 02/04/19, 02/06/19 and 02/07/19 due to "medication pending delivery."
-There was documentation Resident #5 was not administered potassium chloride on 02/05/19 due to "waiting on order for capsules."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with a medication aide (MA) on 02/07/19 at 10:15am revealed:
-She noticed Resident #5 did not have potassium chloride available for administration and planned to follow-up with the pharmacy later that day.
-She had never been told to notify the Primary Care Physician (PCP) if a resident missed medications.

Interview with a second MA on 02/08/19 at 12:45pm revealed:
-When she attempted to administer potassium chloride to Resident #5 on 02/01/19, she realized the potassium chloride was in a tablet form and had instructions to do not crush or chew and Resident #5 had an order to crush all

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medications.
-She did not administer the potassium chloride to Resident #5 and documented on the eMAR "unable to tolerate."
-She then alerted one of the Wellness Nurses (she could not remember which one) and assumed they were contacting Resident #5's Primary Care Provider (PCP) for an order for the capsule form of potassium chloride.
-The last time she administered medications prior to 02/01/19 was 01/18/19 and at that time Resident #5's potassium chloride was in capsule form that could be opened and sprinkled into her applesauce.
-She did not follow back up with the Wellness Nurse or the pharmacy regarding Resident #5's potassium chloride and had no explanation as to why she had not done so.
-She had never been told to notify the PCP if a resident missed medications.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed:
-She had only learned about Resident #5 not having potassium chloride available for administration today (02/08/19) when the hospice RN told her she had ordered it from the pharmacy as a STAT order on 02/07/19 and asked if it came in.
-She had contacted the pharmacy and they said Resident #5's potassium chloride would be delivered to the facility today (02/08/19).
-She was not aware Resident #5 did not have potassium chloride available for administration so she had not notified the PCP.

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Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-It was important Resident #5 received potassium chloride as ordered because she was administered Lasix 20mg three times daily for edema and heart failure.
-If Resident #5 was not administered potassium chloride, it could cause her to have cardiac arrhythmias.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-Resident #5 not being administered potassium chloride while taking Lasix could cause an electrolyte imbalance.
-She would send an order to the facility immediately to have Resident #5's lab work drawn to check for electrolyte imbalances and kidney function.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5

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D 273	Continued From page 17 had missed any doses of her medications. Refer to interview with the Administrator on 02/07/19 at 2:40pm. Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am. Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am. Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm. Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am. Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm. b. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for trazodone 50mg one half tablet (25mg) at bedtime (a medication used as a sedative and to treat depression). Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for trazadone 50mg one half tablet to be administered at 7:00pm. -There was documentation Resident #5 was not administered trazadone for 5 of 31 opportunities from 12/09/18 through 12/13/18 due to "medication pending delivery." Review of Resident #5's January 2019 eMAR	D 273		

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revealed:
-There was an entry for trazadone 50mg one half tablet to be administered at 7:00pm.
-There was documentation Resident #5 was not administered trazadone for 3 of 31 opportunities from 01/05/19 through 01/07/19 due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for trazadone 50mg one half tablet to be administered at 7:00pm.
-There was documentation Resident #5 was not administered trazadone for 5 of 6 opportunities from 02/02/19 through 02/06/19 due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with a medication aide (MA) on 02/07/19 at 10:15am revealed:
-She had documented Resident #5 was not administered trazadone for three days from 02/04/19-02/06/19.
-She had not contacted the pharmacy to follow-up with them regarding Resident #5's trazodone and did not have an explanation as to why she had not done so.
-She had never been told to notify the Primary Care Physician (PCP) if a resident missed medications.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident

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#5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-Not being administered trazadone could cause Resident #5 to feel anxious.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-It was not likely Resident #5 would have any adverse side effects to not being administered trazadone, but she expected the facility to administer medications as ordered.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

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Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

c. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for divalproex sodium 125mg 1 capsule three times daily (a medication used to treat seizures and bipolar disorder).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for divalproex sodium 125mg one capsule to be administered three times daily at 7:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered divalproex sodium for 6 of 93 opportunities from 12/29/18 at 7:00pm through 12/31/18 at 3:00pm due to "medication pending delivery."

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Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for divalproex sodium 125mg one capsule to be administered three times daily at 7:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered divalproex sodium for 1 of 93 opportunities on 01/03/19 at 3:00pm due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for divalproex sodium 125mg one capsule to be administered three times daily at 7:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered divalproex sodium for 5 of 19 opportunities from 02/01/19 at 3:00pm through 02/02/19 at 7:00pm due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Telephone interview with the hospice Registered

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Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

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Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

d. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for Lasix 20mg tablets take 60mg two times daily (a medication used to treat fluid retention).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lasix 20mg three tablets to be administered two times daily at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered Lasix for 3 of 62 opportunities from 12/17/18 at 7:00pm through 12/19/18 at 7:00am due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for Lasix 20mg three tablets to be administered two times daily at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered Lasix for 6 of 62 opportunities from 01/07/19 at 7:00am through 01/09/19 at 7:00pm due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

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Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

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Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

e. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for Lotemax 0.5% ophthalmic solution place one drop in both eyes four times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm (a medication used to treat redness, itching and watering of the eyes).

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for Lotemax 0.5% instill one drop in both eyes four times daily to be administered at 7:00am, 11:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered Lotemax for 4 of 124 opportunities from 01/02/19 at 7:00pm through 01/03/19 at 3:00pm due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or

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the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any other medications so she had not contacted the PCP.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5

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had missed any doses of her medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

f. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for Risperdal 0.25mg one tablet daily (a medication used to treat psychosis).

Review of Resident #5's physician's orders dated 10/27/18 revealed a medication order for Risperdal 0.25mg one tablet three times daily.

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 3:00pm and 8:00pm.
-There was documentation Resident #5 was not administered Risperdal for 4 of 93 opportunities

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from 12/30/18 at 8:00pm through 12/31/18 at 8:00pm due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 3:00pm and 8:00pm from 01/01/19 through 01/25/19.
-There was a second entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 2:00pm and 8:00pm with a start date of 01/26/19.
-There was documentation Resident #5 was not administered Risperdal for 13 of 93 opportunities from 01/01/19 at 3:00pm through 01/03/19 at 3:00pm and again from 01/23/19 at 3:00pm through 01/25/19 at 3:00pm due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.

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-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

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Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

g. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for digoxin 125mcg one tablet daily (a medication used to treat heart failure and heart rhythm problems).

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for digoxin 125mcg one tablet to be administered at 7:00am.
-There was documentation Resident #5 was not administered digoxin for 3 of 31 opportunities from 01/12/19 through 01/14/19 due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.

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-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.
-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

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Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

h. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for diltiazem 240mg one capsule two times daily (a medication used to treat hypertension and chest pain).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for diltiazem 240mg one capsule to be administered at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered diltiazem for 5 of 62 opportunities from 12/29/18 at 7:00pm through 12/31/18 at 7:00pm due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for diltiazem 240mg one capsule to be administered at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered diltiazem for 4 of 62 opportunities from 01/01/19 at 7:00am through 01/01/19 at 7:00pm and again from 01/02/19 at 7:00pm through 01/03/19 at 7:00am due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for diltiazem 240mg one capsule to be administered at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered diltiazem for 1 of 13 opportunities

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on 02/02/19 at 7:00pm due to "medication pending delivery."

Review of Resident #5's record and the eMAR charting notes revealed no documentation Resident #5's primary care physician (PCP) or the hospice Registered Nurse (RN) had been notified regarding any of Resident #5's medications not being available for administration.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications so she had not contacted the PCP.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She was not aware Resident #5 had missed any medications.
-She expected to be notified if Resident #5 missed one dose of any medication because she could also follow-up with the pharmacy.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.

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-She expected the facility to follow their own policy for when to notify her if a resident's medications were not available for administration.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

3. Review of Resident #6's current FL-2 dated 12/17/18 revealed diagnoses included unspecified cerebral infarction, dementia with behaviors, and constipation.

Review of Resident #6's resident register revealed he was admitted on 12/22/18.

a. There was a medication order for divalproex 125mg one tablet twice daily (a medication used

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to treat agitation and stabilize mood).

Review of Resident #6's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for divalproex 125mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation divalproex was administered for 17 out of 19 opportunities.
-There was documentation divalproex was not administered on 12/22/18 at 8:00pm due to "drug refused".
-There was documentation divalproex was not administered 12/23/18 at 7:00am due to "hospitalized".

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for divalproex 125mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation divalproex was not administered 3 out of 62 opportunities.
-There was documentation divalproex was not administered on 01/29/19 at 8:00pm, 01/31/19 at 7:00am, and 01/31/19 at 8:00pm due to "medication pending delivery."

Review of Resident #6's February 2019 eMAR revealed:
-There was an entry for divalproex 125mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation divalproex was not administered 18 out of 21 opportunities.
-There was documentation divalproex was not administered on 02/02/19-02/11/19 at 7:00am, and 02/01/19-02/02/19, 02/04/19-02/10/19 at 8:00pm due to "medication pending delivery".

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Review of Resident #6's record and progress notes revealed no documentation Resident #6's primary care provider (PCP) had been notified regarding divalproex not being administered.

Observation of Resident #6's medications available for administration on 02/08/19 at 9:59am revealed divalproex was not available for administration.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed:
-Resident #6 had been out of divalproex for "a while".
-MAs were responsible for notifying the Wellness Nurse (WN) about missed medications after three missed doses.
-The WN was responsible to notifying the physician if a medication was missed.
-She thought the WN knew about the missed dosages of divalproex.

Telephone interview with a second shift MA on 02/08/19 at 12:48pm revealed:
-She could not remember if she administered divalproex to administer Resident #6.
-She could not remember if she notified the WN about the medication notified being available.
-If the medication was not available for administration, she would have contacted the pharmacy and notified the WN.
-"I really don't know, I don't work on the cart often".
-The WN would be responsible for notifying the physician if a medication was missed.

Interview with the WN on 02/11/19 at 12:50pm revealed:
-She did not know Resident #6 had missed any

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doses of divalproex.
-She did not know divalproex was not available for administration.
-She would expect the MAs to notify her if a medication was not available so that she could notify the physician.
-She had not notified the physician because she did not know about the missed doses of divalproex.

Interview with the Regional RN on 02/08/19 at 11:03am revealed:
-She did not know Resident #6 had missed any doses of divalproex.
-The WN or the RCD would be responsible for notifying the physician after 3 missed doses of medication.

Telephone interview with a nurse from Resident #6's primary care provider's (PCP) office on 02/08/19 at 4:40pm revealed:
-He did not know Resident #6 had missed doses of divalproex.
-He would expect to be notified of missed doses of medications.

Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She did not know Resident #6 had missed any doses of divalproex.
-She expected the MAs to notify the WN after the resident had missed one dose of medication.
-She expected the WN to notify the physician after 3 missed doses.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

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Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

b. Review of Resident #6's FL2 dated 12/17/18 revealed a medication order for carvedilol 3.125mg three tablets twice daily (used to treat high blood pressure and control heart rate).

Review of Resident #6's December 2018 eMAR revealed:
-There was an entry for carvedilol 3.125mg three tablets to be administered twice daily at 7:00am and 8:00pm.
-There was documentation carvedilol was administered for 17 out of 19 opportunities.
-There was documentation carvedilol was not administered on 12/22/18 at 8:00pm due to "drug refused".
-There was documentation carvedilol was not administered 12/23/18 at 7:00am due to "hospitalized".

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for carvedilol 3.125mg three tablets to be administered twice daily at 7:00am and 8:00pm.

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-There was documentation carvedilol was administered 62 out of 62 opportunities.

Review of Resident #6's February 2019 eMAR revealed:
-There was an entry for carvedilol 3.125mg three tablets to be administered twice daily at 7:00am and 8:00pm.
-There was documentation carvedilol was not administered 6 out of 21 opportunities.
-There was documentation carvedilol was not administered on 02/07/19-02/08/19 at 7:00am, and 02/02/19, 02/05/19-02/07/19 at 8:00pm due to "medication pending delivery".

Review of Resident #6's record and progress notes revealed no documentation Resident #6's primary care provider (PCP) had been notified regarding carvedilol not being administered.

Observation of Resident #6's medications available for administration on 02/08/19 at 9:59am revealed carvedilol was not available for administration.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed:
-She did not work the medication cart frequently.
-She noticed on today that the carvedilol was not available for administration.
-She was going to notify the WN on today that the medication was not available.
-She did not know if Resident #6's PCP had been notified, she thought it was the WN responsibility to notify the physician.

Telephone interview with a second shift medication aide (MA) on 02/08/19 at 12:48pm revealed:
-She could not remember if she administered

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carvedilol to Resident #6.
-If a medication was not available for administration, she would have notified the WN.
-The WN would be responsible for notifying the physician of missed doses.
-She could not remember if she notified the WN of missed doses.

Interview with the WN on 02/11/19 at 12:50pm revealed:
-She did not know Resident #6 had missed any doses of carvedilol.
-She did not know carvedilol was not available for administration.
-MAs were responsible for notifying her of missed doses of medications.
-She had not notified the physician because she did not know about the missed doses of carvedilol.

Interview with the Regional RN on 02/08/19 at 11:03am revealed:
-She did not know Resident #6 had missed any doses of carvedilol.
-The MAs were responsible for reporting to the WN after a resident missed one dose of medication.
-The WN and RCD would be responsible for notifying the physician after 3 missed doses.

Telephone interview with a nurse from Resident #6's primary care provider's (PCP) office on 02/08/19 at 4:40pm revealed:
-He did not know Resident #6 had missed doses of carvedilol.
-Resident #6 missing carvedilol could cause his heart rate and blood pressure to increase.
-He would want to be notified of any missed doses of medications.

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Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She did not know Resident #6 had missed any doses of carvedilol.
-She expected the MAs to notify the WN after the resident had missed one dose of medication.
-She expected the WN to notify the physician after three missed doses of medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

c. Review of Resident #6's FL2 dated 12/17/18 revealed a medication order for docusate sodium 100mg one tablet twice daily (used to treat constipation).

Review of Resident #6's December 2018 eMAR revealed:
-There was an entry for docusate sodium 100mg one tablet to be administered twice daily at 7:00am and 8:00pm.

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-There was documentation docusate sodium was administered for 17 out of 19 opportunities.
-There was documentation docusate sodium was not administered on 12/22/18 at 8:00pm due to "drug refused".
-There was documentation docusate sodium was not administered 12/23/18 at 7:00am due to "hospitalized".

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for docusate sodium 100mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation docusate sodium was not administered 9 out of 62 opportunities.
-There was documentation docusate sodium was not administered on 01/14/19-01/17/19 at 7:00am and 01/13/19-01/17/19 at 8:00pm due to "medication pending delivery".

Review of Resident #6's record and progress notes revealed no documentation Resident #6's primary care provider (PCP) had been notified regarding docusate sodium not being administered.

Observation of Resident #6's medications available for administration on 02/08/19 at 9:59am revealed docusate sodium was available for administration.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed:
-She did not know what happened with Resident #6's docusate sodium in January 2019.
-She could not remember if she notified the WN about Resident #6's docusate sodium not being available for administration.
-She had not notified the physician about missed

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doses of docusate sodium.
-The WN was responsible for notifying the physician about missed doses of medications.

Telephone interview with a second shift medication aide (MA) on 02/08/19 at 12:48pm revealed:
-She could not remember Resident #6 missing doses of docusate sodium in January 2019.
-She could not remember if she notified the WN about the medication notified being available.
-If a medication was not available for administration, she would notified the WN.
-The WN was responsible for notifying the physician of missed doses of medication.
-"I really don't know, I don't work on the cart often".

Interview with the WN on 02/11/19 at 12:50pm revealed:
--She did not know Resident #6 had missed any doses of docusate sodium.
-She would expect the MAs to notify her if a medication.
-She was responsible for notifying the physician after 3 missed doses of medication.
-She had not notified the physician about missed doses of docusate sodium because she did not know it was missed.

Interview with the Regional RN on 02/08/19 at 11:03am revealed:
-She did not know Resident #6 had missed any doses of docusate sodium.
-The MAs were responsible for reporting to the WN after a resident missed one dose of medication.
-The WN and RCD would be responsible for notifying the physician after three missed doses of medication.

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Telephone interview with a nurse from Resident #6's primary care provider's (PCP) office on 02/08/19 at 4:40pm revealed:
-The physician did not know Resident #6 had missed doses of docusate sodium.
-The physician would want to be notified of any missed doses of medications.

Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She did not know Resident #6 had missed any doses of docusate sodium.
-She expected the MAs to notify the WN after the resident had missed one dose of medication.
-She expected the WN to notify the physician after 3 missed doses of medications.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

4. Review of Resident #2's current FL-2 dated

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D 273	Continued From page 45 02/05/19 revealed: -Diagnoses included right basil ganglia stroke. -There was a medication order albuterol 90mcg two puffs four times daily as need (used to treat wheezing and shortness of breath). -There was a medication order for alendronate 70mg one tablet every Friday (used to prevent osteoporosis). -There was a medication order for aspirin 325mg one tablet at bedtime (used to prevent blood clots). -There was a medication order for calcium carbonate 500mg two tablets daily as needed (used to treat acid reflux) -There was a medication order for cholecalciferol 1000 units one tablet daily (used to treat vitamin D deficiency). -There was a medication order for clopidogrel 75mg one tablet daily (used to prevent blood clots and stroke). -There was a medication order for cyanocobalamin 100mcg one tablet daily (used to treat vitamin B12 deficiency). -There was a medication order for donezepil 10mg one tablet at bedtime (used to treat memory loss). -There was a medication order for fluticasone nasal 50mcg two sprays in each nostril daily (used to allergies). -There was a medication order for furosemide 20mg one tablet daily (used to treat fluid retention). -There was a medication order for gabapentin 800mg one tablet three times daily (used to treat neuropathy). -There was a medication order for loperamide two tablets every morning as needed (used to treat diarrhea). -There was a medication order for metoprolol tartrate 25mg one tablet twice daily (used to treat	D 273		

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high blood pressure).
-There was a medication order for ocular lubricant one drop in each eye twice daily (used to treat dry eyes).
-There was a medication order for pantoprazole 40mg one tablet daily (used to treat indigestion).

Review of Resident #2's progress notes dated 02/05/19 revealed "resident arrived about 1:30pm via transport" from a skilled rehabilitation facility.

Interview with Resident #2 on 02/06/19 at 10:30am revealed:
-She had been in a skilled rehabilitation facility before returning to the facility on 02/05/19.
-She came back and was supposed to be taking a blood thinner but none of her medications were available.
-She had not received her medication last night (02/05/19) or this morning (02/06/19).
-"I had a stroke, it is very dangerous for me to miss my medications".
-"The Resident Care Director (RCD) promised me that my medications would be here".
-"I don't know what happened, I don't understand".

Review of Resident #2's record and progress notes revealed no documentation Resident #2's primary care provider (PCP) had been notified regarding all medications not being available.

Review of Resident #2's February 2019 electronic Medication Administration Record (eMAR) revealed:
-All medications were not administered in the evening on 02/05/19 and in the morning on 02/06/19 due to "medication pending delivery".

Interview with a medication aide (MA) on

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02/07/19 at 12:40pm revealed:
-Resident #2 came back to the facility on 02/05/19 and her medication were not available for administration.
-She did not knot know if the physician had been notified about Resident #2 missing her medications.
-The Wellness Nurse (WN) would be responsible for notifying the physician of missed doses of medications.

Telephone interview with Resident #2's physician on 02/11/19 at 11:39am revealed:
-She did not know Resident #2 missed any of her medications since returning to the facility.
-No one informed her of any missed medications, she would expect to be notified.

Interview with WN on 02/11/19 at 12:50pm revealed:
-The RCD was responsible for faxing the FL2 to the pharmacy to get medications delivered when a resident was admitted.
-The RCD recently resigned, she did not know why the medications were delivered.
-She had not notified the physician of medication being missed because they were ordered immediately.

Interview with the Regional RN on 02/11/19 at 1:41pm revealed:
-She did not know Resident #2 medications were not available or requested when she arrived on 02/05/19.
-WNs were responsible for notifying the physician after 3 missed doses, however medications used to prevent stroke or heart attack should be discussed with the physician after one missed dose.

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Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She would expect the FL2 to be faxed to the pharmacy once a resident returned or admitted to the facility.
-She expected the WNs to ensure the FL2 was faxed since the RCD resigned.
-She would expected the WN to notify the physician if the resident missed medications after one missed dose of medications used to prevent a stroke or a heart attack.
5. Review of Resident #1's current FL2 dated 07/05/18 revealed diagnoses included Alzheimer dementia, hypertension and hypothyroidism.

a. Review of Resident #1's current FL2 dated 07/05/18 revealed medications included simvastatin 20mg, one tablet every day.

Review of Resident #1's hospital discharge summary dated 12/30/18 revealed medications included simvastatin 20mg, one tablet daily at bedtime.

Review of Resident #1's December electronic medication administration record (eMAR) from 12/09/18-12/27/18 revealed:
-There was an entry for simvastatin 20mg to be administered daily at 7:00pm.
-On 12/09/18-12/27/18 there was documentation the medication was pending delivery (MD), the medication was not available to be administered as ordered..
-There was documentation simvastatin 20 mg was not administered for 19 of 31 opportunities, from 12/09/18-12/27/18.

Review of Resident #1's record and the December 2018 eMAR progress notes revealed:
-There was no documentation Resident #1's

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primary care physician (PCP) had been notified regarding simvastatin not available to be administered as ordered.
-There was no documentation the pharmacy had been contacted to determine why the medication was "pending delivery."

Attempted phone interview with MD on 02/08/19 at 9:10am and on 02/11/19 at 11:24am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

b. Review of Resident #1's current FL2 dated 07/05/18 revealed medications included sertraline 100mg, one and one half tablets daily at bedtime for depression.

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Review of Resident #1's hospital discharge summary dated 12/30/18 revealed medications included sertraline100mg tablet, one and one half tablets daily.

Review of Resident #1's January electronic medication administration record (eMAR) from 01/08/19-01/11/19 revealed:
-There was an entry for sertraline 100mg, one and one half tablets, to be administered daily at 7:00pm.
-On 01/08/19-01/11/19 there was documentation the medication was not available for administration, pending delivery from the pharmacy.
-There was documentation sertraline 100mg, one and one half tablets, was not administered 4 of 31 opportunities, from 01/08/19-01/11/19.

Review of Resident #1's record and the January 2019 eMAR progress notes revealed:
-There was no documentation Resident #1's primary care physician (PCP) had been notified regarding sertraline not being administered.
-There was no documentation the pharmacy had been contacted to determine why the medication was "pending delivery."

Attempted phone interview with MD on 02/08/19 at 9:10am and on 02/11/19 at 11:24am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

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Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

c. Review of Resident #1's current FL2 dated 07/05/18 revealed medications included Vitamin D3 2000 units one capsule daily.

Review of Resident #1's hospital discharge summary dated 12/30/18 revealed medications included Vitamin D3 2000 units, one capsule daily.

Review of Resident #1's January electronic medication administration record (eMAR) from 01/13/19-01/17/19 revealed:
-There was an entry for Vitamin D3 2000 units, to be administered daily at 7:00am.
-On 01/13/19-01/17/19 there was documentation the medication was pending delivery (MD), and not available for administration as ordered.
-There was documentation Vitamin D3 2000 units was not administered 4 of 31 opportunities, from 01/13/19-01/17/19.

Review of Resident #1's record and the January

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2019 eMAR progress notes revealed:
-There was no documentation Resident #1's primary care physician (PCP) had been notified regarding Vitamin D3 not being administered.
-There was no documentation the pharmacy had been contacted to determine why the medication was "pending delivery."

Attempted phone interview with MD on 02/08/19 at 9:10am and on 02/11/19 at 11:24am unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with Regional registered nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a medication aide (MA) on 02/08/19 at 10:17am.

Refer to telephone interview with a second shift MA on 02/08/19 at 12:48pm.

Refer to interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am.

Refer to interview with a Wellness Nurse on 02/07/19 at 11:07am.

Refer to interview with a second Wellness Nurse on 02/11/19 at 12:50pm.

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Interview with the Administrator on 02/07/19 at 2:40pm revealed:
-She relied on the RCD and the Wellness Nurses

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for the clinical aspects of the facility.
-The RCD was responsible for reviewing the missed medication report daily to determine what follow up was necessary.
-She expected the MAs to notify the Wellness Nurse after the resident had missed one dose of medication.
-She thought the RCD and the Wellness Nurses contacted the PCP when there were missed medications.
-She expected the Wellness Nurse to notify the physician after three missed doses.
-It was her expectation the PCP should be notified if a resident's medications were missed.

Interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am revealed:
-The RCD was responsible for oversight of medication orders, eMARs, and she was the primary pharmacy liaison in the community.
-The RCD was to print a daily report, the Administration Summary Report, showing the medications waiting to be received, missed medications and the documented reason indicated by chart code for the missed medications.
-The RCD should follow up with the PCP if a resident missed three doses of medication.
-The MAs could also contact the PCP regarding missed doses of medication, but it was the responsibility of the RCD.
-The RCD did not complete her responsibilities in notifying PCPs of missed medications.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed the Wellness Nurse was responsible for notifying the PCP if a medication was missed.

Telephone interview with a second shift MA on

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02/08/19 at 12:48pm revealed the Wellness Nurse would be responsible for notifying the PCP if a medication was missed.

Interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am revealed:
-The MAs were to tell the SCUC when a resident missed any medications.
-If a medication was missed more than three consecutive days, the PCP must be contacted.
-The MAs were to notify the PCP by calling them and documenting the call in the resident's eMAR or the resident's record.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed:
-There were three part-time Wellness Nurses employed at the facility.
-It was the responsibility of the Wellness Nurses and the RCD to notify the PCP when a resident did not have medications available for administration.

Interview with a second Wellness Nurse on 02/11/19 at 12:50pm revealed:
-There were a few Wellness Nurses working for the facility while a permanent Wellness Nurse was being hired.
-A missed medications report (the Administration Summary Report) was supposed to be reviewed daily by the RCD, however she resigned.
-Based on this report, the RCD would follow up with the PCP.
-She did not know if anyone was reviewing the Administrative Summary Report at this time.
-She would notify the physician if she knew a resident had missed medications.

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The failure of the facility to assure physician

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notification related to missed medications for 5 of 7 residents placed Resident #8 at an increased risk for his symptoms of aggression and agitation not being treated, placed Resident #5 at an increased risk of an electrolyte imbalance and heart arrhythmias, placed Resident #6 at an increased risk for agitation, aggression and stroke, and placed Resident #2 at an increased risk for a hospitalization. The facility's failure to notify the physicians regarding missed medications was detrimental to the health and safety of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/07/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 28, 2019.

D 276 — 10A NCAC 13F .0902(c)(3-4) Health Care — D 276

10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 1 of 3 sampled residents (Resident #4) with orders for daily blood pressures.

The findings are:

Review of Resident #4's current FL2 dated 06/21/18 revealed:
-Diagnoses included hypertension, chronic kidney disease and diabetes.
-Medication orders included amlodipine 10mg daily "hold for systolic blood pressure (SBP) less than 125."

Review of Resident #4's December 2018 electronic medication administration record (eMAR) revealed:
-There was an order entry for amlodipine 10mg one time daily for hypertension, hold for systolic blood pressure less than 125, scheduled for 7:00am.
-There was documentation amlodipine 10mg was administered 31 times the month of December 2018.
-There was no entry on the eMAR for documentation of blood pressures daily prior to administering the amlodipine 10mg.

Review of Resident #4's January 2019 eMAR revealed:
-There was an entry for amlodipine 10mg one time daily for hypertension, hold for systolic blood pressure less than 125, scheduled for 8:00am.
-There was documentation amlodipine was administered 31 times the month of January 2019.

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-There was no entry on the eMAR for documentation of blood pressures daily prior to administering the amlodipine 10mg.

Review of Resident #4's February 2019 eMAR from 02/01/19-02/08/19 revealed:
-There was an entry for amlodipine 10mg one time daily for hypertension, hold for systolic blood pressure less than 125 scheduled for 8:00am.
-There was documentation amlodipine was administered 8 times the month of February 2019.
-There was no entry on the eMAR for documentation of blood pressures daily prior to administering the amlodipine 10mg.

Interview with a medication aide (MA) on 02/06/19 at 11:10am revealed:
-She had known Resident #4 had "high blood pressure" and was taking amlodipine 10mg.
-She did not know the order entry for the amlodipine 10mg included obtaining a blood pressure prior to administering the amlodipine and hold if the systolic blood pressure was less than 125.
-She had never obtained a blood pressure for Resident #4, "there is nowhere to document a blood pressure on the eMAR."

Interview with the Administrator on 02/06/19 at 3:35pm revealed:
-She did not know the MAs were not obtaining a blood pressure prior to administering the amlodipine 10mg to Resident #4.
-She relied on the RCD to enter orders in the eMAR and to check the resident's eMARs for incorrect medications and missed medications.
-There was no one assigned to follow-up on the RCD for completion of her responsibilities.
-She expected the physician's orders to be

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carried out as ordered.

Interview with the Wellness Nurse on 02/07/19 at 3:00pm revealed:
-She did not know of the blood pressure order for Resident #4.
-She was not sure why the MAs were not obtaining the blood pressure prior to administering the amlodipine.
-"The physician's orders should be followed".
-The RCD was responsible for entering all new orders on the eMAR.

Interview with the Regional Registered Nurse on 02/07/19 at 3:08pm revealed:
-The MAs were responsible for documenting on the eMARs.
-The MAs should be documenting the blood pressures prior to administering the amlodipine to Resident #4.
-"My guess is the blood pressures got over looked for Resident #4 due to not having an entry on the eMAR to document the blood pressures results."
-"The MAs were responsible for documenting the blood pressures and medications on the eMAR.
-The RCD was responsible for entering all new orders on the eMAR.

The former RCD was not available for another interview on 02/07/19, 02/08/19 or on 02/11/19.

Interview with Resident #4's Nurse Practitioner (NP) on 02/07/19 at 2:38pm revealed:
-He expected the staff to carry out the orders for blood pressure.
-He would not have written the order if he did not want the blood pressure taken prior to administering the medication.

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D 276	Continued From page 59 Interview with Resident #4 on 02/07/19 at 4:00pm revealed: -She knew she had "high blood pressure" and was taking medications for it. -She was unsure what medications she took for her high blood pressure. -She relied on the facility to administer her medication and was unsure what medications she took every day. -She thought the staff had obtained her blood pressure a few weeks ago.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure contact with the prescribing physician for clarification of orders	D 344		

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for 1 of 8 sampled residents (Resident #3) related to orders for the administration of Lasix.

The findings are:

Review of Resident #3's current FL2 dated 01/08/19 revealed:
-Diagnoses included hypertension.
-There was a medication order for Lasix 20mg to be administered two times daily (a medication used to treat fluid retention).

Review of Resident #3's physician's orders dated 09/25/18 revealed an order for Lasix 20mg one tablet to be administered one time daily.

Review of Resident #3's September and October 2018 electronic medication administration records (eMAR) revealed:
-There was an entry for Lasix 20mg one tablet to be administered once daily at 9:00am.
-There was documentation Resident #3 was administered Lasix 20mg one tablet daily at 9:00am from 09/01/18 through 10/31/18.

Review of Resident #3's November 2018 eMAR revealed:
-There was an entry for Lasix 20mg one tablet to be administered at 9:00am daily with a start date of 06/21/18 and a discontinue date of 11/13/18.
-There was documentation Resident #3 had been administered Lasix 20mg one tablet at 9:00am from 11/01/18 through 11/13/18.
-There was an entry for Lasix 20mg two tablets to be administered at 9:00am daily with a start date of 11/14/18.
-There was documentation Resident #3 had been administered Lasix 20mg two tablets daily at 9:00am from 11/14/18 through 11/30/18.

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Review of Resident #3's December 2018, January and February 2019 eMARs revealed:
-There was an entry for Lasix 20mg two tablets to be administered at 9:00am.
-There was documentation Resident #3 had been administered Lasix 20mg two tablets daily at 9:00am from 12/01/18 through 02/06/19.

Observation of Resident #3's medications available for administration on 02/08/19 at 12:25pm revealed there was no Lasix available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/08/19 at 3:26pm revealed:
-They received faxed physician's orders for Resident #3 on 09/25/18 with an order for Lasix 20mg two tablets once daily.
-They had not received any orders for Resident #3's Lasix since 09/25/18.
-They had dispensed 60 tablets of Lasix 20mg for Resident #3 on 09/24/18, 12/03/18, 12/27/18 and 02/08/19.

Interview with the facility's Regional Registered Nurse (RN) on 02/08/19 at 2:00pm revealed:
-She could not locate an order dated 11/14/18 for Resident #3 to be administered Lasix 20mg two tablets once daily as was entered on the eMAR.
-According to the signed physician's orders, Resident #3 should have been administered Lasix 20mg one tablet once daily from 09/25/18 to 01/08/19 and then increased to Lasix 20mg one tablet twice daily on 01/08/19.
-She could not explain why Resident #3 had been administered Lasix 20mg two tablets once daily from 11/14/18 through 02/06/19.

Telephone interview with Resident #3's Hospice

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RN on 02/08/19 at 3:29pm revealed:
-Resident #3 had been on Hospice services since 06/28/18.
-Resident #3 was ordered Lasix due to a diagnosis of heart failure.
-The Hospice physician had ordered Lasix 20mg two tablets once daily on 06/27/18.
-The Hospice physician had signed Resident #3's orders dated 09/25/18 with Lasix 20mg one tablet once daily, but had not intended to change the order from Lasix 20mg two tablets once daily.
-The Hospice Nurse Practitioner (NP) had signed Resident #3's FL2 dated 01/08/19 with the order for Lasix 20mg to be administered two times daily.
-The NP and physician wanted Resident #3 to be administered Lasix 20mg two tablets once daily and they had not intended to change the order since it was originally given on 06/27/18.
-The facility had not contacted Hospice to request clarification on the order changes for Resident #3's Lasix.

Interview with the Wellness Nurse on 02/11/19 at 10:45am revealed:
-There were three part-time Wellness Nurses employed at the facility.
-The Wellness Nurses were responsible for printing current medication orders from the eMAR system every six months and sending them to the physician to be signed.
-The Wellness Nurses were responsible for entering medications onto renewal FL2s by reviewing residents' current eMARs and sending the FL2s to physicians to be signed.
-She did not complete Resident #3's FL2 dated 01/08/19 and was not sure which Wellness Nurse had done so.
-Whomever entered Resident #3's orders onto the FL2 must have misread the order for Lasix

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D 344	Continued From page 63 20mg two tablets once daily on the January eMAR and had typed it into the FL2 as Lasix 20mg one tablet twice daily. -There was not a second person who reviewed the FL2s for accuracy neither before sending them to the physician nor after receiving them back. -If the Wellness Nurses had noticed the order on the FL2 was different from what had been previously administered, they would have contacted the physician for clarification. Interview with the Administrator on 02/11/19 at 1:25pm revealed: -She expected staff to obtain clarification if there were medication orders on an FL2 or physician's order sheet that did not match what the resident was currently being administered. -The Wellness Nurses were responsible for getting FL2s and physician's orders signed by the physician.	D 344		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a	D 352		

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single unit or unit dose package that already has an expiration date;
(8) auxiliary statements as required of the medication;
(9) the name, address, telephone number of the dispensing pharmacy; and
(10) the name or initials of the dispensing pharmacist.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure Lantus insulin was properly labeled for 1 of 8 sampled residents (Resident #4).

The findings are:

Review of Resident #4's current FL2 dated 06/21/18 revealed:
-Diagnoses included hypertension, chronic kidney disease and diabetes.
-Medication orders included Lantus (a long acting insulin used to control blood sugar levels) inject 15 units subcutaneously (SQ) at bedtime.

Review of Resident #4's record revealed:
-A physician's order dated 09/05/18 that included increase Lantus to 40units SQ daily.
-A physician's order dated 10/28/18 increase Lantus to 45units SQ daily.
-A physician's order dated 11/12/19 Lantus 20 units SQ at bedtime.

Review of Resident #4's November 2018, January and February 2019 eMAR revealed there was an entry for Lantus inject 20 units SQ at bedtime scheduled for 8:00pm.

Observation of Resident #4's Lantus insulin pen available in the medication cart on 02/06/19 at

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3:52pm revealed:
-There was a Lantus insulin pen located in the top drawer of the medication cart.
-The Lantus pen was inside a plastic bag that had a pharmacy generated label.
-The Lantus pen had been labeled by the facility staff with Resident #4's name.
-The pharmacy generated label on the plastic bag had Resident #4's name listed.
-The pharmacy generated label read as follows:
-Lantus solostar 100units/1ml
-Inject 40 units everyday subcutaneously at bedtime.
-The fill date was 09/05/18 with 3 of 4 insulin pens dispensed to the facility.
-Hand written "opened 02/08/19" was documented on the plastic bag.

Interview with the Regional Registered Nurse on 02/06/19 at 4:15pm revealed:
-The RCD was responsible for reviewing medication orders, reviewing the eMAR daily and completing cart audits weekly.
-She did not know Resident #4's Lantus insulin documented on the eMAR for 20 units at bedtime was not the same as the pharmacy generated label on the plastic bag that contained the Lantus pen which was to administer for 40 units at bedtime.
-Third shift MAs were responsible for receiving and sending back medications to the pharmacy.
-Third shift MA were responsible for placing the new medications on the carts for administration.
-The RCD was responsible for placing all orders on the eMAR and excepting new orders after the pharmacy had reviewed them.
-She was not sure why the pharmacy had not sent new instructions and a new label for Resident #4 when the order for the Lantus had changed.

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-"My guess was the MAs were re-using the bag to hold the pen".
-The facility policy was all medications should be labeled correctly with the resident's name, dosage and administration times.

Interview with a second shift medication aide (MA) on 02/06/19 at 3:45am revealed:
-She had administered Resident #4's Lantus on several occasions and thought the dosage was 20 units.
-She compared the medications to the eMAR prior to administering medications.
-She never had used the scanner or been trained on using the scanners to verify a medication prior to administering.
-She did not know Resident #4's pharmacy generate label on the plastic bag with the Lantus insulin pen was labeled 40 units SQ at bedtime, "I really never looked at the dosage amount just for the Lantus".
-She did know the Lantus was ordered on the eMAR as 20 units at bedtime.
-"I guess whoever received the insulin on third shift just used the old insulin bag to place the pen in."

Interview with a first shift MA on 02/07/19 at 9:08am revealed:
-She was not familiar with Resident #4's medications or Resident #4's eMARs.
-She usually worked on another floor in the facility.
-She compared all the resident's medication to the eMAR prior to administering the medications.
-She was unsure why the pharmacy generated label did not match Resident #4's current order on the eMAR for Lantus insulin.
-"I guess we were just using the same baggie to put the pens in."

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-"I am not sure what happened".
-The medications should be correctly labeled with the resident's name and strength of the drug.
-"I look at the meds and then compare to the computer."
-"I do not work second shift so I cannot speak for them".
-The MAs do not scan the bar code on the medications for verification.
-"We do have scanners in the bottom drawer but we do not use them."
-"I have never been shown how to scan meds or if we are supposed to".

Telephone interview with the contracted facility pharmacist on 02/07/19 at 10:25am revealed:
-The current Lantus insulin order for Resident #4 was 45 units filled 11/30/18.
-The pharmacy had not dispensed any Lantus to the facility since 12/17/18.
-The pharmacy had dispensed 3 Lantus pen each enough for a 30 day supply on 12/17/18.
-The Lantus insulin pens were dispensed with a pharmacy generated label which was included on the plastic bag which held the box of 3 Lantus pens.
-The facility staff were responsible for faxing orders to the pharmacy, but the facility staff entered all orders on the eMAR.
-The pharmacy does not dispense any medications to the facility without a pharmacy generated label which included resident's name, the medication, the dosage, the time and route of administration.

Interview with the Administrator on 02/07/19 at 11:00am revealed:
-She did not know until 02/07/19 Resident #4's Lantus insulin was labeled incorrectly and on the medication cart.

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D 352	Continued From page 68 -She did not know Resident #4's current order for Lantus insulin was for 20 units at bedtime and the pharmacy generated label on the Lantus located on the medication cart was for 40 units of Lantus insulin at bedtime. -She was not sure why the MAs were using an old pharmacy label for the Lantus pens. -The MAs do not use the scanners to scan the medications in the eMAR system -The third shift MAs used the scanner when the pharmacy delivered new medication to the facility. -The third shift MAs were responsible for scanning and double checking the new medications on the eMAR for accuracy. -She was not aware the pharmacy had not received any new orders to decrease the insulin to 20 units SQ at bedtime. -The RCD was responsible for auditing eMARs monthly for "holes and duplicate orders". -She relied on the RCD to oversee all MAs and to fax medication orders to the pharmacy. -She relied on the RCD to place all orders on the eMAR computer system and to complete medication cart audits weekly. -There was no one over-seeing the RCD for completion of resident's order, faxing orders to the pharmacy, or completing medications cart audits. -The facility policy was all medications should be labeled with the resident's name and the correct medication dosage. Interview with Resident #4 on 02/07/19 at 4:00pm revealed she relied on the facility to administer her medication and was unsure how much insulin she received. Review of the facility "Community Medication Oversight Program" revealed: -Weekly cart/MAR checks will be performed and	D 352		

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D 352	Continued From page 69 monitored for expired drugs, poor storage practice, incorrect of missing documentation, general cleanliness and organization cart. -Weekly cart audits will be performed by the RCD or licensed nurse. -Monthly cart audits will include an in-depth audit of medication carts and MAR. -The effectiveness of the weekly medication cart audits was evaluated and training and education opportunities were identified. Attempted interview on 02/07/19, 02/08/19 and on 02/11/19 with the former RCD was unsuccessful.	D 352		
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 and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 358		

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Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 6 of 7 sampled residents (Resident #4, #8, #5, #6, #2, and #1) including Humalog insulin (Resident #4), medications not available for administration including Seroquel and melatonin (Resident #8), medications not available for administration including potassium chloride, trazodone, divalproex sodium, Lasix, Lotemax, Risperdal, digoxin and diltiazem (Resident #5), medications not available for administration including divalproex, docusate sodium and carvedilol (Resident #6), medications not available for administration including albuterol, alendronate, aspirin, calcium carbonate, cholecalciferol, clopidogrel, cyanocobalamin, donezepil, fluticasone nasal spray, furosemide, gabapentin, loperamide, metoprolol tartrate, ocular lubricant and pantoprazole (Resident #2), and medications not available for administration including simvastatin, sertraline and Vitamin D3 (Resident #1).

The findings are:

1. Review of Resident #4's current FL2 dated 06/21/18 revealed:
-Diagnoses included hypertension, chronic kidney disease and diabetes.
-There were orders to check fingerstick blood sugars (FSBS) before meals and at bedtime.
-Medication orders included Humalog (a rapid acting insulin used to reduce blood sugar levels) flexpen Sliding Scale Insulin (SSI), 0-150=0 units, 151-200=2 units, 201-251=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. If the blood sugar was over 400, give 12 units, repeat in 3 hours and apply SSI. If the blood sugar was

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lower than 60 give 1 ampule of glucagon as an intramuscular (IM) injection and recheck FSBS in 20 minutes.

Review of Resident #4's record revealed a signed physician's order dated 10/28/18 to administer Humalog 15 units subcutaneously (SQ) two times daily before breakfast and before lunch along with SSI. Administer 20 units of Humalog prior to dinner along with the SSI. Hold the insulin if the blood sugar (BS) was below 100, give orange juice and recheck in 30 minutes. Notify the physician if the BS was greater than 400.

Observation of the medication pass on 02/06/19 at 11:48am revealed:
-At 11:48am the medication aide (MA) checked Resident #4's FSBS using aseptic technique. The FSBS result was 380.
-The MA removed a plastic bag which contained an insulin pen from the medication cart that was labeled with Resident #4's name.
-The pharmacy generated label, on the plastic bag, was labeled with Resident #4's name with the following directions: "Humalog kwikPen (a rapid acting insulin used to lower blood sugar) inject 15 units subcutaneously before breakfast and lunch along with sliding scale insulin (SSI) and inject 20 units subcutaneously before dinner with SSI."
-There were directions on the Humalog kwikpen to administer 15 units with sliding scale insulin parameters at breakfast and lunch and administer 20 units at dinner with sliding scale insulin parameters.
-The SSI order, which was visible on a computer monitor, indicated the parameters for a FSBS result of 351-400, was 10 units of Humalog.
-The MA primed the Humalog pen, loaded the cartridge with 25 units of insulin and administered

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the insulin to Resident #4's in the lower right abdominal region.
-The MA asked another staff person to transport Resident #4, who was in a wheelchair, into the dining room area for lunch.
-The MA documented on the eMAR 25 units of Humalog were administered.

Observation made in the dining room on 02/06/19 at 11:53am revealed Resident #4 was not located in the dining room area.

Interview with a dietary staff on 02/06/19 at 11:53 am revealed Resident #4 was taken back to her room.

Interview with the MA on 02/06/19 at 11:57am revealed:
-"I did not give her [Resident #4] enough insulin."
-She had used the Humalog insulin pen to administer 15 additional units of Humalog to Resident #4.
-"There is a new order to give 15 units of Humalog."
-She was prompted on the eMAR to administer an additional Humalog 15 units before lunch along with the SSI.
-The MA stated she had "verified the order".

Review of the resident's record revealed:
-There was an order dated 10/28/18 Humalog 15 units SQ two times daily before breakfast and lunch with the SSI, Humalog 20 units SQ in the evening before dinner with the SSI.
-There were no other Humalog insulin orders in the record.

Review of Resident #4's December 2018 electronic Medication Administration Record (eMAR) revealed:

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-There was an entry for Humalog SSI three times daily scheduled at 7:30am, 11:30am, and 4:30pm: inject as per sliding scale, 0-150=0 units, 151-200=2 units, 201-251=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. If the BS was over 400 administer 12 units of insulin. Hold the insulin if the BS was below 100, give orange juice and recheck in 30 minutes. Notify the physician if the BS was greater than 400.
-There was an entry for Humalog inject 15 units SQ two times daily prior to breakfast and lunch along with the SSI.
-There was an entry for Humalog inject 20 units SQ in the evening prior to dinner along with the SSI scheduled for 4:30pm.
-There was an order entry to check FSBS at bedtime scheduled for 8:00pm.
-There was documentation the Humalog 15 units scheduled for 7:30am prior to breakfast was administered 27 times appropriately using the SSI, and held 4 times due to SSI instructions for FSBS below 150. The FSBS ranged from 388-106.
-There was documentation the Humalog 15 units scheduled for 11:30am prior to lunch was administered 19 times appropriately using the SSI, and held 11 times due to SSI instructions for FSBS below 150. The FSBS ranged from 332-87.
-There was documentation the Humalog 20 units scheduled for 4:30pm prior to dinner was administered 19 times using the SSI, and held 11 times due to SSI instructions for FSBS below 150. The FSBS ranged from 429-74.
-There was documentation the FSBS scheduled at 8:00pm ranged from 486-94.

Review of Resident #4's January 2019 eMAR revealed:
-There was an entry for Humalog SSI three times daily scheduled at 7:30am, 11:30am, and

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4:30pm: inject as per sliding scale, 0-150=0 units, 151-200=2 units, 201-251=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. If the BS was over 400 give 12 units of insulin. Hold the insulin if the BS was below 100, give orange juice and recheck in 30 minutes. Notify the physician if the blood sugar was greater than 400.
-There was an entry for Humalog insulin, inject 15 units SQ two times daily prior to breakfast and lunch along with the SSI.
-There was an entry for Humalog insulin, inject 20 units SQ in the evening prior to dinner along with the SSI scheduled for 4:30pm.
-There was an entry to check FSBS at bedtime scheduled for 8:00pm.
-There was documentation the Humalog insulin 15 units scheduled for 7:30am prior to breakfast was administered 25 times using the SSI, and held 6 times due to SSI instructions for FSBS below 150. The FSBS ranged from 306-125.
-There was documentation the Humalog insulin 15 units scheduled for 11:30am prior to lunch was administered 11 times using the SSI, and held 19 times due to SSI instructions for FSBS below 150. The FSBS ranged from 260-42.
-There was documentation the Humalog insulin 20 units scheduled for 4:30pm prior to dinner was administered 23 times using the SSI, and held 8 times due to SSI instructions for FSBS below 150. The FSBS ranged from 349-65.
-There was documentation the FSBS scheduled at 8:00pm ranged from 388-49.

Review of Resident #4's February 2019 eMAR from 02/01/19 to 02/07/19 revealed:
-There was an entry for Humalog SSI three times daily scheduled at 7:30am, 11:30am, and 4:30pm: inject as per sliding scale, 0-150=0 units, 151-200=2 units, 201-251=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. If the

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BS was over 400 administer 12 units of insulin. Hold the insulin if the BS was below 100, give orange juice and recheck in 30 minutes. Notify the physician if the BS was greater than 400.
-There was an entry for Humalog inject 15 units SQ two times daily prior to breakfast and lunch along with the SSI.
-There was an entry for Humalog inject 20 units SQ in the evening prior to dinner along with the SSI scheduled for 4:30pm.
-There was an entry to check FSBS at bedtime scheduled for 8:00pm.
-There was documentation the Humalog 15 units scheduled for 7:30am prior to breakfast was administered 7 times appropriately using the SSI. The FSBS ranged from 369-203.
-There was documentation the Humalog 15 units scheduled for 11:30am prior to lunch was administered 6 times appropriately using the SSI, and held 1 times due to SSI instructions for FSBS below 150. The FSBS ranged from 408-134.
-There was documentation the Humalog 20 units scheduled for 4:30pm prior to dinner was administered 5 times appropriately using the SSI, and held 2 times due to SSI instructions for FSBS below 150. The FSBS ranged from 391-104.
-There was documentation the FSBS scheduled at 8:00pm ranged from 448-54.

Observation of Resident #4's medications on the medication cart on 02/06/19 at 11:48am revealed Humalog kwikpen was available for administration.

Interview with the Administrator on 02/06/19 at 12:02pm revealed:
-She did not know the current order for Resident #4's Humalog insulin prior to the lunch meal.
-The facility was using a new computerized system which was the reason the new order was

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not in the resident's record.
-The Resident Care Director (RCD) was responsible for entering all new orders in the computer system for the residents.
-To review resident's orders you would need a computer and password, or request the RCD or the Health and Wellness Director to print the orders.
-She relied on the RCD to over-see the clinical staff which included the MAs.

Interview with the Administrator and the Regional Registered Nurse (RN) on 02/06/19 at 12:05pm revealed:
-The RCD was responsible for new orders and placing them on the eMAR.
-The facility was using a computer system for new orders for the residents.
-She did not know Resident #4 was on Humalog insulin but would access the computer for verification of the insulin orders.

Observation on 02/06/19 at 12:07pm revealed the Regional RN used the computer to review the orders on the eMAR for Resident #4 who received the Humalog insulin.
-There was an entry for Humalog insulin inject 15 units SQ two times a day before breakfast and before lunch, along with the SSI.
-There was a second entry for Humalog SSI according to the following scale: for FSBS result of 0-150 =0 151- 200 = 2units; 201-250 = 4units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units. If the BS was 401 administer 12 units. Notify the physician if the BS was greater than 400.
-There was a third entry for Humalog insulin inject 15 units SQ two times daily before breakfast and before lunch along with the SSI.

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Interview the Regional RN on 02/06/19 at 12:07pm revealed:
-When she reviewed Resident #4's eMAR she had known why the MA had made the medication error, and would immediately speak with the MA.
-The MA had administered 25 units of Humalog insulin entry for the SSI scheduled for 11:30am prior to lunch, then documented on the other Humalog insulin inject 15 units prior to lunch entry an additional 15 units were administered for a total of 40 units of Humalog administered to the resident.

Interview with the Administrator on 02/06/19 at 3:35pm revealed:
-She and the Regional RN had spoken to the MA who had administered the Humalog insulin to Resident #4.
-The MA had not known she had administered an additional 15 units of Humalog insulin to Resident #4 prior to the lunch meal on 02/06/19 resulting in a medication error.
-The MA was not familiar with the insulin orders for Resident #4.
-The MA was pulled from the medication cart until further training had been completed.
-The physician was notified about the medication error.
-Resident #4's FSBS would be taken every hour until stable.

Review of Resident #4 February 2019 eMAR, from 02.06/19-02/07/19 revealed there was documentation the FSBS at 8:00pm on 02/06/19 was 221 and on 02/07/19 at 7:30am the FSBS was 256.

Interview with the MA on 02/07/19 at 9:08am revealed:
-She had worked at the facility for about two

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years as a MA.
-She performed the FSBS checks and administered the Humalog insulin on 02/06/19 to Resident #4.
-She had not received any training on the care of the diabetic resident at the facility.
-She did not know she had made the medication error on 02/06/19 until the Administrator and the Regional Nurse informed her.
-She usually worked on the other floor and another MA told her Resident #4 had new orders for insulin.
-When she said on 02/06/19 she had "verified the order" for Humalog insulin she meant she had seen it on the eMAR to administer.
-She administered medications by comparing the medication and the order entry on the eMAR that was how she verified the Humalog insulin order.
-"There were two orders for the lunch time insulin that popped up on the computer."
-She had administered the SSI with the 15 units prior to lunch and documented on the eMAR under the entry for the SSI 25 units had been administered. A second order appeared on the eMAR prompting her to administer an additional 15 units prior to lunch.
-She administered 15 more units of insulin and documented it under the other Humalog entry on the eMAR.

The former RCD was not available for another interview on 02/07/19, 02/08/19 or on 02/11/19.

Interview with Resident #4's Nurse Practitioner (NP) on 02/07/19 at 2:38pm revealed:
-The Wellness Nurse contacted him regarding to Resident #4 who had received 15 additional units of Humalog prior to the lunch meal on 02/06/19 for a total of 40 units of insulin.
-He told the nurse to monitor Resident #4 and

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complete FSBS checks hourly.
-He told the nurse to contact him if any symptoms of hypoglycemia occurred with Resident #4.
-He knew Resident #4's FSBS was 88 on 02/06/18 at 3:47pm, but did not drop any lower that day.
-He had told the nurse to hold the 20 units of Lantus scheduled on 02/06/19 at 8:00pm.
-He had seen Resident #4 today in the facility to follow up on the medication error and to assess for hypoglycemia.

2. a. Further review of Resident #8's current FL2 dated 11/28/18 revealed a physician's order for Seroquel 50mg at bedtime.

Review of Resident #8's Resident Register revealed an admission date of 10/24/18 to the Special Care Unit (SCU).

Review of Resident #8's November 2018 electronic medication administration record (eMAR) revealed:
-There was an order entry for Seroquel 50mg (used for psychosis) at bedtime scheduled for 8:00pm.
-There was documentation Seroquel 50mg was not administered for 3 consecutive nights on 11/23/18, 11/24/18 and on 11/25/18.

Review of Resident #8's hospital discharge summary dated 11/28/18 revealed:
-Resident #8 was admitted to the hospital on 11/26/18 diagnosed with agitation.
-Resident #8 was an involuntary commitment "as he might pose a threat to himself or others."
-There was an order for Resident #8 to have a psychiatric evaluation while in the hospital.
-Home medications at discharge included Seroquel 50mg each night at bedtime.

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-Resident #8 returned to the facility SCU on 11/28/19.

Review of Resident #8's physician's order dated 11/29/18 for a psychiatric evaluation.

Telephone interview with a pharmacist from the facility contracted pharmacy on 02/11/19 at 10:15am revealed:
-The pharmacy dispensed Seroquel 50mg a quantity of 30 tablets on 10/24/18 , and on 11/28/18 a quantity of 30 tablets.
-Seroquel was used as an anti-psychotic for anxiety and to promote sleep. If Seroquel was missed for 3-4 consecutive days it could cause agitation, depression or hallucinations.
-The pharmacy had an order dated 12/09/18 to discontinue Seroquel 50mg at bedtime.
-The facility was responsible for faxing or scanning the orders to the pharmacy.
-The facility staff entered the orders onto the eMAR system.
-The facility could use the eMAR to re-order medications as long as it was a non-narcotic.
-"Medications are prescribed by the physician and should be administered as ordered."

Review of Resident #8's record revealed there was a signed physician order dated 12/09/18 discontinued Seroquel 50mg at bedtime.

Interview with a SCU medication aide (MA) on 02/11/19 at 10:30am revealed:
-If medications were not available for administration the MAs were to let the nurse know.
-The Resident Care Coordinator (RCC) was responsible for reviewing the eMARs, but "I am not sure when she did it."
-"I do not ever review what medications were

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given or not given on the other shifts."
-"If a resident missed three days of a medication I would call the physician or tell the nurse."

Telephone interview with Resident #8's psychiatric NP on 02/11/19 at 11:20am revealed:
-She did not know Seroquel 50mg was not administered as ordered for 3 consecutive nights on 11/23/18, 11/24/18 and on 11/25/18 due to reason given as medication pending delivery.
-Resident #8 was admitted to the hospital for behaviors under involuntary commitment on 11/26/18.
-The NP was not seeing Resident #8 at that time but "definitely I would have wanted to know."
-"If (Resident #8) was not taking his medications as ordered I could not treat his symptoms or provide the best care."
-"I would want to know if any meds were missed."
-The facility staff did not make her aware of any of the missed medication, "I definitely want to know if my patients are missing meds."

Interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am and at 12:15pm revealed:
-The MAs were to tell her when a resident missed any medications, "These residents in SCU need all their medications administered due to dementia and behaviors."
-The MAs could re-order medication using the eMAR system.
-She knew Resident #8 was admitted to the hospital for behaviors under involuntary commitment on 11/26/18.
-She did not know Resident #8 had missed 4 consecutive days of Melatonin 5mg 11/22/18, 11/23/18, 11/24/18 and on 11/25/18 the reason documented as MD (medication pending delivery).
-She did know melatonin was used to promote

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sleep.
-She did know Resident #8 had behaviors in the facility on 02/08/19 and was sent to the ED for evaluation.
-She did not know on 02/11/19 Resident #8's Seroquel was not in the facility or available for administering as ordered.
-"There must be a communication problem with the MAs not reporting missed medications to me."
-"I am not sure why the MAs were not re-ordering medications."
-The MAs, Wellness Nurse, RCD or the SCUC could contact the physician.
-She had not contacted the physician concerning the 3 missed doses of Seroquel 50mg for Resident #8.

Interview with the Administrator on 02/11/19 at 12:30pm revealed:
-She did not know Seroquel 50mg was not administered as ordered to Resident #8 for 3 consecutive nights on 11/23/18, 11/24/18 and on 11/25/18.
-She knew missing Seroquel could cause behaviors.
-She knew Resident #8 was admitted to the hospital for behaviors under involuntary commitment on 11/26/18.
-She thought there might be a problem with the eMAR system when the MAs request re-fills on the medications and the eMAR was not accepting the request.
-She was not sure why the MAs did not inform the SCUC or the nurse when Resident #8 was out of his medications.
-The RCD was responsible for reviewing the eMAR daily for "missed meds and holes".
-She did not know the physician was not made aware of the 3 consecutive days Resident #8 missed his Seroquel 50mg.

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b. Further review of Resident #8's current FL2 dated 11/28/18 revealed a physician's order for melatonin 5mg at bedtime.

Review of Resident #8's November 2018 eMAR revealed:
-There was an order entry for melatonin 5mg (used for insomnia) scheduled for 8:00pm.
-There was documentation melatonin 5mg was missed four consecutive nights on 11/22/18, 11/23/18, 11/24/18 and on 11/25/18 the reason documented was (MD=medication pending delivery).

Review of Resident #8's hospital discharge summary dated 11/28/19 revealed:
-Resident #8 was admitted to the hospital on 11/26/18 with the diagnosis of agitation.
-Resident #8 was an involuntary commitment "as he might pose a threat to himself or others."
-There was an order for Resident #8 to have a psychiatric evaluation while in the hospital.
-Home medications at discharge included melatonin 5mg each night at bedtime.
-Resident #8 returned to the facility SCU on 11/28/19.

Review of Resident #8's February 2019 eMAR from 02/01/19 to 02/10/19 revealed:
-There was an entry for melatonin 5mg at bedtime scheduled for 8:00pm.
-There was documentation melatonin 5mg was not administered on 02/01/19, the reason "DR" (drug refused).
-There was documentation melatonin 5mg was not administered as ordered on four consecutive nights on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19, the reason documented as MD (medication pending delivery).

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-There was documentation melatonin 5mg was not administered as ordered on 02/09/19 and on 02/10/19, the reason MD (medication pending delivery).

Review of Resident #8's emergency department (ED) discharge summary dated 02/08/19 revealed:
-Resident #8 was sent to the ED for behaviors with a diagnosis of major neurocognitive behaviors.
-Resident #8 was sent back to the facility on the same day on 02/08/19.
-Medications at discharge included melatonin 5mg each night at bedtime.

Telephone interview with the pharmacist from the facility contract pharmacy on 02/11/19 at 10:15am revealed:
-The pharmacy dispensed melatonin 5mg on 10/24/18 for a quantity of 30 tablets, on 11/28/18 for a quantity of 30 tablets and on 01/03/19 for a quantity of 30 tablets.
-The melatonin 5mg was an active order for Resident #8.
-Melatonin was used to promote sleep. If melatonin was missed 4 consecutive days it could cause insomnia which could lead to behaviors.
-"Medications are prescribed by the physician and should be administered as ordered."
-The facility was responsible for faxing or scanning the orders to the pharmacy for medication refills.

Observation of medications on hand for Resident #8 on 02/11/19 at 10:30am revealed there was no melatonin 5mg tablets for administration on the medication cart.

Interview with a SCU MA on 02/11/19 at 10:30am

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revealed:
-She did not know why Resident #8's melatonin 5mg was not on the medication cart for administration.
-If medications are not available for administration the MAs were to let the nurse know.
-The melatonin 5mg was a night time medication and she had not administered the melatonin.
-The Resident Care Coordinator (RCC) was responsible for reviewing the eMARs, but "I am not sure when she did it."
-"I do not ever review what medications were given or not given on the other shifts."
-Third shift never mentioned Resident #8 was out of the melatonin 5mg.
-"If a resident missed three days of a medication I would call the physician or tell the nurse."

Telephone interview with Resident #8's psychiatric NP on 02/11/19 at 11:20am revealed:
-Resident #8 was prescribed melatonin 5mg at bedtime for insomnia to promote sleep.
-If melatonin was not administered for four consecutive nights it could cause sleep deprivation which would lead to behaviors.
-She did not know the melatonin 5mg was not to administered as ordered for Resident #8 for four consecutive days of melatonin on 11/22/18, 11/23/18, 11/24/18 and on 11/25/18, the reason documented as MD (medication pending delivery) and on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19 or on 02/09/19 and on 02/10/19 reason documented as medication pending delivery.
-She did not know Resident #8's melatonin 5mg was not available in the facility for administering as ordered on 02/11/19.
-She did know Resident #8 had behaviors in the facility on 02/08/19 and was sent to the ED for evaluation.

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D 358	Continued From page 86 -"If (Resident #8) was not taking his medications as ordered I could not treat his symptoms or provide the best care." -The facility did not made her aware of any of the missed medication, "I definitely want to know if my patients are missing meds." -"I would want to know if any meds were missed." Interview with the SCU Coordinator (SCUC) on 02/11/19 at 10:08am and at 12:15pm revealed: -She had worked in the facility for about 2 years. -The MAs were to tell the SCUC when a resident missed any medications, "These residents in SCU need all the medications administered due to dementia and behaviors." -The MAs fill out a re-order form if a medication is need, then the form is faxed to the pharmacy. -The MAs could re-order medication using the eMAR system. -She had not received a re-order form requesting medications for Resident #8. -The RCD was responsible for new orders and entering the medication on the eMAR. -She did know Resident #8 was admitted to the hospital for behaviors under involuntary commitment on 11/26/18. -She did not know Resident #8 had missed four consecutive days of Melatonin 5mg 11/22/18, 11/23/18, 11/24/18 and on 11/25/18. -She knew melatonin was used to promote sleep. -She did not know Resident #8 was not administered melatonin 5mg on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19 or on 02/09/19 and on 02/10/19. -She knew Resident #8 had behaviors in the facility on 02/08/19 and was sent to the ED for evaluation. -She did not know on 02/11/19 Resident #8's melatonin 5mg was not in the facility or available for administering as ordered.	D 358		

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-"There must be a communication problem with the MAs not reporting missed medications to me."
-"I am not sure why the MAs were not re-ordering medications."
-The MAs, Wellness Nurse, RCD or the SCUC could contact the physician.
-She had not contacted the physician concerning the 3 missed doses of Seroquel 50mg for Resident #8.

Interview with the Administrator on 02/11/19 at 12:30pm revealed:
-She knew Resident #8 was admitted to the hospital for behaviors under involuntary commitment on 11/26/18.
-She did not know Resident #8 had missed four consecutive days of Melatonin 5mg 11/22/18, 11/23/18, 11/24/18 and on 11/25/18
-She knew Resident #8 had behaviors in the facility on 02/08/19 and was sent to the ED for evaluation.
-She did not know Resident #8 was not administered melatonin 5mg as ordered on 02/04/19, 02/05/19, 02/06/19 and on 02/07/19 or on 02/09/19 and on 02/10/19.
-She did know melatonin was used to promote sleep.
-She knew melatonin 5mg was not available on the medication cart on 02/11/19 to administer as ordered for Resident #8.
-A MA in SCU had requested a refill for the melatonin 5mg on 02/10/19 and the request form was on her desk.
-She thought there might be a problem with the eMAR system when the MAs request refills on the medications the eMAR was not accepting the request.
-She was not sure why the MAs did not inform the SCUC or the nurse when Resident #8 was out of his medications.

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-The RCD was responsible for reviewing the eMAR daily for "missed meds and holes".

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with Regional Registered Nurse (RN) on 02/08/19 at 9:45am.

Refer to interview with a Wellness Nurse on 02/08/19 at 10:38am.

Refer to interview with Special Care Unit Coordinator (SCU Coordinator) on 02/09/19 at 10:55am.

3. Review of Resident #5's current FL2 dated 11/07/18 revealed diagnoses included dementia, hypertension, cataracts, arrhythmia, and atrial fibrillation.

a. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for potassium chloride 10mEq CR one capsule two times daily (a mineral supplement used to treat or prevent low amounts of potassium in the blood).

Review of Resident #5's physician's orders dated 11/16/18 revealed a medication order for

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potassium chloride ER 20mEq one tablet daily.

Review of Resident #5's December 2018 and January 2019 electronic Medication Administration Records (eMAR) revealed:
-There was an entry for potassium chloride ER 20mEq one tablet to be administered daily at 8:00am.
-There was documentation Resident #5 was administered potassium chloride as ordered from 12/01/18 through 01/31/19.

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for potassium chloride ER 20mEq one tablet to be administered daily at 8:00am.
-There was documentation Resident #5 was not administered potassium chloride for 7 of 7 opportunities from 02/01/19 through 02/07/19.
-There was documentation Resident #5 was not administered potassium chloride on 02/01/19, 02/02/19 and 02/03/19 due to "unable to tolerate."
-There was documentation Resident #5 was not administered potassium chloride on 02/04/19, 02/06/19 and 02/07/19 due to "medication pending delivery."
-There was documentation Resident #5 was not administered potassium chloride on 02/05/19 due to "waiting on order for capsules."

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was no potassium chloride ER 20mEq available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident

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#5 was potassium chloride 10mEq two capsules daily dated 12/04/18.
-On 11/17/18, the pharmacy dispensed 30 tablets of potassium chloride 20mEq for Resident #5.
-On 12/04/18, the pharmacy dispensed 60 capsules of potassium chloride 10mEq for Resident #5.
-The pharmacy had not received a refill request for Resident #5's potassium chloride since 12/04/18.
-The pharmacy did not know of any issues with refill requests not reaching them.

A second telephone interview with a representative from the facility's contracted pharmacy on 02/11/19 at 12:30pm revealed:
-The pharmacy received a new order for Resident #5 on 02/07/19 for potassium chloride 20mEq one tablet daily.
-On 02/07/19, the pharmacy dispensed 30 tablets of potassium chloride 20mEq for Resident #5.

Interview with a medication aide (MA) on 02/07/19 at 10:15am revealed:
-She normally worked second shift and today (02/07/19) was the first day she had been on the medication cart during the time Resident #5 should have been administered potassium chloride.
-She noticed Resident #5 did not have potassium chloride available for administration and planned to follow-up with the pharmacy later that day.

Interview with a second MA on 02/08/19 at 12:45pm revealed:
-When she attempted to administer potassium chloride to Resident #5 on 02/01/19, she realized the potassium chloride was in a tablet form with instructions to not crush or chew and Resident #5 had an order to crush all medications.

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-She did not administer the potassium chloride to Resident #5 and documented on the eMAR "unable to tolerate."
-She then alerted one of the Wellness Nurses (she could not remember which one) and assumed they were contacting Resident #5's Primary Care Provider (PCP) for an order for the capsule form of potassium chloride.
-The last time she was on the medication cart passing medications prior to 02/01/19 was 01/18/19 and at that time Resident #5's potassium chloride was in capsule form that could be opened and sprinkled into her applesauce.
-She did not follow back up with the Wellness Nurse or the pharmacy regarding Resident #5's potassium chloride and had no explanation as to why she had not done so.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.
-It was important Resident #5 received potassium

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chloride as ordered because she was administered Lasix 20mg three times daily for edema and heart failure.
-If Resident #5 was not administered potassium chloride, it could cause her to have cardiac arrhythmias.

Interview with the Regional RN on 02/08/19 at 9:13am revealed:
-In checking the eMAR system, it appeared potassium chloride had been ordered from the pharmacy for Resident #5 on 12/11/18 and 12/28/18, but she was unable to locate a faxed order.
-She did not know if the RCD had been notified Resident #5 was mising any medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She did not know Resident #5 had missed any medications.
-Resident #5 not being administered potassium chloride while taking Lasix, could cause Resident #5 to have an electrolyte imbalance.
-She would send an order to the facility immediately to have Resident #5's lab work drawn to check for electrolyte imbalances and kidney function.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed:
-She had only learned about Resident #5 not having potassium chloride available for administration today (02/08/19) when the Hospice RN told her she had ordered it from the pharmacy

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as a STAT order on 02/07/19 and asked if it came in.
-She had contacted the pharmacy and they said Resident #5's potassium chloride would be delivered to the facility today (02/08/19).
-She did not know Resident #5 had missed any other medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

b. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for trazodone 50mg one half tablet (25mg) at bedtime (a medication used as a sedative and to treat depression).

Review of Resident #5's December 2018 electronic Medication Administration Record

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(eMAR) revealed:
-There was an entry for trazodone 50mg one half tablet to be administered at 7:00pm.
-There was documentation Resident #5 was not administered trazodone for 5 of 31 opportunities from 12/09/18 through 12/13/18 due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for trazodone 50mg one half tablet to be administered at 7:00pm.
-There was documentation Resident #5 was not administered trazodone for 3 of 31 opportunities from 01/05/19 through 01/07/19 due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for trazodone 50mg one half tablet to be administered at 7:00pm.
-There was documentation Resident #5 was not administered trazodone for 5 of 6 opportunities from 02/02/19 through 02/06/19 due to "medication pending delivery."

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was no trazodone 50mg available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was trazodone 50mg one half tablet daily.
-The pharmacy dispensed 15 tablets of trazodone 50mg (a 30 day supply) for Resident #5 on 11/19/18, 12/13/18, and 01/06/19.
-The pharmacy had not received a refill request

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for trazodone for Resident #5 since 01/06/19.

Interview with a medication aide (MA) on 02/07/19 at 10:15am revealed she had not contacted the pharmacy to follow-up with them regarding Resident #5's trazodone and did not have an explanation as to why she had not done so.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.
-Not being administered trazodone, could cause Resident #5 to feel anxious.

Interview with the Regional RN on 02/08/19 at 9:13am revealed:
-In checking the eMAR system, it appeared trazodone had not been ordered for Resident #5, and she was unable to locate a faxed order.
-She did not know if the RCD had been notified Resident #5 was mising any medications.

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Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She did not know Resident #5 had missed any medications.
-It was not likely Resident #5 would have any adverse side effects from not being administered trazodone, but she expected the facility to administer medications as ordered.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she did not know Resident #5 had missed any medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

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Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

c. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for divalproex sodium 125mg 1 capsule three times daily (a medication used to treat seizures and bipolar disorder).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for divalproex sodium 125mg one capsule to be administered three times daily at 7:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered divalproex sodium for 6 of 93 opportunities from 12/29/18 at 7:00pm through 12/31/18 at 3:00pm due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for divalproex sodium 125mg one capsule to be administered three times daily at 7:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered divalproex sodium for 1 of 93 opportunities on 01/03/19 at 3:00pm due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for divalproex sodium 125mg one capsule to be administered three times daily at 7:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not

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administered divalproex sodium for 5 of 19 opportunities from 02/01/19 at 3:00pm through 02/02/19 at 7:00pm due to "medication pending delivery."

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was divalproex sodium 125mg available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was divalproex sodium 125mg one capsule three times daily.
-The pharmacy dispensed 90 capsules of divalproex sodium 125mg for Resident #5 on 11/30/18, 12/21/18 and 02/02/19.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.

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Interview with the Regional RN on 02/08/19 at 9:13am revealed she did not know if the RCD had been notified Resident #5 was mising any medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She did not know Resident #5 had missed any medications.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she was not aware Resident #5 had missed any medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on

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02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

d. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for Lasix 20mg tablets take 60mg two times daily (a medication used to treat fluid retention).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lasix 20mg three tablets to be administered two times daily at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered Lasix for 3 of 62 opportunities from 12/17/18 at 7:00pm through 12/19/18 at 7:00am due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for Lasix 20mg three tablets to be administered two times daily at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered Lasix for 6 of 62 opportunities from 01/07/19 at 7:00am through 01/09/19 at 7:00pm due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for Lasix 20mg three tablets to be administered two times daily at 7:00am and 7:00pm.
-There was documentation Resident #5 was

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administered Lasix as ordered.

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was Lasix 20mg available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was Lasix 20mg three tablets two times daily.
-The pharmacy had dispensed 90 tablets, a fifteen day supply, of Lasix 20mg for Resident #5 on 11/27/18, 12/19/18, 01/08/19 and 01/24/19.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.

Interview with the Regional RN on 02/08/19 at 9:13am revealed she did not know if the RCD had been notified Resident #5 was mising any

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medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She was not aware Resident #5 had missed any medications.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she did not know Resident #5 had missed any medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she did not know Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

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Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

e. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for Risperdal 0.25mg one tablet daily (a medication used to treat psychosis).

Review of Resident #5's physician's orders dated 10/27/18 revealed a medication order for Risperdal 0.25mg one tablet three times daily.

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 3:00pm and 8:00pm.
-There was documentation Resident #5 was not administered Risperdal for 4 of 93 opportunities from 12/30/18 at 8:00pm through 12/31/18 at 8:00pm due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 3:00pm and 8:00pm from 01/01/19 through 01/25/19.
-There was a second entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 2:00pm and 8:00pm with a start date of 01/26/19.
-There was documentation Resident #5 was not administered Risperdal for 13 of 93 opportunities from 01/01/19 at 3:00pm through 01/03/19 at 3:00pm and again from 01/23/19 at 3:00pm through 01/25/19 at 3:00pm due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR

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revealed:
-There was an entry for Risperdal 0.25mg one tablet to be administered at 8:00am, 2:00pm and 8:00pm.
-There was documentation Resident #5 was administered Risperdal as ordered.

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was Risperdal 0.25mg available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was Risperdal 0.25mg one tablet three times daily.
-The pharmacy dispensed 30 tablets of Risperdal 0.25mg for Resident #5 on 11/22/18 because they had an order for Risperdal 0.25mg one tablet daily.
-The pharmacy dispensed 60 tablets of Risperdal 0.25mg for Resident #5 on 01/03/19 because they had an order for Risperdal 0.25mg two tablets daily.
-The pharmacy dispensed 90 tablets of Risperdal 0.25mg for Resident #5 on 01/25/19 because they received the order for Risperdal 0.25mg three tablets daily.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of

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02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.

Interview with the Regional RN on 02/08/19 at 9:13am revealed she did not know if the RCD had been notified Resident #5 was mising any medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She did not know Resident #5 had missed any medications.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she did not know Resident #5 had missed any medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she did not know Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

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Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

f. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for digoxin 125mcg one tablet daily (a medication used to treat heart failure and heart rhythm problems).

Review of Resident #5's December 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for digoxin 125mcg one tablet to be administered at 7:00am.
-There was documentation Resident #5 had been administered digoxin as ordered.

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for digoxin 125mcg one tablet to be administered at 7:00am.
-There was documentation Resident #5 was not administered digoxin for 3 of 31 opportunities from 01/12/19 through 01/14/19 due to "medication pending delivery."

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Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for digoxin 125mcg one tablet to be administered at 7:00am.
-There was documentation Resident #5 was administered digoxin for 7 of 7 opportunities.

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was digoxin available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was digoxin 125mcg one tablet daily.
-The pharmacy dispensed 30 tablets of digoxin 125mcg for Resident #5 on 12/06/18 and 01/13/19.
-The pharmacy dispensed 15 tablets of digoxin 125mcg for Resident #5 on 02/05/19.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure medications were ordered in a timely manner so residents would not miss any doses.

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-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.

Interview with the Regional RN on 02/08/19 at 9:13am revealed she did not know if the RCD had been notified Resident #5 was mising any medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and Hospice.
-She did not know Resident #5 had missed any medications.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she did not know Resident #5 had missed any medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she was not aware Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

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Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

g. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for diltiazem 240mg one capsule two times daily (a medication used to treat hypertension and chest pain).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for diltiazem 240mg one capsule to be administered at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered diltiazem for 5 of 62 opportunities from 12/29/18 at 7:00pm through 12/31/18 at 7:00pm due to "medication pending delivery."

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for diltiazem 240mg one capsule to be administered at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered diltiazem for 4 of 62 opportunities from 01/01/19 at 7:00am through 01/01/19 at 7:00pm and again from 01/02/19 at 7:00pm through 01/03/19 at 7:00am due to "medication pending delivery."

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Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for diltiazem 240mg one capsule to be administered at 7:00am and 7:00pm.
-There was documentation Resident #5 was not administered diltiazem for 1 of 13 opportunities on 02/02/19 at 7:00pm due to "medication pending delivery."

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed diltiazem was available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was diltiazem 240mg one capsule two times daily.
-The pharmacy had dispensed 60 capsules of diltiazem 240mg for Resident #5 on 11/11/18, 01/03/19 and 02/02/19.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure

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medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.

Interview with the Regional RN on 02/08/19 at 9:13am revealed she did not know if the RCD had been notified Resident #5 was mising any medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She did not know Resident #5 had missed any medications.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she did not know Resident #5 had missed any medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she did not know Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on

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02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

h. Review of Resident #5's current FL2 dated 11/07/18 revealed a medication order for Lotemax 0.5% ophthalmic solution place one drop in both eyes four times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm (a medication used to treat redness, itching and watering of the eyes).

Review of Resident #5's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lotemax 0.5% instill one drop in both eyes four times daily to be administered at 7:00am, 11:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was administered Lotemax as ordered.

Review of Resident #5's January 2019 eMAR revealed:
-There was an entry for Lotemax 0.5% instill one drop in both eyes four times daily to be administered at 7:00am, 11:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was not administered Lotemax for 4 of 124 opportunities from 01/02/19 at 7:00pm through 01/03/19 at

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3:00pm due to "medication pending delivery."

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for Lotemax 0.5% instill one drop in both eyes four times daily to be administered at 7:00am, 11:00am, 3:00pm and 7:00pm.
-There was documentation Resident #5 was administered Lotemax as ordered.

Observation of Resident #5's medications available for administration on 02/07/19 at 10:04am revealed there was Lotemax 0.5% ophthalmic solution available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 3:18pm revealed:
-The current order the pharmacy had for Resident #5 was Lotemax 0.5% instill one drop in both eyes four times daily.
-The pharmacy dispensed 5cc (a 28 day supply) of Lotemax 0.5% for Resident #5 on 12/06/18, 01/03/19, and 02/03/19.

Interview with the Wellness Nurse on 02/07/19 at 11:07am revealed she did not know Resident #5 had missed any medications.

Telephone interview with the hospice Registered Nurse (RN) on 02/07/19 at 2:43pm revealed:
-Resident #5 had been receiving hospice services since 11/16/18.
-She had last seen Resident #5 on the morning of 02/07/19 and she did not appear to be having any health issues outside of her baseline.
-She did not know Resident #5 had missed any medications.
-It was the facility's responsibility to assure

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medications were ordered in a timely manner so residents would not miss any doses.
-If the issue was a need for a new prescription, the facility was responsible for notifying her and within the day she could have a new prescription to the pharmacy.

Interview with the Regional RN on 02/08/19 at 9:13am revealed she did not know if the RCD had been notified Resident #5 was mising any medications.

Attempted interview with the RCD on 02/08/19 at 9:15am was unsuccessful.

Telephone interview with Resident #5's PCP on 02/08/19 at 10:22am revealed:
-Resident #5 was being followed by both her and hospice.
-She did not know Resident #5 had missed any medications.

Interview with a second Wellness Nurse on 02/08/19 at 1:18pm revealed she did not know Resident #5 had missed any other medications.

Interview with the Administrator on 02/11/19 at 1:25pm revealed she did not know Resident #5 had missed any doses of her medications.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on

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02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

4. Review of Resident #6's current FL2 dated 12/17/18 revealed diagnoses included unspecified cerebral infarction, dementia with behaviors, and constipation.

Review of Resident #6's Resident Register revealed he was admitted on 12/22/18.

a. There was a medication order for divalproex 125mg one tablet twice daily (a medication used to treat agitation and stabilize mood).

Review of Resident #6's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for divalproex 125mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation divalproex was administered for 17 out of 19 opportunities from 12/01/18-12/31/18.
-There was documentation divalproex was not administered on 12/22/18 at 8:00pm due to "drug refused".
-There was documentation divalproex was not administered on 12/23/18 at 7:00am due to

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"hospitalized".

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for divalproex 125mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation divalproex was not administered 3 out of 62 opportunities 01/01/19-01/31/19.
-There was documentation divalproex was not administered on 01/29/19 at 8:00pm, 01/31/19 at 7:00am, and 1/31/19 at 8:00pm due to "medication pending delivery."

Review of Resident #6's February 2019 eMAR revealed:
-There was an entry for divalproex 125mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation divalproex was not administered 18 out of 21 opportunities from 02/01/19-02/11/19.
-There was documentation divalproex was not administered on 02/02/19-02/11/19 at 7:00am, and 02/01/19-02/02/19, 02/04/19-02/10/19 at 8:00pm due to "medication pending delivery".

Observation of Resident #6's medications available for administration on 02/08/19 at 9:59am revealed divalproex was not available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/08/19 at 9:20am revealed:
-The pharmacy had dispensed 60 tablets of divalproex 125mg for Resident #6 on 12/23/18.
-The pharmacy had received an electronic refill request from the facility on 01/24/19.

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-The pharmacy had received no other refill requests from the facility since 01/24/19.
-Divalproex 125mg was discontinued in error in the pharmacy computer system.
-The pharmacy could not explain the reason for discontinuing the medication, "we do not have a discontinue order".
-The facility had not requested the refill since 01/24/19, therefore the error was not caught by the pharmacy.

Interview with Resident #6's responsible party (RP) on 02/08/19 at 3:33pm revealed:
-He relied on the facility to order and administer Resident #6's medications.
-He did not know if Resident #6 missed any of his medications.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed:
-Resident #6 had been out of divalproex for "a while".
-She thought the medication was going to be delivered.
-She provided the Wellness Nurse (WN) a list of medications that were not available for administration on "last week".
-She had not notified the pharmacy, because she thought the medication would eventually be delivered.
-She thought the MA before her had already called the pharmacy to check on the status of the divalproex.
-She had documented twice in February 2019 Resident #6 was not administered his divalproex.
-The MAs were responsible for contacting the pharmacy to check on the medication daily if it was not available.
-She did not know why she had not called the pharmacy to check on the status of the

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divalproex.

Telephone interview with a second shift medication aide (MA) on 02/08/19 at 12:48pm revealed:
-She could not remember if she administered divalproex to Resident #6.
-Resident #6 came with divalproex from the skilled rehabilitation facility that was administered before the divalproex from the contracted pharmacy was administered.
-She could not remember if she contacted the pharmacy about the divalproex.
-She could not remember if she notified the WN about the medication being unavailable.
-If the medication was not available for administration, she would have contacted the pharmacy and notified the WN.
-"I really don't know, I don't work on the cart often".

Review of Resideent #6's Accident/Incident Report dated 01/24/19 revealed Resident #6 "was involved in an altercation with another resident in which [Resident #6] attempted to put a resident in a head lock".

Observation of Resident #6 on 02/06/19 at 12:05pm revealed:
-Resident #6 walked from the hall where his room was located to the Special Care Unit (SCU) dining room area for the lunch meal service.
-Resident #6 noticed a working non-staff member on the unit, and he asked the SCU Coordinator who she was and what she was doing there.
-The non-staff member introduced herself to Resident #6 for a second time, and the SCU Coordinator explained the non-staff member was there to observe the lunch meal service.
-The SCU Coordinator escorted Resident #6 to

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his dining chair on the other side of the dining room.
-Approximately five minutes later, Resident #6 approached the non-staff member, asked what she was doing there and told her to "take her paper and find the front door. You better get out of here."
-Resident #6 blocked the non-staff member from exiting the dining room and had to be repeatedly encouraged by staff to move aside so the non-staff member could exit.
-The staff attempted to redirect Resident #6 by encouraging him to sit down and eat lunch, but subsequently the SCU Coordinator and personal care aide (PCA) had to escort the non-staff member into the SCU Coordinator's office.
-Resident #6 continued to watch the non-staff member through the window in the SCU Coordinator's office despite efforts of the staff to redirect him by offering to take him for a walk and encouraging him to eat lunch.
-The Administrator and a male staff person were called to the SCU in an effort to redirect Resident #6.
-The male staff person repeatedly offered to play a game with Resident #6, but was unable to redirect him away from the non-staff member.
-The non-staff member had to exit out the back entrance of the SCU Coordinator's office and exit the SCU.

Interview with a PCA on 02/06/19 at 12:15pm revealed:
-"He (Resident #6) is obsessed with (the non-staff member), and he won't quit until he can't see her anymore."
-Resident #6 would sometimes act this way when someone he did not recognize came to the unit.
-"It was hit or miss" as to whether he would act that way, and the staff could not predict his

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behavior.

Interview with the WN on 02/11/19 at 12:50pm revealed:
-She did not know Resident #6 had missed any doses of divalproex.
-She did not know divalproex was not available for administration.
-She would expect the MAs to notify her if a medication was not available so that she could determine the delay.
-A missed medications report was supposed to be reviewed daily by the Resident Care Director (RCD), however she resigned.
-She did not know if the missed medications report had been reviewed.

Interview with the Regional RN on 02/08/19 at 11:03am revealed:
-She did not know Resident #6 had missed any doses of divalproex.
-Medications should be reordered at least 5 days before running out.
-The MAs were responsible for reporting to the WN after a resident missed one dose of medication.
-The MAs and/or the WN should be contacting the pharmacy to get an update on the status of the medication daily.
-The RCD was responsible for reviewing eMARs for missed doses, but she recently resigned, "the process had obviously not been followed".

Telephone interview with a nurse from Resident #6's primary care provider's (PCP) office on 02/08/19 at 4:40pm revealed:
-Resident #6 was prescribed divalproex to stabilize mood and treat agitation.
-He did not know Resident #6 had missed doses of divalproex.

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-Resident #6 missing divalproex could cause him to be more agitated and aggressive towards staff and other residents.

Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She did not know Resident #6 had missed any doses of divalproex.
-The MAs should have contacted the pharmacy to get the divalproex delivered.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

b. Review of Resident #6's FL2 dated 12/17/18 revealed a medication order for carvedilol 3.125mg three tablets twice daily (used to treat high blood pressure and control heart rate).

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Review of Resident #6's December 2018 eMAR revealed:
-There was an entry for carvedilol 3.125mg three tablets to be administered twice daily at 7:00am and 8:00pm.
-There was documentation carvedilol was administered for 17 out of 19 opportunities from 12/01/18-12/31/18.
-There was documentation carvedilol was not administered on 12/22/18 at 8:00pm due to "drug refused".
-There was documentation carvedilol was not administered 12/23/18 at 7:00am due to "hospitalized".

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for carvedilol 3.125mg three tablets to be administered twice daily at 7:00am and 8:00pm.
-There was documentation carvedilol was administered 62 out of 62 opportunities from 01/01/19-01/31/19.

Review of Resident #6's February 2019 eMAR revealed:
-There was an entry for carvedilol 3.125mg three tablets to be administered twice daily at 7:00am and 8:00pm.
-There was documentation carvedilol was not administered 6 out of 21 opportunities from 02/01/19-02/11/19.
-There was documentation carvedilol was not administered on 02/07/19-02/08/19 at 7:00am, and 02/02/19, 02/05/19-02/07/19 at 8:00pm due to "medication pending delivery".

Observation of Resident #6's medications available for administration on 02/08/19 at 9:59am revealed carvedilol was not available for

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administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/08/19 at 9:20am revealed:
-The pharmacy had dispensed 180 tablets of carvedilol 3.125mg for Resident #6 on 12/23/18.
-The pharmacy had received no other refill requests from the facility since 12/23/18.
-A refill request would be required, medications were not automatically refilled.

Interview with Resident #6's responsible party (RP) on 02/08/19 at 3:33pm revealed:
-He relied on the facility to order and administer Resident #6's medications.
-He did not know if Resident #6 missed any of his medications.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed:
-She did not work the medication cart frequently.
-She noticed on today (02/08/19) that the carvedilol was not available for administration.
-She thought the medication was going to be delivered.
-She had not notified the pharmacy, because she thought the medication would eventually be delivered.
-The MAs were responsible for contacting the pharmacy to check on the medication daily if it was not available.
-She did not realize Resident #6 missed 6 doses of carvedilol.

Telephone interview with a second shift medication aide (MA) on 02/08/19 at 12:48pm revealed:
-She could not remember if the carvedilol was to administer for Resident #6.

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-Resident #6 came with carvedilol from the skilled rehabilitation facility that was administered before using carvedilol delivered by the contracted pharmacy.
-She could not remember if she contacted the pharmacy about the carvedilol needing to be refilled.
-She could not remember if she notified the WN about the medication being unavailable.
-If a medication was not available for administration, she would have contacted the pharmacy and notified the WN.
-"I really don't know, I don't work on the cart often".

Interview with the WN on 02/11/19 at 12:50pm revealed:
-She did not know Resident #6 had missed any doses of carvedilol.
-She did not know carvedilol was not available for administration.
-She would expect the MAs to notify her if a medication was not available so that she could determine the delay.
-A missed medications report was supposed to be reviewed daily by the RCD, however she resigned.

Interview with the Regional RN on 02/08/19 at 11:03am revealed:
-She did not know Resident #6 had missed any doses of carvedilol.
-Medications should be reordered at least 5 days before running out.
-The MAs were responsible for reporting to the WN after a resident missed one dose of medication.
-The MAs and/or the WN should be contacting the pharmacy to get an update on the status of the medication.

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-The RCD was responsible for reviewing eMARs for missed doses, but she recently resigned, "the process had obviously not been followed".

Telephone interview with a nurse from Resident #6's primary care provider's (PCP) office on 02/08/19 at 4:40pm revealed:
-Resident #6 was prescribed carvedilol to treat high blood pressure and control heart rate.
-He did not know Resident #6 had missed doses of carvedilol.
-Resident #6 missing carvedilol could cause his heart rate and blood pressure to increase, "he would be at risk for a stroke".

Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She did not know Resident #6 had missed any doses of carvedilol.
-The MAs should have contacted the pharmacy to get the carvedilol delivered.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

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Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

c. Review of Resident #6's FL2 dated 12/17/18 revealed a medication order for docusate sodium 100mg one tablet twice daily (used to treat constipation).

Review of Resident #6's December 2018 eMAR revealed:
-There was an entry for docusate sodium 100mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation docusate sodium was administered for 17 out of 19 opportunities from 12/01/18-12/31/18.
-There was documentation docusate sodium was not administered on 12/22/18 at 8:00pm due to "drug refused".
-There was documentation docusate sodium was not administered on 12/23/18 at 7:00am due to "hospitalized".

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for docusate sodium 100mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation docusate sodium was not administered 9 out of 62 opportunities from 01/01/19-01/31/19.
-There was documentation docusate sodium was not administered on 01/14/19-01/17/19 at 7:00am and 01/13/19-01/17/19 at 8:00pm due to "medication pending delivery".

Review of Resident #6's February 2019 eMAR

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revealed:
-There was an entry for docusate sodium 100mg one tablet to be administered twice daily at 7:00am and 8:00pm.
-There was documentation docusate sodium was administered as ordered from 02/01/19-02/11/19.

Observation of Resident #6's medications available for administration on 02/08/19 at 9:59am revealed docusate sodium was available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/08/19 at 9:20am revealed:
-The pharmacy had dispensed 30 tablets of docusate sodium 100mg for Resident #6 on 12/23/18.
-The pharmacy had dispensed 60 tablets of docusate sodium 100mg for Resident #6 on 01/17/19.

Interview with Resident #6's responsible party (RP) on 02/08/19 at 3:33pm revealed:
-He relied on the facility to order and administer Resident #6's medications.
-He did not know Resident #6 missed any of his medications being missed.

Interview with a medication aide (MA) on 02/08/19 at 10:17am revealed:
-She did not work the medication cart frequently.
-She did not know what happened with Resident #6's docusate sodium in January 2019.
-She could not remember if she notified the WN about Resident #6's docusate sodium not being available for administration.
-She do not know why it took so long for the docusate sodium to be delivered to the facility.
- The MAs were responsible for contacting the

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pharmacy within 5 days of running out a medication.
-The MAs were responsible for checking on medications daily if it was delivered from the pharmacy.

Telephone interview with a second shift medication aide (MA) on 02/08/19 at 12:48pm revealed:
-She could not remember Resident #6 missing doses of docusate sodium in January 2019.
-She could not remember if she contacted the pharmacy about the docusate sodium needing to be refilled.
-She could not remember if she notified the WN about the medication notified being available.
-If a medication was not available for administration, she would have contacted the pharmacy and notified the WN.
-"I really don't know, I don't work on the cart often".

Interview with the WN on 02/11/19 at 12:50pm revealed:
-She did not know Resident #6 had missed any doses of docusate sodium.
-She would expect the MAs to notify her if a medication was not available so that she could determine the delay.
-A missed medications report was supposed to be reviewed daily by the RCD, however she resigned.
-She did not know if the missed medications report had been reviewed.

Interview with the Regional Director of Resident Care (RDRC) on 02/08/19 at 11:03am revealed:
-She did not know Resident #6 had missed any doses of docusate sodium
-Medications should be reordered at least 5 days

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before running out.
-The MAs were responsible for reporting to the WN after a resident missed one dose of medication.
-The MAs and/or the WN should be contacting the pharmacy to get an update on the status of the medication.
-The RCD was responsible for reviewing eMARs for missed doses, but she recently resigned, "the process had obviously not been followed".

Telephone interview with a nurse from Resident #6's primary care provider's (PCP) office on 02/08/19 at 4:40pm revealed:
-Resident #6 was prescribed docusate sodium to treat constipation.
-He did not know Resident #6 had missed doses of docusate sodium.
-Resident #6 missing docusate sodium could cause him to be more constipated.

Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She did not know Resident #6 had missed any doses of docusate sodium.
-The MAs should have contacted the pharmacy to get the carvedilol delivered.

Based on observation, interview, and record review, Resident #6 was not interviewable.

5. Review of Resident #2's current FL-2 dated 02/05/19 revealed:
-Diagnoses included right basil ganglia stroke.
-There was a medication order for albuterol 90mcg two puffs four times daily as need (used to treat wheezing and shortness of breath).
-There was a medication order for alendronate 70mg one tablet every Friday (used to prevent osteoporosis).

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-There was a medication order for aspirin 325mg one tablet at bedtime (used to prevent blood clots).
-There was a medication order for calcium carbonate 500mg two tablets daily as needed (used to treat acid reflux)
-There was a medication order for cholecalciferol 1000 units one tablet daily (used to treat vitamin D deficiency).
-There was a medication order for clopidogrel 75mg one tablet daily (used to prevent blood clots and stroke).
-There was a medication order for cyanocobalamin 100mcg one tablet daily (used to treat vitamin B12 deficiency).
-There was a medication order for donezepil 10mg one tablet at bedtime (used to treat memory loss).
-There was a medication order for fluticasone nasal 50mcg two sprays in each nostril daily (used to allergies).
-There was a medication order for furosemide 20mg one tablet daily (used to treat fluid retention).
-There was a medication order for gabapentin 800mg one tablet three times daily (used to treat neuropathy).
-There was a medication order for loperamide two tablets every morning as needed (used to treat diarrhea).
-There was a medication order for metoprolol tartrate 25mg one tablet twice daily (used to treat high blood pressure).
-There was a medication order for ocular lubricant one drop in each eye twice daily (used to treat dry eyes).
-There was a medication order for pantoprazole 40mg one tablet daily (used to treat indigestion).

Review of Resident #2's progress notes dated

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02/05/19 revealed "resident arrived about 1:30pm via transport" from skilled rehabilitation facility.

Interview with Resident #2 on 02/06/19 at 10:30am revealed:
-She had been in a skilled rehabilitation facility before returning to the facility on 02/05/19.
-She came back and was supposed to be taking a blood thinner but none of her medications were available.
-She had not received her medication last night (02/05/19) or this morning (02/06/19).
-"I had a stroke, it is very dangerous for me to miss my medications".
-"The Resident Care Director (RCD) promised me that my medications would be here",
-"I don't know what happened, I don't understand".

Review of Resident #2's medications available for administration on 02/06/19 revealed there were no medications available to be administered.

Review of Resident #2's February 2019 electronic Medication Administration Record (eMAR) revealed:
-All medications were not administered in the evening on 02/05/19 and in the morning on 02/06/19 due to "medication pending delivery".

Review of" Weights and Vitals summary" for Resident #6 revealed:
-Her blood pressure on 02/05/19 was 150/90.
-Her blood pressure on 02/06/19 was 140/70.

Telephone interview with a representative from the contracted pharmacy on 02/07/19 at 3:09pm revealed:
-Resident #2's FL2 was received via fax on 02/06/19 at 11:07am.

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-A staff member called requesting an immediate delivery of medications on 02/06/19 at 11:30am.
-Medications were not filled for a resident until they were admitted to the facility and an FL2 or signed physician orders were received.
-A request to fill Resident #2's was not received before 02/06/19 at 11:07am.
-All medications listed on Resident #2's FL2 was delivered in the evening on 02/06/19.

Interview with Resident #2 on 02/07/19 at 11:04am revealed:
-She finally received her medication "yesterday evening" (02/06/19).
-"I don't know what took so long for the medication to come into the building".

Interview with a medication aide (MA) on 02/07/19 at 12:40pm revealed:
-Resident #2 came back to the facility on 02/05/19 and her medication was not available for administration.
-When residents were admitted to the facility, the Wellness Nurse (WN) and the Resident Care Director (RCD) were responsible for ordering medications from the pharmacy when they arrive.
-She did not know why Resident #2's medications were not available for administration when she arrived.
-The RCD resigned, therefore the WNs were responsible for ordering the medications.

Telephone interview with Resident #2's physician on 02/11/19 at 11:39am revealed:
-She did not know Resident #2 missed any of her medications since returning to the facility.
-No one informed her of any missed medications, she would expect to be notified.
-She would expect Resident #2 to receive her medication daily as ordered.

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-Resident #2 would be at risk for being hospitalized if she missed any of her blood pressure or blood thinner medications.

Interview with the WN on 02/11/19 at 12:50pm revealed:
-She had not faxed the FL2 to the pharmacy to get Resident #2's medications delivered.
-The RCD was responsible for faxing the FL2 to the pharmacy to get medications delivered when a resident was admitted.
-The RCD recently resigned, she did not know why the medications were not delivered before she came back to the facility.
-Resident #2's medications should have been available for administration when she was admitted.
-Resident #2 complained about medications being unavailable and they were ordered from the pharmacy immediately by the RCD before she resigned.

Interview with the Regional Director of Resident Care (RDRC) on 02/11/19 at 1:41pm revealed:
-She did not know Resident #2 medications were not available or requested when she arrived on 02/05/19.
-She would expect the FL2 for Resident #2 to be faxed to the pharmacy once she returned to the facility.
-She did not know why Resident #2's FL2 had not been faxed to the pharmacy when she arrived.
-She did not know Resident #2's medications were not available for administration until 02/06/19 in the evening after Resident #2 complained.
-Since the RCD resigned, the WNs were responsible for ensuring the FL2 was faxed to the pharmacy to get medications delivered.

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Interview with the Administrator on 02/11/19 at 1:41pm revealed:
-She would expect the FL2 to be faxed to the pharmacy once a resident returned or was admitted to the facility.
-She expected the WNs to ensure the FL2 was faxed since the RCD resigned.
-She did not know Resident #2's medications were not available for administration until 02/06/19 in the evening after Resident #2 complained.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

6. Review of Resident #1's current FL2 dated 07/05/18 revealed:
-Diagnoses included Alzheimer dementia,

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hypertension and hypothyroidism.
-Requested level of care was documented as a memory care unit.

a. Review of Resident #1's current FL2 dated 07/05/18 revealed medications included simvastatin 20mg, one tablet every day, for high blood cholesterol levels.

Review of Resident #1's hospital discharge summary dated 12/30/18 revealed medications included simvastatin 20mg, one tablet daily at bedtime.

Review of Resident #1's December electronic Medication Administration Record (eMAR) from 12/09/18-12/27/18 revealed:
-There was an entry for simvastatin 20mg to be administered daily at 7:00pm.
-On 12/09/18-12/27/18 there was documentation the medication was pending delivery (MD).
-There was documentation simvastatin was not administered 19 of 31 opportunities to Resident #1 in December 2018.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 12:10pm revealed:
-The process to request refill medications between the facility and the pharmacy was as follows:
-The facility staff, (MAs and nurses), could electronically order a refill medication at their computer terminal.
-The facility staff could also request a refill for a medication by removing the attached label on the bubble pack, affixing it to a refill order sheet and faxing it to the pharmacy.
-The pharmacy technician reviewed the order for accuracy, validated the order and keyed in the

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request.
-Once the verification process was completed, a computer generated message was sent to the facility to confirm the approval process was completed.
-If a refill order had been received by 5:00pm the medication would arrive that evening by courier.
- A medication would not be immediately delivered if there was an insurance issue or the medication was ordered too early.
-There was an on call pharmacy representative every evening until 10:30pm to receive faxes and phone calls if there were any questions from the evening staff.
-The dispense history for simvastatin 20 mg for the past 3 months was as follows: on 11/06/18, thirty tablets of simvastatin 20mg were sent to the facility; on 12/27/18, thirty tablets of simvastatin were sent to the facility; simvastatin 20mg was discontinued on 01/21/19.
-There was no documented communication from the facility staff to the pharmacy staff from 12/09/18-12/26/18 regarding the refill order for simvastatin 20mg.
-The refill request from the facility staff to the pharmacy staff for simvastatin 20 mg was received on 12/27/18.
-A bubble pack of 30 tablets of simvastatin 20mg was sent to the facility by courier on 12/27/18.

Review of Resident #1's subsequent physician order dated 01/21/19 on 02/08/19 at 1:05pm revealed simvastatin 20mg, one tablet in the evening was discontinued.

Attempted phone interview with the primary care provider (PCP) on 02/08/19 at 9:10am and on 02/11/19 at 11:24am was unsuccessful.

Based on observations, interviews, and record

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reviews it was determined Resident #1 was not interviewable.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift MA on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am.

b. Review of Resident #1's current FL2 dated 07/05/18 revealed medications included sertraline 100mg, one and one half tablets (150mg)daily at bedtime for depression.

Review of Resident #1's hospital discharge summary dated 12/30/18 revealed medications included sertraline100mg tablet, one and one half tablets daily.

Review of Resident #1's January electronic Medication Administration Record (eMAR) from 01/08/19-01/11/19 revealed:

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-There was an entry for sertraline 100mg 1 1/2 tablets, to be administered daily at 7:00pm.
-On 01/08/19-01/11/19 there was documentation the medication was pending delivery (MD).
-There was documentation sertraline 100mg, one and one half tablets, was not administered 4 of 31 opportunities.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 12:10pm revealed
-There was no documented communication from the facility staff to the pharmacy staff from 01/08/19-01/11/19 regarding the refill order for sertraline.
-The refill request from the facility staff to the pharmacy staff for sertraline 100mg was received on 01/11/19.
-A bubble pack of 30 tablets of sertraline 100mg was sent to the facility by courier on 01/11/19.

Attempted phone interview with MD on 02/08/19 at 9:10am and on 02/11/19 at 11:24am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to interview with a second MA on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

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Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on 02/08/19 at 9:13am and 9:45am..

c. Review of Resident #1's current FL2 dated 07/05/18 revealed medications included vitamin D3 2000 units one capsule daily for immune function.

Review of Resident #1's hospital discharge summary dated 12/30/18 revealed medications included vitamin D3 2000 units, one capsule daily.

Review of Resident #1's January electronic Medication Administration Record (eMAR) from 01/13/19-01/17/19 revealed:
-There was an entry for vitamin D3 200 units, to be administered daily at 7:00am.
-On 01/13/19-01/17/19 there was documentation the medication was pending delivery (MD).
-There was documentation Vitamin D3 2000units was not administered 4 of 31 opportunities.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/19 at 12:10pm revealed:
-There was no documented communication from the facility staff to the pharmacy staff from 01/13/19-01/17/19 regarding the refill order for Vitamin D3 2000 units daily.

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-The refill request for Vitamin D3 was received from the facility staff to the pharmacy staff on 01/17/19.
-A bubble pack of 30 tablets of vitamin D3 was sent to the facility by courier on 01/17/19.

Review of Resident #1's subsequent physician order dated 01/21/19 at 1:05pm revealed vitamin D3 had been discontinued.

Attempted phone interview with MD on 02/08/19 at 9:10am and on 02/11/19 at 11:24am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to interview with a second medication aide (MA) on 02/07/19 at 10:15am.

Refer to interview with a first shift medication aide (MA) on 02/07/19 at 11:30am.

Refer to interview with a second shift MA on 02/07/19 at 3:55pm.

Refer to interview with the Wellness Nurse on 02/07/19 at 11:07am.

Refer to a second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:

Refer to interview with the Administrator on 02/07/19 at 2:40pm.

Refer to a second interview with the Administrator on 02/11/19 at 1:25pm.

Refer to interview with the Regional RN on

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02/08/19 at 9:13am and 9:45am.

____

Interview with a medication aide (MA) on 02/07/19 at 10:15am revealed:
-The MAs were responsible for ordering medications when the resident's supply had five days remaining.
-She ordered medications electronically through the eMAR system and faxed a refill request to the pharmacy.
-The MAs were to place the faxed order in a binder at the Assisted Living (AL) nurse's station.
-The MAs were able to look in the eMAR computer system to see if the medication had already been ordered.
-Some MAs would only fax a refill request to the pharmacy and not order through the eMAR system. If that was the case, the only way to see if the order had been placed would be to walk over to the AL nurse's station and check the fax binder.
-If she did not have a medication available to administer, she was to check to see if it had been ordered and if it had, she was to call the pharmacy to follow-up on why the medication had not arrived at the facility.
-She had never been told to document the contact with the pharmacy.

Interview with a second medication aide (MA) on 02/07/19 at 11:30am revealed:
-She ordered medications when there were 5 doses or less remaining in the bubble pack.
-She ordered the medications electronically from the computer terminal on the medication cart.
-She could fax the refill request by removing the medication label from the bubble pack, attaching it to the medication reorder form and sending it to the pharmacy.

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-She could also call the pharmacy to confirm the receipt of the fax.
-There were instances when the pharmacy staff had not received the electronic refill request, so she called the pharmacy or sent a fax refill request if she had the time.
-If she had ordered refill medications, and they had not arrived in a few days, she contacted the pharmacy and followed up on the status of the medication.
-The order history tab indicated whether a medication had been previously ordered.
-If she saw the documentation "MD" (medication pending delivery) she would call the pharmacy.
-When a refill medication was ordered before 5:00pm, the pharmacy courier delivered it that night during third shift.

Interview with a second shift MA on 02/07/19 at 3:55pm revealed:
-The MAs were supposed to order refill medication when the current bubble pack had less than 3 tablets remaining.
-If the fill history on the eMAR dashboard indicated the medication had not been ordered, she would order the refill medication electronically.
-If there was no medication on the cart for the order, and the fill history showed the medication was ordered, she would check with another more experienced MA as to what should be done.
-There was no nurse in the building in the evening.
-Sometimes we were told by one of the MAs there was a nurse on call, and we could call them.
-"I could fax the order over to the pharmacy again, I guess."

Interview with the Wellness Nurse on 02/07/19 at

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11:07am revealed:
-There were three part-time Wellness Nurses employed at the facility.
-The MAs were responsible for ordering medications when the resident's supply had seven days remaining by faxing the refill request to the pharmacy.
-She was unsure if the MAs had the capability to order medications electronically through the eMAR system.
-If the facility did not receive a medication after it was ordered, the MAs were responsible for either contacting the pharmacy themselves, or they could notify one of the Wellness Nurses (WN), and the WN would contact the pharmacy to follow-up.

A second interview with a Wellness Nurse on 02/08/19 at 10:38am revealed:
-Refill requests for medications with 5 or less doses in the bubble pack was the responsibility of the MA that was on the cart during the medication pass.
-Medication refill requests were electronically sent to the pharmacy staff by the MAs from their computer terminal.
-The MAs could also fax a refill request to the pharmacy by removing the label of the medication from the bubble pack and affixing it to the re-order form.
-The Wellness Nurses and RCD received computer generated alerts on the eMAR system, from the pharmacy, when a refill was due for a medication.
-If there was a problem with a refill order, a computer generated alert would also be sent out to the nurses on the eMAR system.
-The Wellness Nurses followed up with the pharmacy if there was a medication concern and the RCD was not available to address.

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-The MAs should follow up with a call to the pharmacy if the medication had not arrived in two days.
-She could not produce a policy regarding the follow up procedure for medications that had been ordered but not received by the facility.
-If the MA was not scheduled to be on the medication cart for several days, the RCD or Wellness Nurse should follow up with the pharmacy.

Interview with the Administrator on 02/07/19 at 2:40pm revealed:
-She relied on the RCD and the Wellness Nurses for the clinical aspects of the facility.
-She was not sure who was responsible for ordering refill medications in the facility.
-She did not know the pharmacy policy for ordering refill medications.
-If the nurses came to her with a medication concern related to the pharmacy, she would call the account manager of the pharmacy and the manager resolved the issue.
-It was the responsibility of the RCD to train the MAs and supervise them, as well as oversight for all clinical aspects of the residents.
-She depended on the RCD to complete her responsibilities and to give her any relevant updates daily.
-She did not know the RCD was not completing her responsibilities.

A second interview with the Administrator on 02/11/19 at 1:25pm revealed:
-It was the MAs responsibility to order medications and notify either the Wellness Nurses or the RCD if a medication was not available for administration.
-It was the RCD's responsibility to print a "missed medication" report daily and address any

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medications that had not been administered, and she thought the former RCD had been doing so.

Interview with the Regional RN on 02/08/19 at 9:13am and 9:45am revealed:
-The MAs were responsible for ordering medications when a resident's supply had five days remaining.
-The MAs were required to order medications electronically through the eMAR system and it was optional for them to follow-up with a faxed order to the pharmacy.
-If a medication was not available for administration during the day, the MAs should notify whichever Wellness Nurse was on duty that day so they could follow-up with the pharmacy and make sure they received the order.
-If a medication was not available for administration in the evening or on weekends, the MAs should notify the Resident Care Director (RCD).
-She could find no documentation this process was followed.
-The RCD was responsible for supervising the Wellness Nurses and the MAs and their responsibilities.
-The RCD was responsible for oversight of medication orders, eMARs, and she was the primary pharmacy liaison in the community.
-The RCD was responsible for medication cart audits weekly and monthly. The last documented cart audit, signed by the RCD, was dated 01/26/19.
-The RCD was to print a daily report, the Administration Summary Report, showing the medications waiting to be received, missed medications and the documented reason indicated by chart code for the missed medications.
-The RCD would follow up with the pharmacy

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staff regarding medications not delivered to the community.
-The pharmacy generated electronic alerts were sent on the eMAR system to the nursing staff regarding refills requested too soon, insurance concerns and other issues that may arise.
-Follow up conversations with the pharmacy regarding refill medications not received at the facility should have been documented by the RCD or Wellness Nurse.
-She relied on good communication and documentation between the nurses and the MAs for a seamless medication administration for the residents and follow up with the pharmacy.
-The RCD did not complete her responsibilities in medication oversight and the MAs were not following the refill order process.
-There was no one supervising the RCD.
-The Wellness Nurses were not communicating effectively shift to shift to ensure there was follow up.
-Lack of communication and turnover resulted in poor follow up and errors in medication administration.

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The facility failed to assure medications were administered as ordered by a licensed prescribing practitioner related to Resident #4 receiving 15 additional units of Humalog insulin resulting in a medication error placing Resident #4 at risk for hypoglycemia, Resident #8 with a hospital admission and another visit to the emergency department (ED) related to missed administration of medications Seroquel and melatonin, Resident #5's missed medications including potassium chloride, trazodone, divalproex sodium, Lasix, Lotemax, Risperdal, digoxin, and diltiazem placing her at risk for electrolyte imbalance and heart irregularities, Resident #6's missed medications including divalproex, docusate

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sodium and carvedilol, Resident #3's missed medications including albuterol, alendronate, aspirin, calcium carbonate, cholecalciferol, clopidogrel, cyanocobalamin, donezepil, fluticasone nasal spray, furosemide, gabapentin, loperamide, metoprolol tartrate, ocular lubricant and pantoprazole placing her at risk for a blood clot or a stroke, Resident #1's missed medications included simvastatin, sertraline and vitamin D3. This failure to assure medications were available and administered as ordered by the prescribing physician placed residents at substantial risk that serious physical harm and neglect of residents would occur and constitutes a Type A2 Violation.

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The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 02/07/19 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 13, 2019.

D912 — D912

G.S. 131D-21(2) Declaration of Residents' Rights

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:
2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, interviews, and record

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D912	Continued From page 148 reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to training on care of diabetic residents, health care referral and follow-up, and medication administration. The findings are: A. Based on observations, record reviews and interviews, the facility failed to assure 3 of 4 staff sampled (Staff A, B and E) who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag 164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 5 of 7 sampled residents (Residents #8, #5, #6, #2 and #1) related to missed medications including Seroquel and melatonin (Resident #8), potassium chloride, trazodone, divalproex sodium, Lasix, Lotemax, Risperdal, digoxin, diltiazem (Resident #5), divalproex, docusate sodium and carvedilol (Resident #6), albuterol, alendronate, aspirin, calcium carbonate, cholecalciferol, clopidogrel, cyanocobalamin, donezepil, fluticasone nasal spray, furosemide, gabapentin, loperamide, metoprolol tartrate, ocular lubricant and pantoprazole (Resident #2) and simvastatin, sertraline and vitamin D3 (Resident #1) . [Refer to Tag 273 10A NCAC 13F .0902 (b) Health Care (Type B Violation)]. C. Based on observations, interviews, and record	D912		

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D912	Continued From page 149 reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 6 of 7 sampled residents (Resident #4, #8, #5, #6, #2, and #1) including Humalog insulin (Resident #4), medications not available for administration including Seroquel and melatonin (Resident #8), medications not available for administration including potassium chloride, trazodone, divalproex sodium, Lasix, Lotemax, Risperdal, digoxin and diltiazem (Resident #5), medications not available for administration including divalproex, docusate sodium and carvedilol (Resident #6), medications not available for administration including albuterol, alendronate, aspirin, calcium carbonate, cholecalciferol, clopidogrel, cyanocobalamin, donezepil, fluticasone nasal spray, furosemide, gabapentin, loperamide, metoprolol tartrate, ocular lubricant and pantoprazole (Resident #2), and medications not available for administration including simvastatin, sertraline and Vitamin D3 (Resident #1).[Refer to Tag 358 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)].	D912		