Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041077	A. BUILDING: ______ B. WING ______	R 09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HOUSE	5918 NETFIELD RD GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 09/05/19 through 09/06/19 and 09/09/19.	{D 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in this statement of Deficiencies of Correction Action Report; the plan of correction is prepared solely as a matter of compliance of law.	
{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: Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up regarding a physician's order for a Hospice and Palliative Care referral for 1 of 5 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL2 dated 05/07/19 revealed diagnoses included paroxysmal atrial fibrillation. Review of Resident #4's record revealed: -An order dated 08/08/19 for a Hospice and Palliative Care referral. -There was no documentation Resident #4 was referred to Hospice. Interview with the Director of Resident Care	{D 273}	Plan of Correction date: 10/24/19 Executive Director (ED), Director of Resident Care (DRC) and/or Memory Care Manager (MCM) will audit all resident charts to identify any non-compliance related to health care referral and follow up. Identified issues will be addressed immediately. ED, DRC and MCM will complete random weekly chart audits to ensure proper follow up regarding referrals and order processing. DRC will provide training to Med Aides (MAs) regarding process for health care referral and follow up when new referrals are received. MAs will notify ED and DRC Regarding any issues related to referrals.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carrie Oat [signature] TITLE: Executive Director (X6) DATE: 10/21/19

Received and accepted. AJS 10/22/19

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(DRC) on 09/09/19 at 2:24 pm revealed he did not know Resident #4 had a Hospice and Palliative Care referral dated 08/08/19 until today.

Interview with the Executive Director (ED) on 09/09/19 at 3:38 pm revealed:
-The previous Memory Care Manager (MCM) was responsible for sending the Hospice and Palliative Care referral to the contracted agency.
-Prior to 09/09/19, she did not know the Hospice and Palliative Care referral ordered on 08/08/19 was not sent for Resident #4.
-No one checked behind the MCM to make sure the referral was sent.
-She faxed the Hospice and Palliative Care referral to the contracted agency on 09/09/19 after she was made aware it had not been completed as ordered.

Interview with a medication aide (MA) on 09/10/19 at 9:00 am revealed:
-She was the MCM until 08/12/19 and was responsible for the Memory Care Unit (MCU) and the Assisted Living (AL).
-She was now working as a MA on third shift.
-She would have been responsible for sending the Hospice and Palliative Care referral to the contracted agency on 08/08/19.
-She did not remember an order for a Hospice and Palliative Care referral for Resident #4.

Interview with Resident #4's family member on 09/10/19 at 9:05 am revealed the facility had discussed Hospice and Palliative Care with her but no decision had been made.

Interview with Resident #4's Primary Care Provider (PCP) on 09/10/19 at 9:15 am revealed:
-Resident #4 requested to see her weekly for different ailments.

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{D 273}	Continued From page 2 -Resident #4 had chronic generalized pain. -She did not know Resident #4 was not referred to Hospice as ordered on 08/08/19. -She expected the facility to send the referral to Hospice as ordered. -She referred Resident #4 to Hospice to assist with pain and emotional support. Interview with a representative from the contracted Hospice agency on 09/10/19 at 10:26 pm revealed: -They did not receive a Hospice referral for Resident #4 on 08/08/19. -They received the Hospice referral on 09/09/19.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure implementation of physician's for 2 of 5 sampled	D 276	ED, DRC and/or MCM will audit all resident charts to identify any non-compliance related to health care. Identified issues will be addressed immediately. DRC will provide staff training to all Med Aides (MAs) regarding documentation of written procedures, treatments and PCP orders. ED, DRC and MCM will complete random weekly chart audits and PCP order audits to ensure proper documentation is completed regarding health care orders.	

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residents (Residents #1 and #4) with orders for daily blood pressures (BP) for one week (#1) and an order to check weight monthly (#4).

The findings are:

1. Review of Resident #1's current hospital FL2 dated 01/08/19 revealed:
-Diagnoses included behavioral disturbances, anxiety, atrial fibrillation, insomnia, and lower extremity neuropathy.
-There was an order to check and record vital signs one time monthly on the second day of the month.

Review of Resident #1's physician's order dated 08/06/19 revealed:
-There was a one time order to check daily BPs for one week.
-The diagnosis for the order was elevated BP.
-The order was faxed to the facility from the Primary Care Provider (PCP).

Review of Resident #1's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for vital signs (temperature, pulse, respirations, and BPs) scheduled to be taken on 08/02/19 and documented as 134/72.
-There was no entry for BP to be taken daily for one week starting on 08/06/19.
-There was no documentation of BPs obtained from 08/06/19 to 08/13/19.

Review of Resident #1's Home Health notes revealed:
-There was documentation of vital signs collected by a Home Health Nurse (HHN) on 08/06/19.
-The BP documented on 08/06/19 at 3:45 pm was 172/68.

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D 276	Continued From page 4 -The manual BP documented on 08/06/19 at 3:55 pm was 178/62. -On 08/06/19, The HHN documented that the Primary Care Provider (PCP) was notified and no new orders were received. Interview with the Director of Resident Care (DRC) on 09/05/19/19 at 12:46 pm revealed he was unable to locate the BP recordings from 08/06/19 to 08/13/19. Second interview with the DRC on 09/05/19 at 4:11 pm revealed: -BP recordings were documented in the eMAR. -The contracted pharmacy had access to the eMAR system and added orders. -The DRC, Executive Director (ED), Memory Care Manager (MCM), and Supervisor had access into the eMAR system and could add, remove, change, or discontinue orders. -MA's were responsible for eMAR audits. Interview with a medication aide (MA) on 09/05/19 at 5:15 pm revealed: -She was not trained to make changes in the eMAR system; only Supervisors could make changes in the eMAR system. -The MAs, the ED, and the DRC were responsible for faxing orders to the pharmacy. Interview with a second MA on 09/06/19 at 7:37 am revealed: -She did not know there was an order for BPs to be taken daily for one week starting on 08/06/19. -She did not know what happened to the BP order on 08/06/19. -She worked as the MCM from 03/03/19 to 08/12/19. -She processed orders when she was the MCM. -The MCM and Supervisor were responsible for	D 276		

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ensuring implementation of orders.
-Orders for BPs could be added manually in the eMAR or the order could have been sent to the contracted pharmacy and the pharmacy would put the order into the eMAR.
-Only the MCM and Supervisor could add orders into the eMAR.
-She expected MAs to collect BPs per order.
-BPs were to be documented in the eMAR.
-She did not know if the PCP was notified of the BPs not collected as ordered on 08/06/19.

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

Interview with Resident #1's family member on 09/06/19 at 9:08 am revealed:
-She visited Resident #1 once a month at the facility.
-Resident #1 had a history of hypertension 10 years ago, but then Resident #1 developed issues with low BP (date unknown).

Interview with Resident #1's PCP on 09/06/19 at 9:25 am revealed:
-She ordered Resident #1's BP to be checked daily for one week on 08/06/19.
-She wanted to see if the hypertensive results collected on 08/06/19 were a pattern or trend for Resident #1 and order additional medications if needed.
-She was not notified of any BP results collected from the order on 08/06/19.
-She did not know the BPs were not collected as ordered.
-She was concerned that the order was not completed because she wanted to look at Resident #1's BP trend for a week.
-Resident #1 did not have a history of

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hypertension.
-Resident #1 did not display any signs of hypertension and was last seen by the PCP on 09/03/19.

Interview with the Home Health Agency's Performance Improvement Coordinator 09/06/19 at 11:45 am revealed:
-The nurse notified the PCP of the BP recordings on 08/06/19 based on nursing judgement and Resident #1 was not on an anti-hypertensive medication.
-Abnormal vital signs collected by the Home Health agency were reported to the ED.
-She did not receive a new order from the PCP.

Interview with the ED on 09/06/19 at 10:45am revealed:
-The MAs were responsible for checking and recording vital signs.
-Vital signs were obtained monthly and per provider request.
-Vital sign orders were sent to the contracted pharmacy.
-She did not know Resident #1 had an order for BP to be taken daily for one week starting on 08/06/19.
-She was not aware that the BPs were not checked by staff per the order on 08/06/19.
-The order for the BP to be checked daily for one week on 08/06/19 should have populated in the eMAR if the order was sent to the pharmacy.
-Orders were sent to the pharmacy by MAs or electronically sent by the provider.
-She did not know if the PCP was notified of the BPs not collected as ordered on 08/06/19.

Interview with the DRC on 09/06/19 at 11:15 am revealed:
-The MAs were responsible for checking and

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recording vital signs.
-Vital signs were obtained one time a month or as ordered by a provider.
-He did not know there was an order for BPs to be taken daily for one week starting on 08/06/19.
-The order was likely never faxed to the pharmacy or put into the eMAR by the facility staff.
-He did not know who received the order for BPs to be taken for a week on 08/06/19.
-He expected MAs to notify Supervisors and providers of abnormal BPs.
-A training on obtaining vital signs, documenting, and reporting of abnormal ranges was completed at the end of August 2019.
-He did not know if there was a vital sign policy before the training in August 2019.

Interview with the ED on 09/06/19 at 11:55 am revealed there was no policy for vital signs.

A second interview with the first MA on 09/06/19 at 4:30 pm revealed:
-The MAs obtained and recorded vital signs.
-Vitals were obtained when they came up as due on the eMAR.
-There was no order for daily BP checks for one week starting on 08/06/19 on Resident #1's eMAR.
-BPs would be documented on the eMAR.

2. Review of Resident #4's current FL2 dated 05/07/19 revealed:
-Diagnosis included paroxysmal atrial fibrillation.
-There was an order to obtain monthly weights.

Review of Resident #4's July 2019 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain monthly weights on

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the 23rd of each month.
-On 07/23/19, staff did not document a weight was obtained.

Review of Resident #4's August 2019 eMAR revealed there was no entry to obtain monthly weights.

Review of Resident #4's September 2019 eMAR revealed there was no entry to obtain monthly weights.

Review of Resident #4's record revealed no additional documentation of weights obtained.

Interview with Resident #4 on 09/09/19 at 1:00 pm revealed:
-Staff checked her weight "periodically".
-She did not know when staff obtained the last weight.

Interview with the personal care aide (PCA) on 09/09/19 at 11:30 am revealed:
-The PCAs were responsible for obtaining weights.
-She did not know Resident #4 had an order for monthly weights.

Interview with the medication aide (MA) on 09/09/19 at 12:02 pm revealed:
-She was the Memory Care Manager (MCM) until 08/12/19 and was responsible for the Memory Care Unit (MCU) and the Assisted Living (AL).
-She did not know Resident #4 was ordered monthly weights.
-A contracted company was performing monthly vitals and monthly weights, but they no longer came to the facility.
-The contracted company found the facility scale was not calibrated correctly.

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-The PCAs were responsible for obtaining weights and reported the weight to the supervisor.
-She did not know if the scale was recalibrated.

Interview with the Director of Resident Care (DRC) on 09/09/19 at 2:24 pm revealed:
-The PCA was responsible for checking monthly weights.
-It was the facility policy for staff to check weights monthly for all residents.
-He did not know why the monthly weight entry was no longer present on the eMAR.
-He would expect staff to notify the DRC or the Executive Director (ED) if the weight entry was removed from the eMAR.
-He did not know monthly weights were not monitored for Resident #4 in July 2019 and August 2019.

Interview with the ED on 09/09/19 at 3:38 pm revealed:
-The PCA was responsible for obtaining monthly weights.
-The MA was responsible for making sure the PCA obtained the weights.
-She did not know Resident #4's weight was not obtained July 2019 and August 2019.
-She would expect staff to let her know if a weight was not obtained.
-She did not know the scale was not calibrated correctly.
-The pharmacy or designated staff entered orders into the eMAR system.
-The DRC/ED/Supervisors were responsible for ensuring orders were entered into the eMAR system.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 09/10/19 at 9:15 am revealed:

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D 276	Continued From page 10 -She started seeing Resident #4 in June 2019. -She was unsure why the monthly weight was ordered because it was carried over from a previous provider. -She expected staff to check Resident #4's weight monthly. -She expected staff to notify her if weights were not obtained. -She knew Resident #4's weight was obtained in July because she used her weight to adjust medication. -She did not have a record of the July 2019 weight.	D 276		
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 B VIOLATION	D 358	Pharmacy Foundations Training conducted with Beth Wilson(Omnicare) included med administration process, as it relates to meds not in facility, duplicate orders, administration of medications per PCP orders and notify management immediately regarding issues related to medications not being available. ED, DRC and MCM will conduct resident chart audits and cart audits. Any identified issues will be addressed immediately. ED, DRC, MCM will conduct training to MAs regarding medication administration not in facility and administration of medications. MAs will notify DRC and/or MCM when medications are not available for administration. DRC and/or MCM will contact pharmacy immediately to have the medications delivered in a timely manner. DRC and MCM will conduct weekly chart audits and cart audits to ensure medication administration compliance. ED will monitor compliance through random audits and observations.	

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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 4 of 5 residents sampled for record review (#1, #2, #3, #4) including errors with an antipsychotic medication and an antibiotic (#1), an antibiotic, an antihypertensive medications, an anti-psychotic medication, an antidepressant medication, a sleep aid medication and a medication used to treat reflux (#2), an antipsychotic, an antidepressant, a thyroid medication, and an anti-anxiety medication (#3), and an anti-depressant, lubricant eye drops, a proton-pump inhibitor, and a topical analgesic patch (#4).

The findings are:

1. Review of Resident #2's current FL-2 dated 01/09/19 revealed diagnoses included dementia, cerebral infarction, type 2 diabetes, epilepsy, recurrent seizures, hernia, history right femur fracture, major depressive disorder, calculus of kidney and gastroesophageal reflux disease (GERD) with esophagitis.

a. Review of Resident #2's after visit summary from the emergency department dated 07/20/19 revealed:
-Resident #2 was diagnosed with a urinary tract infection (UTI).
-Resident #2 was prescribed Cephalexin 500 mg twice daily for seven days. (Cephalexin is an antibiotic used to treat bacterial infections).

Review of Resident #2's lab results revealed:
-The emergency department nurse practitioner wrote a note on Resident #2's lab results to stop

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Cephalexin and to start Amoxicillin 500 mg twice daily for five days. (Amoxicillin is an antibiotic used to treat bacterial infections); the note was dated 07/24/19.
-The note was signed by the nurse practitioner.

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Cephalexin 500 mg twice daily with scheduled administration times as 8:00 am and 8:00 pm.
-Cephalexin was documented as administered on 07/22/19-07/23/19 at 8:00 am and 8:00 pm.
-Cephalexin was documented as administered on 07/24/19 at 8:00 am; the reason documented was medication unavailable.
-Cephalexin was not documented as administered on 07/24/19 at 8:00 pm the reason documented was medication unavailable.
-Cephalexin was not documented as administered on 07/25/19-07/26/19 at either scheduled administration time; the reason documented was medication unavailable.
-There was no entry for Amoxicillin.

Review of Resident #2's August 2019 eMAR revealed there was no entry for Cephalexin or Amoxicillin.

Review of Resident #2's care notes revealed:
-On 07/17/19, staff documented Resident #2 was very aggressive toward staff.
-On 07/20/19, staff documented Resident #2 was sent to the emergency department to be evaluated secondary to a change in condition.
-On 07/21/19, staff documented Resident #2 was very aggressive and tried to attack staff.
-On 07/22/19, staff documented Resident #2 was trying to kiss a female resident and "had a few

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words" when he was told not to kiss the female resident.
-On 07/24/19, staff documented a nurse from the emergency department had called to stop Resident #2's current antibiotic because the bacteria was resistant; a new prescription would be faxed to the facility.
-On 08/05/19, staff documented "Resident #2's behavior was back; Resident #2 was fighting staff and other residents.
-On 08/30/19, staff documented Resident #2 had a change in condition and was not able to feed himself which was unusual.
-On 09/05/19, staff documented Resident #2 was very aggressive and involved with attacking someone.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed Cephalexin and Amoxicillin was not available to be administered.

Interview with a Medication Aide (MA) on 09/05/19 at 3:12 pm revealed:
-She did not administer Cephalexin to Resident #2 on 07/25/19 or 07/26/19 because the medication was not on the cart.
-She did not recall thinking anything about the Cephalexin because she may have thought the antibiotic had been finished.
-The new order for the antibiotic would have been processed by a manager or the supervisor.

Interview with another MA on 09/06/19 at 7:35 am revealed:
-Resident #2 only had two tablets of Cephalexin.
-She had tried to contact the pharmacy when Resident #2 needed more tablets; she did not follow-up on Resident #2's antibiotic any further.

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Telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am revealed:
-Fourteen Cephalexin 500 mg had been dispensed for Resident #2 on 07/20/19.
-Amoxicillin was not dispensed for Resident #2; there was no order on file for Amoxicillin for Resident #2.
-There was no documentation staff from the facility had called the pharmacy about Amoxicillin for Resident #2.

Interview with a personal care aide (PCA) on 09/06/19 at 1:59 pm revealed:
-Resident #2 had been more aggressive; she noticed the change in July 2019.
-The staff had to keep a "closer-eye" on Resident #2 because of his aggressiveness toward staff and other residents.
-Resident #2 "used to not be like this."
-She did not know what had caused the change in Resident #2's behavior; Resident #2 had not been sent "out" for his behavior.
-Resident #2 was sent "out" for a urinary tract infection in July 2019.
-Resident #2's antibiotic was stopped.

Telephone interview with Resident #2's family member on 09/06/19 at 9:34 am revealed:
-He had been notified Resident #2 had a UTI. (He did not recall the date, but it was a couple of months ago).
-He was under the impression the UTI had been resolved.

Telephone interview with a nurse at the emergency department on 09/06/19 at 10:29 am revealed:
-Resident #2's Cephalexin had been stopped and Amoxicillin had been prescribed instead.

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-A prescription for Amoxicillin had been faxed to the facility to the attention of [named] medication aide on 07/24/19 at 3:00 pm.
-She was concerned Resident #2 was not administered his antibiotic as ordered.
-Resident #2 could still have an UTI.
-It was very concerning because Resident #2 could become septic if his UTI went untreated. (Sepsis is an immune response characterized by fever, difficulty breathing, low blood pressure, confusion, and can potentially be life-threatening).

Interview with the Director of Resident Care (DRC) on 09/06/19 at 12:59 pm revealed:
-He was not aware Resident #2 did not receive his antibiotic as ordered.
-He was concerned Resident #2 could still have an UTI.
-If Resident #2 had not received his medication as ordered Resident #2 could have been septic.
-The Memory Care Manager (MCM) would have been responsible for making sure the new order for the antibiotic was filled.
-The facility did not currently have a MCM.

Interview with the Executive Director on 09/06/19 at 10:52 am revealed:
-She was not aware Resident #2 did not receive his antibiotic as ordered.
-The MCM would have been responsible for making sure the medication was available.
-She was concerned missed medication could have resulted in a change in Resident #2's condition.

Refer to confidential staff interviews.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

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Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

b. Review of Resident #2's physician's orders

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dated 01/09/19 revealed an order for Risperidone 2 mg at bedtime. (Risperidone is an antipsychotic medication).

Review of a prescription dated 01/25/19 for Resident #2 revealed an order for Risperidone 1 mg at bedtime signed by Resident #2's primary care provider (PCP).

Review of a second prescription dated 07/25/19 for Resident #2 revealed an order for Risperidone 1 mg at bedtime signed by the on-call provider for Resident #2's PCP.

Review of a third prescription dated 08/08/19 for Resident #2 revealed an order for Risperidone 1 mg at bedtime signed by Resident #2's PCP.

Review of a fax from the facility's contracted pharmacy dated 07/26/19 revealed a request for clarification for the prescription for one tablet; "did the provider mean for Resident #2 to have only one tablet?"

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Risperidone 1 mg daily with a scheduled administration time at 8:00 pm.
-Risperidone 1 mg was documented as unavailable on 07/04/19, 07/05/19, 07/10/19-07/17/19, 07/21/19-07/22/19, 07/24/19.
-Risperidone was documented as administered on 07/01/19-07/03/19, 07/06/19-07/09/19, 07/18/19-07/20/19 and 07/23/19.
-The dates of 07/25/19-07/31/19 were electronically marked out with an "X" for Risperidone 1 mg.
-There was a second entry to administer Risperidone 2 mg daily with a scheduled

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administration time at 8:00 pm.
-The dates of 07/01/19-07/24/19 were electronically marked out with an "X" for Risperidone 2 mg.
-Risperidone 2 mg was not documented as administered from 07/25/19-07/31/19; the reason documented was order change.
-Resident #2 missed 20 doses of Risperidone 1 mg out of 31 opportunities due to medication being unavailable and no entry on the eMAR for Risperidone 1 mg on 07/25/19-07/31/19.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Risperidone 2 mg daily with a scheduled administration time at 8:00 pm.
-Risperidone 2 mg was documented as administered on 08/01/19-08/03/19.
-Risperidone 2 mg was documented as unavailable on 08/04/19-08/08/19.
-The dates of 08/09/19-08/31/19 were electronically marked out with an "X" for Risperidone 2 mg.
-There was an entry to administer Risperidone 1 mg daily with a scheduled administration time at 8:00 pm.
-The dates of 08/01/19-08/08/19 were electronically marked out with an "X" for Risperidone 1 mg.
-Risperidone 1 mg was documented as administered from 08/09/19-08/30/19.
-Risperidone 1 mg was documented as not available on 08/31/19.
-Resident #2 was administered 3 doses of Risperidone 2 mg without an order; the current order was for Risperidone 1 mg.
-Resident #2 missed 6 doses of Risperidone out of 31 opportunities due to medication being unavailable and/or order change.

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Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Risperidone 1 mg daily with a scheduled administration time at 9:00 pm.
-Risperidone 1 mg was documented as unavailable on 09/01/19-09/02/19.
-Risperidone 1 mg was documented as administered on 09/03/19-09/04/19.
-Resident #2 missed 2 doses of Risperidone out of 4 opportunities due to medication being unavailable.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of twenty-seven Risperidone 1 mg dispensed on 08/14/19.
-Nineteen tablets had been administered; eight tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Risperidone revealed:
-Thirty tablets of Risperidone 1 mg was dispensed on 06/18/19.
-There were no dispensing records for Risperidone 1 mg for July 2019.
-Thirty tablets of Risperidone 2 mg was dispensed on 07/09/19.
-Three tablets of Risperidone 1 mg were dispensed on 08/08/19.
-Twenty-seven tablets of Risperidone 1 mg were dispensed on 08/14/19.

Interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am revealed:
-On 07/09/19, a fax was received for a refill request for Risperidone 1 mg for Resident #2.
-The attached signed physician's orders dated 01/09/19 had an order for Risperidone 2 mg.
-Risperidone 2 mg was keyed in based on the

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signed physicians order sent with the refill request.
-Since there was an order on file for Risperidone 1 mg; it should have then been clarified.
-The only thing she could think of may have happened was the person who keyed the refill request in for Risperidone thought the resident was receiving two different strengths at different times.

Review of a fax dated 07/10/19 from the contracted pharmacy requesting a clarification on the order received for Resident #2's Risperidone 2 mg.

Review of Resident #2's care notes revealed:
-On 07/17/19 staff documented Resident #2 was very aggressive toward staff.
-On 07/20/19 staff documented Resident #2 was sent to the emergency department to be evaluated secondary to a change in condition.
-On 07/21/19 staff documented Resident #2 was very aggressive and tried to attack staff.
-On 07/22/19 staff documented Resident #2 was trying to kiss a female resident and "had a few words" when he was told not to kiss the female resident.
-On 08/05/19 staff documented "Resident #2's behavior was back; Resident #2 was fighting staff and other residents.
-On 08/30/19 staff documented Resident #2 had a change in condition and was not able to feed himself which was unusual.
-On 09/05/19 staff documented Resident #2 was very aggressive and involved with attacking someone.

Interview with a medication aide (MA) on 09/05/19 at 5:26 pm revealed:
-Resident #2 was taking Risperidone 2 mg daily

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for several months; the order for Risperidone 2 mg was changed to Risperidone 1 mg. (she did not recall the date it was changed).
-When she saw there was an entry on the eMAR for Risperidone 2 mg, she did not administer the medication because she had not seen a new order to change the dosage.
-She talked to the Director of Resident Care (DRC) and the DRC told her he would have the order clarified.
-She did not hear anything back from the DRC, so she gave a note to the Memory Care Manager (MCM) requesting a refill on Risperidone 1 mg; she put on the note Risperidone 2 mg was available but Resident #2 needed Risperidone 1 mg.
-Resident #2's primary care provider (PCP) had been called about clarification multiple times by several MAs; she did not know if the calls had been documented.
-Resident #2's family member was contacted to request assistance getting Risperidone medication clarified.
-Resident #2 did not receive his Risperidone 1 mg because the only dose on the cart was the wrong dose.

Interview with another MA on 09/06/19 at 7:15 am revealed:
-She knew there had been a problem with Resident #2's Risperidone but did not recall the specifics.
-On 07/23/19, she had called the on-call PCP to request a refill on Resident #2's Risperidone 1 mg.
-The on-call PCP instructed her to split the Risperidone 2 mg in half and administer to Resident #1 until he could consult with Resident #2's PCP.
-Resident #2's temperament had changed;

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Resident #2's temper was shorter.
-Resident #2 had been more violent and verbally abusive.

Interview with Resident #2's family member on 09/06/19 at 9:34 am revealed:
-He usually visited the facility to see Resident #2 on a weekly basis.
-He accompanied Resident #2 on his routine medical appointments.
-Resident #2 had seemed different lately. (He could not say how long).
-Resident #2 had been more negative and Resident #2 had "usually never complained."
-He had received a call from staff at the facility (he did not recall who) asking for his assistance to get in touch with Resident #2's PCP to get medication for aggressiveness.
-Staff had reported to him Resident #2 had been more agitated.
-He was surprised to hear Resident #2 had been "like this" because Resident #2 had always been mild-mannered.

Interview with a personal care aide (PCA) on 09/06/19 at 1:59 pm revealed:
-Resident #2 had been more aggressive; she noticed the change in July 2019.
-The staff had to keep a "closer-eye" on Resident #2 because of his aggressiveness toward staff and other residents.
-Resident #2 "used to not be like this."
-She did not know what had caused the change in Resident #2's behavior; Resident #2 had not been sent "out" for his behavior.

Interview with a MA on 09/06/19 at 2:13 pm revealed Resident #2 had been aggressive for the past two months; she did not know why Resident #2 had been more aggressive.

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Telephone interview with a nurse at Resident #2's primary care provider's (PCP) office on 09/06/19 at 4:35 pm revealed:
-Resident #2's Risperidone order had "been crazy."
-They had left a lot of messages at the facility and were not getting returned calls.
-The facility would leave a message asking if Resident #2's Risperidone was 1 mg or 2 mg.
-The PCP kept sending an order over for 1 mg.
-She did not know why there was so much confusion over Resident #2's Risperidone.
-It was noted in Resident #2's record that staff from the facility had called the PCP about Resident #2 having behaviors and asked what Resident #2 could be administered to decrease his "urges."
-This behavior was "so" out of character for Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 09/06/19 at 5:12 pm revealed:
-He expected Resident #2's Risperidone to be administered as ordered.
-If Resident #2's Risperidone was not administered as ordered Resident #2 could experience behavior changes.

Interview with the Director of Resident Care (DRC) on 09/06/19 at 12:59 pm revealed:
-He was not aware Resident #2 had missed doses of Risperidone.
-Resident #2 was aggressive and Risperidone administered as ordered could have "knocked the edge off" and possibly prevented some of the aggressiveness Resident #2 had exhibited.

Interview with the Executive Director on 09/06/19

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at 10:52 am revealed:
-She was aware Resident #2 had not received his Risperidone as ordered.
-The staff had a hard time getting the Risperidone clarified.
-She knew there had been a lot of attempts to get the medication clarified.
-There should be faxes filed in Resident #2 record of attempts to get the Risperidone clarified.
-There should be documentation in Resident #2's care notes related to attempts at getting clarification for the Risperidone.
-She was concerned Resident #2 did not receive his Risperidone as ordered because Resident #2 had a history of agitation.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative

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from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

c. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Carvedilol 3.125 mg twice daily. (Carvedilol is used to treat high blood pressure and heart disease).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an for Carvedilol 3.125 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm.
-Carvedilol was documented as administered 07/01/19-07/12/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as unavailable on 07/13/19 at 8:00 am.
-Carvedilol was documented as administered on 07/13/19 at 8:00 pm.
-Carvedilol was documented as administered 07/14/19-07/28/19 at 8:00 am and 8:00 pm.

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-Carvedilol was documented as unavailable on 07/29/19 and 07/30/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as unavailable on 07/31/19 at 8:00 am.
-Carvedilol was documented as administered 07/31/19 at 8:00 pm.
-Resident #2 missed 6 doses of Carvedilol out of 63 opportunities due to medication being unavailable.

Review of Resident #2's eMAR for July 2019 revealed:
-There was an entry Resident #2's blood pressure on 07/05/19 was 132/74; pulse was 78 at 10:13 am.
-There was an entry Resident #2's blood pressure on 07/20/19 was 190/130 pulse was 72 at 3:39 pm. (Resident #2 was sent to the emergency department on 07/20/19).
-There was an entry Resident #2's blood pressure on 07/24/19 was 158/80; pulse was 59 at 11:18 am.
-There was an entry Resident #2's blood pressure on 07/26/19 was 171/67; pulse was 66 at 6:40 am.
-There was an entry Resident #2's blood pressure on 07/27/19 was 140/83; pulse was 69 at 6:16 am.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Carvedilol 3.125 mg twice daily with scheduled administration times at 8:00 am and 8:00pm.
-Carvedilol was documented as unavailable 08/01/19 at 8:00 am.
-Carvedilol was documented as administered on 08/01/19 at 8:00 pm.
-Carvedilol was documented as unavailable 08/02/19 at 8:00 am.

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-Carvedilol was documented as administered on 08/02/19 at 8:00 pm.
-Carvedilol was documented as unavailable 08/03/19 at 8:00am and 8:00 pm.
-Carvedilol was documented as administered on 08/04/19 at 8:00 am.
-Carvedilol was documented as unavailable on 08/04/19 at 8:00 pm.
-Carvedilol was documented as unavailable 08/05/19-06/06/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as administered on 08/07/19-08/31/19 at 8:00 am and 8:00 pm.
-Resident #2 missed 9 doses of Carvedilol out of 63 opportunities due to medication being unavailable.

Review of Resident #2's eMAR for August 2019 revealed:
-There was an entry Resident #2's blood pressure on 08/05/19 was 138/76; pulse was 78 at 2:08 pm.
-There was an entry Resident #2's blood pressure on 08/11/19 was 167/80; pulse was 78 at 9:24 pm.
-There was an entry Resident #2's blood pressure on 08/15/19 was 134/68; pulse was 78 at 1:00 am.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Carvedilol 3.125 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm.
-Carvedilol was documented as administered on 09/01/19-09/05/19 at 8:00 am.
-Carvedilol was documented as administered on 09/01/19-09/04/19 at 8:00 pm.

Review of Resident #2's vitals for September 2019 revealed there was an entry Resident #2's

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blood pressure on 09/05/19 was 137/70; pulse was 70 at 7:03 am.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There were two bubble packs of thirty Carvedilol dispensed on 08/10/19.
-Nine tablets had been administered; twenty-one tablets were available to be administered in one of the bubble packs.
-Fourteen tablets had been administered; sixteen tablets were available to be administered in the second bubble pack.
-There was a total of 36 tablets available to be administered.

Review of pharmacy dispensing records for Resident #2's Carvedilol revealed:
-Sixty tablets were dispensed on 07/09/19.
-Eight tablets were dispensed on 08/07/19.
-Sixty tablets were dispensed on 08/10/19.

Based on observation of medications on hand and record review for Resident #2 for August 2019 and September 2019 there should have been 9 Carvedilol tablets available for administration; thirty-six tablets were available to be administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-She did not recall "right off" anything about Resident #2's Carvedilol.
-She did not recall Resident #2 having a high blood pressure when she had checked it.
-She did not recall Resident #2 having any headaches or complaints of dizziness.

Interview with Resident #2's family member on 09/06/19 at 9:34 am revealed:

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-He usually visited the facility to see Resident #2 on a weekly basis.
-He accompanied Resident #2 on his routine medical appointments.
-Resident #2 took blood pressure medications.
-Resident #2 had not complained to him of having any headaches or feeling dizzy.

Telephone interview with Resident #2's primary care provider (PCP) on 09/06/19 at 5:12 pm revealed:
-He was not aware Resident #2's Carvedilol had not been administered as ordered.
-He was concerned Resident #2's Carvedilol had not been administered as ordered; possible outcome of not getting Carvedilol would be hypertension or stroke. (Hypertension is an abnormally high blood pressure that can lead to complications such as a stroke).

Interview with the Director of Resident Care (DRC) on 09/06/19 at 12:59 pm revealed:
-He was not aware Resident #2 had missed doses of Carvedilol.
-He did not know why there were more Carvedilol tablets on hand than should be based on dispensing records and medication documented as administered.
-Resident #2 could have experienced heart palpitations and abnormal heart rhythm without his Carvedilol being administered as ordered.

Interview with the Executive Director on 09/06/19 at 10:52 am revealed:
-She was not aware Resident #2 had not been administered his Carvedilol as ordered.
-She was concerned Resident #2 could have increased blood pressure as a result of not being administered Carvedilol as ordered.

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Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to the confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

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Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

d. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Lisinopril 20 mg daily. (Lisinopril is used to treat high blood pressure and heart disease).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lisinopril 20 mg daily with a scheduled administration time at 8:00 am.
-Lisinopril was documented as administered on 07/01/19 through 07/25/19 at 8:00 am.
-Lisinopril was documented as unavailable on 07/26/19-07/31/19 at 8:00 am.
-Resident #2 missed 6 doses of Lisinopril out of 31 opportunities due to medication being unavailable.

Review of Resident #2's eMAR for July 2019 revealed:
-There was an entry Resident #2's blood pressure on 07/26/19 was 171/67; pulse was 66 at 6:40 am.
-There was an entry Resident #2's blood pressure on 07/27/19 was 140/83; pulse was 69 at 6:16 am.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Lisinopril 20 mg daily with a scheduled administration time at 8:00 am.
-Lisinopril was documented as unavailable on 08/01/19 through 08/06/19 at 8:00 am.
-Lisinopril was documented as administered on 08/07/19 through 08/31/19 at 8:00 am.
-Resident #2 missed 6 doses of Lisinopril out of

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31 opportunities due to medication being unavailable.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Lisinopril 20 mg daily with a scheduled administration time at 8:00 am.
-Lisinopril was documented as administered on 09/01/19 through 09/05/19 at 8:00 am.

Review of Resident #2's vitals for September 2019 revealed Resident #2's blood pressure on 09/05/19 was documented as 137/70; pulse was 70 at 7:03 am.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of thirty Lisinopril dispensed on 08/07/19.
-No tablets had been administered; thirty tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Lisinopril revealed:
-Thirty tablets were dispensed on 07/09/19.
-Thirty tablets were dispensed on 08/07/19.
-Nine tablets were dispensed on 09/01/19.

Based on observation of medications on hand and record review for Resident #2 for August 2019 and September 2019 there should have been 1 tablet of Lisinopril available for administration; thirty tablets were available to be administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-She did not recall "right off" an issue with Resident #2's Lisinopril.
-She did not recall Resident #2 having a high

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blood pressure when she had checked it.
-She did not recall Resident #2 having any headaches or complaints of dizziness.

Interview with Resident #2's family member on 09/06/19 at 9:34am revealed:
-He usually visited the facility to see Resident #2 on a weekly basis.
-He accompanied Resident #2 on his routine medical appointments.
-Resident #2 took blood pressure medications.
-Resident #2 had not complained to him of having any headaches or feeling dizzy.

Interview with a MA on 09/06/19 at 2:13 pm revealed she did not recall Resident #2 having any high blood pressures; she had not taken Resident #2's blood pressure during her shifts.

Telephone interview with Resident #2's primary care provider (PCP) on 09/06/19 at 5:12 pm revealed:
-He was not aware Resident #2's Lisinopril had not been administered as ordered.
-He was concerned Resident #2's Lisinopril had not been administered as ordered; he did not want Resident #2 to have hypertension or a stroke. (Hypertension is an abnormally high blood pressure that can lead to complications such as a stroke).

Interview with the Director of Resident Care Director (DRC) on 09/06/19 at 12:59 pm revealed:
-He was not aware Resident #2 had missed doses of Lisinopril.
-He did not know why there were more tablets of Lisinopril on hand than should be based on dispensing records and medication documented as administered.

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-Resident #2 could have experienced heart palpitations and abnormal heart rhythm without his Lisinopril administered as ordered.

Interview with the Executive Director on 09/06/19 at 10:52 am revealed:
-She was not aware Resident #2 had not been administered his Lisinopril as ordered.
-She was concerned Resident #2 could have increased blood pressure as a result of not being administered Lisinopril as ordered.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

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Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

e. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Mirtazapine 30 mg at bedtime. (Mirtazapine is an antidepressant).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Mirtazapine 30 mg daily with a scheduled administration time at 8:00 pm.
-Mirtazapine was documented as administered on 07/01/19 through 07/06/19 at 8:00 pm.
-Mirtazapine was documented as unavailable on 07/07/19-07/17/19 at 8:00 pm.
-Mirtazapine was documented as administered on 07/18/19 through 07/31/19.
-Resident #2 missed 11 doses of Mirtazapine out of 31 opportunities due to medication being unavailable.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Mirtazapine 30 mg daily with a scheduled administration time at 8:00 pm.

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-Mirtazapine was documented as administered on 08/01/19 through 08/07/19 at 8:00 pm.
-The dates of 08/08/19-08/31/19 electronically marked out with an "X" for Mirtazapine 30 mg at 8:00 pm.
-There was a second entry for Mirtazapine 30 mg daily with a scheduled administration time as 9:00 pm.
-The dates of 08/01/19-08/08/19 were electronically marked out with an "X" for Mirtazapine 30 mg at 9:00 pm.
-Mirtazapine was documented as administered on 08/09/19 through 08/19/19 at 9:00 pm.
-Mirtazapine was documented as unavailable on 08/20/19 through 08/23/19 at 9:00 pm.
-Mirtazapine was documented as administered on 08/24/19 through 08/30/19 at 9:00 pm.
-Mirtazapine was documented as unavailable on 08/31/19.
-It was documented Resident #2 missed 5 doses of Mirtazapine out of 31 opportunities due to medication being unavailable and/or order changes.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Mirtazapine 30 mg daily with a scheduled administration time at 9:00 pm.
-Mirtazapine was documented as unavailable on 09/01/19 and 09/02/19.
-Mirtazapine was documented as administered on 09/03/19 and 09/04/19.
-It was documented Resident #2 missed 2 doses of Mirtazapine out of 4 opportunities due to medication being unavailable.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of thirty Mirtazapine dispensed on 08/07/19.

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-Nine tablets had been administered; twenty-one tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Mirtazapine revealed:
-Thirty tablets were dispensed on 07/09/19.
-Thirty tablets were dispensed on 08/07/19.

Based on observation of medications on hand and record review for Resident #2 for August 2019 and September 2019 there should have been 15 tablets of Mirtazapine available for administration; twenty-one tablets were available to be administered.

Interview with a Medication Aide (MA) on 09/06/19 at 7:15 am revealed:
-She worked as the Memory Care Manager (MCM) from 03/03/19 to 08/12/19.
-She would receive a daily report of duplicate orders when she worked as the MCM.
-She did not recall an issue "right off" with Resident #2's Mirtazapine.
-She did not recall a duplicate order.
-She had seen an increase in depression for Resident #2.
-Resident #2's temperament had changed; Resident #2's temper was shorter.

Interview with Resident #2's family member on 09/06/19 at 9:34 am revealed:
-He usually visited the facility to see Resident #2 on a weekly basis.
-He accompanied Resident #2 on his routine medical appointments.
-Resident #2 seemed "a little depressed."
-Resident #2 had been negative in conversations and usually never complained.

Interview with a personal care aide (PCA) on

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09/06/19 at 1:59 pm revealed:
-She thought Resident #2 had been more emotional for the past few months.
-Resident #2 sometimes "just wanted to be alone" and this was not usual.
-She thought Resident #2 had been having more mood swings over past couple of months.

Interview with a MA on 09/06/19 at 2:13 pm revealed she did not recall Resident #2 having any signs or symptoms of depression; Resident #2 had been more aggressive.

Telephone interview with Resident #2's primary care provider (PCP) on 09/06/19 at 5:12 pm revealed:
-He was not aware Resident #2's Mirtazapine had not been administered as ordered.
-He was concerned Resident #2's Mirtazapine had not been administered as ordered; without Mirtazapine, Resident #2 could have a change in his behaviors.

Interview with the Resident Care Director (RCD) on 09/06/19 at 12:59 pm revealed:
-Resident #2 took Mirtazapine as a mood stabilizer.
-He was not aware Resident #2 had missed doses of Mirtazapine.
-He did not know why there were more tablets of Mirtazapine on hand than should be based on dispensing records and medication documented as administered.
-Resident #2's mood could have improved if his Mirtazapine been administered as ordered.

Interview with the Executive Director on 09/06/19 at 10:52 am revealed:
-She was not aware Resident #2 had not been administered his Mirtazapine as ordered.

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-She did not know Resident #2's Mirtazapine had duplicate orders.
-She had not seen any changes in Resident #2's mood.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

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Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

f. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Melatonin 3 mg at bedtime(Melatonin is a sleep aide).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Melatonin 3 mg daily with a scheduled administration time at 8:00 pm.
-Melatonin was documented as administered on 07/01/19 through 07/31/19 at 8:00 pm.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Melatonin 3 mg daily with a scheduled administration time at 8:00 pm.
-Melatonin was documented as administered on 08/01/19 through 08/16/19 at 8:00 pm.
-Melatonin was documented as unavailable on 08/17/19 through 08/22/19.
-Melatonin was documented as administered on 08/23/19 through 08/30/19.
-Melatonin was documented as unavailable on 08/31/19.
-It was documented Resident #2 missed 6 doses of Melatonin out of 31 opportunities due to medication being unavailable.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Melatonin 3 mg daily with

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a scheduled administration time at 8:00 pm.
-Melatonin was documented as unavailable on 09/01/19 and 09/02/19.
-Melatonin was documented as administered on 09/03/19 and 09/04/19.
-It was documented Resident #2 missed 2 doses of Melatonin out of 4 opportunities due to medication being unavailable.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of eighteen Melatonin dispensed on 08/23/19.
-Nine tablets had been administered; nine tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Melatonin revealed:
-Thirty tablets were dispensed on 07/09/19.
-Eighteen tablets were dispensed on 08/23/19.

Based on observation of medications on hand and record review for Resident #2 for August 2019 and September 2019 there should have been 6 tablets of Melatonin available for administration; nine tablets were available to be administered.

Interview with a Medication Aide (MA) on 09/06/19 at 7:15 am revealed:
-She did not recall anything about Resident #2's Melatonin.
-She had not seen any changes in Resident #2's sleeping pattern.

Interview with Resident #2's family member on 09/06/19 at 9:34 am revealed:
-Resident #2 has had problems with sleeping.
-Resident #2 was always asleep in his wheelchair in the day room area when he came to visit

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weekly.

Interview with a personal care aide (PCA) on 09/06/19 at 1:59 pm revealed:
-Resident #2 did not sleep well at night.
-She had put Resident #2 to bed, and he would sometimes sleep 2-3 hours and at other times just 30 minutes.
-Resident #2 did not ever sleep all night.
-She did not know if Resident #2 took any medication to help him sleep.

Interview with a MA on 09/06/19 at 2:13 pm revealed no one had reported to her Resident #2 had not been sleeping; Resident #2 took a lot of naps during the day.

Telephone interview with Resident #2's primary care provider (PCP) on 09/06/19 at 5:12 pm revealed:
-He was not aware Resident #2's Melatonin had not been administered as ordered.
-He was concerned Resident #2's Melatonin had not been administered as ordered; without Mirtazapine, Resident #2 could have a change in his behaviors.

Interview with the Director of Resident Care (DRC) on 09/06/19 at 12:59 pm revealed:
-He was not aware Resident #2 had missed doses of Melatonin.
-He did not know why there were more tablets of Melatonin on hand than should be based on dispensing records and medication documented as administered.
-If Resident #2 did not sleep it could contribute to his increased agitation.

Interview with the Executive Director on 09/06/19 at 10:52 am revealed:

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D 358	Continued From page 43 -She was not aware Resident #2 had not been administered his Melatonin as ordered. -Resident #2 needed his Melatonin because he did not sleep at night. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to confidential staff interviews. Refer to interview with a MA on 09/05/19 at 6:00 pm. Refer to interview with a MA on 09/06/19 at 7:15 am. Refer to interview with a MA on 09/09/19 at 10:41 am. Refer to interview with a MA on 09/06/19 at 2:13 pm. Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am. Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm. Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm. Refer to interview with the DRC on 09/06/19 at 11:15 am. Refer to interview with the ED on 09/05/19 at 5:04 pm.	D 358		

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Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

g. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Pantoprazole 40 mg daily(Pantoprazole is used to treat reflux).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Pantoprazole 40 mg daily with a scheduled administration time at 6:00 am.
-Pantoprazole was documented as administered on 07/01/19 through 07/25/19 at 6:00 am.
-Pantoprazole was documented as unavailable on 07/26/19 through 07/30/19.
-Pantoprazole was documented as administered on 07/31/19.
-It was documented Resident #2 missed 6 doses of Pantoprazole out of 31 opportunities due to medication being unavailable.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Pantoprazole 40 mg daily with a scheduled administration time at 6:00 am.
-Pantoprazole was documented as unavailable on 08/01/19.
-Pantoprazole was documented as administered 08/02/19 through 08/31/19.
-It was documented Resident #2 missed 1 dose of Pantoprazole out of 31 opportunities due to medication being unavailable.

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Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Pantoprazole 40 mg daily with a scheduled administration time at 6:00 am.
-Pantoprazole was documented as administered 09/01/19 through 09/04/19.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of thirty Pantoprazole dispensed on 07/09/19; there were eight tablets available to be administered.
-There was a second bubble pack of thirty Pantoprazole dispensed on 08/08/19; no tablets had been administered.
-There was a total of 38 tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Pantoprazole revealed:
-Thirty tablets were dispensed on 07/09/19.
-Thirty tablets were dispensed on 08/07/19.

Based on observation of medications on hand and record review for Resident #2 for August 2019 and September 2019 there should have been 7 tablets of Pantoprazole available for administration; thirty-eight tablets were available to be administered.

Interview with a Medication Aide (MA) on 09/06/19 at 7:15 am revealed:
-She did not recall anything about Resident #2's Pantoprazole.
-Resident #2 had not complained of any reflux.

Interview with the Director of Resident Care (DRC) on 09/06/19 at 12:59 pm revealed:
-He was not aware Resident #2 had missed

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D 358	Continued From page 46 doses of Pantoprazole. -He did not know why there were more tablets of Pantoprazole on hand than should be based on dispensing records and medication documented as administered. -He expected Resident #2 to be administered his Pantoprazole as ordered because Resident #2 could experience increased problems with gastroesophageal reflux disease. Interview with the Executive Director on 09/06/19 at 10:52 am revealed: -She was not aware Resident #2 had not been administered his Pantoprazole as ordered. -She was not aware Resident #2 had any problems with reflux, but if Pantoprazole was prescribed, "Resident #2 must have needed it". Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to confidential staff interviews. Refer to interview with a MA on 09/05/19 at 6:00 pm. Refer to interview with a MA on 09/06/19 at 7:15 am. Refer to interview with a MA on 09/09/19 at 10:41 am. Refer to interview with a MA on 09/06/19 at 2:13 pm. Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.	D 358		

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Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

2. Review of Resident #3's current FL-2 dated 05/20/19 revealed diagnosis included Alzheimer's Disease.

a. Review of Resident #3's physician's orders dated 05/20/19 revealed an order for Levothyroxine 25mg daily. (Levothyroxine is used to treat an underactive thyroid gland (hypothyroidism).

Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Levothyroxine 25 mg daily with a scheduled administration time at 6:00 am.
-Levothyroxine was documented as administered on 07/01/19 at 6:00 am.

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-The dates of 07/02/19-07/31/19 were electronically marked out with an "X" for Levothyroxine at 6:00 am.
-There was a second entry for Levothyroxine 25 mg with an administration time of 1:00am.
-The dates of 07/01/19-07/22/19 were electronically marked out with an "X" for Levothyroxine at 1:00 am.
-Levothyroxine was documented as not administered; wrong time on 07/23/19-07/25/19.
-There was a third entry for Levothyroxine 25 mg daily with a scheduled administration time as 6:00 am.
-The dates of 07/01/19-07/25/19 were electronically marked out with an "X" for Levothyroxine at 6:00 am.
-Levothyroxine 25 mg was documented as administered on 07/26/19-07/31/19 at 6:00 am.
-It was documented Resident #3 missed 24 doses of Levothyroxine out of 31 opportunities.

Observation of Resident #3's medications on hand on 09/06/19 at 2:15 pm revealed:
-There was a bubble pack of Levothyroxine dispensed on 07/11/19 for thirty tablets.
-Five tablets had been administered; twenty-five tablets were available for administration.

Review of pharmacy dispensing records for Resident #2's Levothyroxine revealed:
-Thirty tablets of Levothyroxine 25 mg were dispensed on 07/10/19.
-Thirty tablets of Levothyroxine 25 mg were dispensed on 08/07/19.

Based on observation of medication on hand and record review for Resident #3 for July 2019 and August 2019 there should have been 4 tablets available for administration; twenty-five tablets were available to be administered.

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Interview with a Medication Aide (MA) on 09/09/19 at 12:20 pm revealed:
-She did not administer Levothyroxine to Resident #3 because it was administered by third shift staff.
-Resident #3 had changes in her behavior that started "about July 2019."

Interview with a personal care aide (PCA) on 09/09/19 at 12:35 pm revealed:
-Resident #3 had changed; she used to be able to redirect Resident #3, but now Resident #3 could not be redirected.
-Resident #3's change in behavior had been going on for the last few months (July 2019 to present).

Interview with Resident #3's primary care provider (PCP) on 09/09/19 at 10:35 am revealed:
-She had prescribed Resident #3 Levothyroxine because Resident #3 had an elevated TSH. [High TSH (Thyroid-stimulating hormone) levels can mean the thyroid was not making enough thyroid hormones].
-She monitored Resident #3's thyroid because abnormal thyroid levels could make Resident #3's dementia worse.
-Resident #3's last TSH levels were "fine"; she did not recall when the TSH level was performed.
-She expected Resident #3's medication to be administered as ordered and to be notified if there was a problem with obtaining the medication.

Telephone interview with Resident #3's family member on 09/09/19 at 9:42 am revealed:
-He had received a lot of calls related to the change in Resident #3's behavior.
-Resident #3 had become uncharacteristically more aggressive; historically Resident #3 had

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always been docile and sweet.
-Resident #3 had "pretty big swings in her behavior."

Interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm revealed MAs should have noticed duplicate orders and notified the Executive Director (ED), Memory Care Manager (MCM), or a Supervisor

Interview with the DRC on 09/09/19 at 11:25 am revealed:
-He was not aware Resident #3 did not receive her Levothyroxine as ordered.
-He was concerned Resident #3 could have had ongoing problems with her thyroid if left untreated.

Interview with the ED on 09/06/19 at 10:45 am revealed the MA should notify the MCM if there was a duplicate order in the eMAR.

Interview with the ED on 09/09/19 at 11:49 am revealed:
-She was not aware Resident #3 did not receive Levothyroxine as ordered.
-She did not know Resident #3's Levothyroxine had duplicate orders.
-Resident #3 could have had a change in her condition if her Levothyroxine was not administered as ordered.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

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D 358	Continued From page 51 Refer to interview with a MA on 09/06/19 at 7:15 am. Refer to interview with a MA on 09/09/19 at 10:41 am. Refer to interview with a MA on 09/06/19 at 2:13 pm. Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am. Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm. Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm. Refer to interview with the DRC on 09/06/19 at 11:15 am. Refer to interview with the ED on 09/05/19 at 5:04 pm. Refer to interview with the ED on 09/06/19 at 11:55 am. Refer to interview with the ED on 09/09/19 at 3:36 pm. Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm. b. Review of Resident #3's physician's orders dated 05/20/19 revealed an order for Risperidone 0.5 mg twice daily. (Risperidone is an antipsychotic medication).	D 358		

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Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Risperidone 0.5 mg at bedtime with a scheduled administration time at 8:30 am and 8:30 pm.
-Risperidone was documented as unavailable on 07/01/19 and 07/02/19.
-Risperidone was documented as not administered; wrong time on 07/03/19-07/23/19 at 8:30 am; Risperidone was documented as administered on 07/24/19 at 8:30 am.
-Risperidone was documented as not administered; wrong time on 07/25/19 at 8:30 am.
-The dates of 07/26/19-07/31/19 were electronically marked out with an "X" for Risperidone at 8:30 am.
-The dates of 07/01/19-07/24/19 were electronically marked out with an "X" for Risperidone at 8:30 pm.
-Risperidone was documented as not administered; wrong time on 07/25/19-07/28/19 at 8:30 pm.
-Risperidone was documented as unavailable on 07/29/19 and 07/30/19 at 8:30 pm.
-Risperidone was documented as administered on 07/31/19 at 8:30 pm.
-It was documented Resident #3 missed 29 doses of Risperidone out of 31 opportunities due to medication being scheduled at the wrong time and/or medication not being available.

Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Risperidone 0.5 mg at bedtime with a scheduled administration time at 8:30 pm.
-Risperidone was documented as administered

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on 08/01/19 and 08/02/19 at 8:30 pm.
-Risperidone was documented as unavailable on 08/03/19 and 08/28/19.
-The dates of 08/29/19-08/31/19 were electronically marked out with an "X" for Risperidone at 8:30 pm.
-There was a second entry to administer Risperidone 0.5 mg at bedtime with a scheduled administration time as 1:00 am.
-The dates of 08/01/19-08/28/19 and 08/30/19-08/31/19 were electronically marked out with an "X" for Risperidone at 1:00 am.
-Risperidone was documented as wrong time on 08/29/19 at 1:00am.
-There was a third entry for Risperidone 0.5 mg to be administered at bedtime with a scheduled administration time of 9:00 pm
-The dates of 08/01/19-08/28/19 were electronically marked out with an "X" for Risperidone at 9:00 pm.
-Risperidone was documented as administered on 08/29/19-08/31/19 at 9:00 pm.
-It was documented Resident #3 missed 14 doses of Risperidone out of 31 opportunities.

Observation of Resident #3's medications on hand on 09/06/19 at 2:15 pm revealed:
-There was a bubble pack of Risperidone 0.5 mg dispensed on 08/28/19 for thirteen tablets.
-Seven tablets had been administered; six tablets were available for administration.

Review of pharmacy dispensing records for Resident #2's Risperidone revealed:
-Three tablets of Risperidone 0.5 mg was dispensed on 06/09/19.
-Risperidone was not dispensed in July 2019.
-Thirteen tablets of Risperidone were dispensed on 08/28/19.

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Review of Resident #3's care notes revealed:
-On 07/05/19 staff documented Resident #3 was very aggressive toward staff.
-On 08/17/19 staff documented Resident #3 was becoming more confused at times.

Interview with a Medication Aide (MA) on 09/06/19 at 5:38 pm revealed:
-Resident #3's Risperidone had been out; she called the pharmacy about it.
-She did not document who she talked to but passed it on to the next shift.
-Resident #3 had changes in her behavior that started "about July 2019."

Interview with a personal care aide (PCA) on 09/09/19 at 12:35 pm revealed:
-Resident #3 had changed; she used to be able to redirect Resident #3, but now Resident #3 could not be redirected.
-Resident #3's change in behavior had been going on for the last few months (July 2019 to present).
-Resident #3 was more verbally aggressive and argumentative.

Interview with Resident #3's primary care provider (PCP) on 09/09/19 at 10:35 am revealed:
-Resident #3's Risperidone was managed by the mental health provider.
-She coordinated Resident #3's care with the mental health provider due to behavioral issues.

Telephone interview with Resident #3's mental health provider on 09/09/19 at 2:00 pm revealed:
-She was not aware Resident #3 had missed doses of Risperidone.
-Resident #3 was taking Risperidone due to hallucinations and behaviors.
-Resident #3 could not go without medication for

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a long period of time and then start it back up without consulting the provider because some medications would need to be started at a lower dose.
-Resident #3's Risperidone was at a starting dosage so she was "fine" with it being started back, but if the Risperidone had been at a higher dose and started back it could have increased Resident #3's risk of falls.
-Resident #3 could not go on and off her Risperidone, a "steady state" was important.
-Resident #3 could have an increase in her behaviors without her medication being maintained at a therapeutic dose.
-The facility staff could have called her at any time with any questions or concerns with Resident #3's medication.

Telephone interview with Resident #3's family member on 09/09/19 at 9:42 am revealed:
-He had received a lot of calls related to the change in Resident #3's behavior.
-Resident #3 had become uncharacteristically more aggressive; historically Resident #3 had always been docile and sweet.
-Resident #3 had "pretty big swings in her behavior."

Interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm revealed MAs should have noticed duplicate orders in the eMAR and notified the Executive Director (ED), Memory Care Manager (MCM), or Supervisor.

Interview with the DRC on 09/09/19 at 11:25 am revealed:
-He was not aware Resident ## did not receive her Risperidone as ordered.
-He was concerned Resident #3 's increased agitation and behaviors could have been a result

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of not receiving her Risperidone as ordered.

Interview with the ED on 09/06/19 at 10:45 am revealed the MAs should notify the MCM if there was a duplicate order in the eMAR.

Second interview with the ED on 09/09/19 at 11:49 am revealed:
-She was not aware Resident #3 did not receive her Risperidone as ordered.
-She was not aware Resident #3's Risperidone had duplicate orders in the eMAR.
-Resident #3 would have a change in her behaviors if she did not receive her Risperidone as ordered.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at

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1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

c. Review of Resident #3's physician's orders dated 07/23/19 revealed an order for Paxil 20 mg one tablet daily. (Paxil is an antidepressant medication).

Review of Resident #3's physician's orders dated 08/05/19 revealed an order for Paxil 20 mg take two tablets at bedtime.

Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Paxil 20 mg (one tablet) once a day with a scheduled administration time at 8:00 am.
-Paxil 20 mg was documented as administered at 8:00am on 08/01/19-08/14/19 and 08/19/19-08/20/19.
-Paxil 20 mg was documented as unavailable on 08/15/19-08/18/19 at 8:00 am.

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-The dates of 08/21/19-08/31/19 were electronically marked out with an "X" for Paxil 20 mg at 8:00 am.
-There was a second entry for Paxil 20 mg (take 2 tablets=40 mg) with a scheduled administration time as 9:00 pm.
-The dates of 08/01/19-08/09/19 were electronically marked out with an "X" for Paxil 40 mg at 9:00 pm.
-Paxil 40 mg was documented as administered 08/10/19-08/16/19 and on 08/18/19-08/31/19.
-Paxil 40 mg was documented as unavailable on 08/17/19 at 9:00 pm.
-Paxil was administered at 8:00 am (20 mg) and 9:00 pm (40 mg) on 08/10/19-08/14/19 and on 08/19/19-08/20/19.

Based on record reviews and interviews, Resident #3 was administered two doses of Paxil for seven days at 8:00 am (20 mg) and 9:00 pm (40 mg) due to medication duplicated on the eMAR.

Observation of Resident #3's medications on hand on 09/06/19 at 2:15 pm revealed:
-There were two bubble packs of Paxil 20 mg dispensed on 08/09/19 for a total of sixty tablets.
-One bubble pack had 14 of 30 tablets available to be administered; the second pack had 20 of 30 tablets available to be administered.

Review of pharmacy dispensing records for Resident #2's Paxil revealed:
-Eighteen tablets of Paxil 0.25 mg were dispensed on 07/24/19.
-Sixty tablets of Paxil 0.25 mg were dispensed on 08/09/19.

Review of Resident #3's care notes revealed:
-On 07/05/19, staff documented Resident #3 was

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very aggressive toward staff.
-On 08/17/19, staff documented Resident #3 was becoming more confused at times.

Interview with a Medication Aide (MA) on 09/06/19 at 5:38 pm revealed Resident #3's Paxil was administered at night; she did not know the morning shift had administered Paxil to Resident #3.

Interview with another MA on 09/09/19 at 12:20 pm revealed:
-She administered the Paxil because it was on Resident #3's eMAR for her daytime medication.
-At first, she did not know Resident #3 had been administered Paxil at night.
-She usually would have seen the Paxil bubble pack was labeled administer at bedtime; she did not "catch it".
-Once she realized Paxil was being administered in the am and pm and she "brought it up" to someone (she did not recall who or when).
-Once she had seen Paxil was supposed to be administered only at night, she did not administer Paxil in the mornings.
-Resident #3 had not seemed depressed but had changes in her behavior that started "about July 2019."

Interview with a personal care aide (PCA) on 09/09/19 at 12:35 pm revealed:
-Resident #3 had changed; she used to be able to redirect Resident #3, but now Resident #3 could not be redirected.
-Resident #3's change in behavior had been going on for the last few months (July 2019 to present).
-Resident #3 was more verbally aggressive and argumentative.

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Interview with Resident #3's primary care provider (PCP) on 09/09/19 at 10:35 am revealed:
-Resident #3 was prescribed Paxil due to sexually inappropriate behavior.
-Paxil was a selective serotonin reuptake inhibitor (SSRIs); SSRI's can be used to decrease libido.
-If Resident #3 was administered too much Paxil she could have experienced tremors.
-She expected Resident #3's Paxil to be administered as ordered and the facility staff to call her for clarification.

Telephone interview with Resident #3's family member on 09/09/19 at 9:42 am revealed:
-He had received a lot of calls related to the change in Resident #3's behavior.
-He had received several calls Resident #3 had become affectionate with another resident.
-This was not a normal behavior for his family member.

Interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm revealed MAs should have noticed duplicate orders and notified the Executive Director (ED), Memory Care Manager (MCM), or Supervisor.

Interview with the DRC on 09/09/19 at 11:25 am revealed:
-He was not aware Resident ## had received a higher dose of Paxil than had been prescribed.
-Resident #3 could have experienced increased sedation, which would have increased her risk for falls.

Interview with the ED on 09/06/19 at 10:45 am revealed the MAs should notify the MCM if there was a duplicate order in the eMAR.

Interview with the ED on 09/09/19 at 11:49 am

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revealed:
-She was not aware Resident #3 had received Paxil twice due to a duplicate order.
-The original order for Paxil should have been taken out when the new order was entered in the eMAR system.
-The MA who administered the medication should have seen the Paxil bubble pack was labeled for "at bedtime" and clarified the order.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at

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11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

d. Review of Resident #3's physician's orders dated 05/20/19 revealed an order for Alprazolam 0.25 mg three times daily. (Alprazolam is used to treat anxiety).

Review of Resident #3's physician's order dated 08/05/19 revealed an order for Alprazolam 0.25mg take one tablet twice daily.

Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Alprazolam three times a day with a scheduled administration time at 8:30 am, 1:30 pm, and 8:30 pm.
-Alprazolam was documented as administered three times daily at 8:30 am, 1:30 pm, and 8:30 pm 07/01/19-through 07/23/19.
-Alprazolam was documented as administered at 8:30 am and 1:30 pm on 07/24/19; Alprazolam was documented as unavailable at 8:30 pm.
-Alprazolam was documented as unavailable on 07/25/19-07/28/18 at 8:30 am, 1:30 pm, and 8:30 pm.
-The dates of 07/29/19-07/31/19 were electronically marked out with an "X" for

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Alprazolam at 8:30 am, 1:30 pm, and 8:30 pm.
-There was a second entry for Alprazolam twice a day with a scheduled administration time as 8:00 am and 8:00 pm.
-The dates of 07/01/19-07/28/19 were electronically marked out with an "X" for Alprazolam at 8:00 am and 8:00 pm.
-Alprazolam was documented as administered on 07/29/19-07/31/19 at 8:00 am and 8:00 pm.
-It was documented Resident #3 missed 13 doses of Alprazolam out of 93 opportunities due to medication being unavailable.

Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Alprazolam twice a day with a scheduled administration time at 8:00 am and 8:00 pm.
-Alprazolam was documented as administered twice daily at 8:00 am and 8:00 pm 08/01/19-through 08/20/19.
-Alprazolam was documented as administered at 8:00 am on 08/21/19; the 8:00 pm dose was electronically marked out.
-The dates of 08/22/19-08/31/19 were electronically marked out with an "X" for Alprazolam at 8:00 am and 8:00 pm.
-There was a second entry for Alprazolam 0.25 mg take one tablet daily with a scheduled administration time as 8:00 am.
-The dates of 08/01/19-08/21/19 were electronically marked out with an "X" for Alprazolam at 8:00 am.
-Alprazolam was documented as administered on 08/22/19-08/28/19 at 8:00 am.
-The dates of 08/29/19-08/31/19 were electronically marked out with an "X" for Alprazolam at 8:00 am.
-There was a third entry for Alprazolam 0.25 mg

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GUILFORD HOUSE	5918 NETFIELD RD GREENSBORO, NC 27455

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daily with a scheduled administration time as 8:00 am and 8:00 pm.
-The dates of 08/01/19-08/28/19 were electronically marked out with an "X" for Alprazolam at 8:00 am and 8:00 pm.
-Alprazolam was documented as administered 08/29/19-08/31/19 at 8:00 am and 8:00 pm.
-It was documented Resident #3 missed 7 doses of Alprazolam out of 62 opportunities due to duplicate entry.

Observation of Resident #3's medications on hand on 09/06/19 at 2:15 pm revealed:
-There were two bubble packs of Alprazolam 0.25 mg dispensed on 08/28/19 for a total of 60 tablets.
-One bubble pack had 20 of 30 tablets available to be administered; the second pack had 30 of 30 tablets available to be administered.

Review of pharmacy dispensing records for Resident #3's Alprazolam revealed:
-Sixty tablets of Alprazolam 0.25 mg was dispensed on 07/28/19.
-Sixty tablets of Alprazolam 0.25 mg was dispensed on 08/28/19.

Interview with a Medication Aide (MA) on 09/06/19 at 5:38 pm revealed:
-She did not administer Resident #3's Paxil at 8:00pm because it did not "pop-up" on the eMAR on her shift.
-She thought she had seen an order to discontinue; she thought the evening dose had been discontinued.
-Resident #3's Alprazolam was "popping up" on the eMAR at 8:00 pm now (she did not know when Alprazolam started back at 8:00 pm).

Interview with another MA on 09/09/19 at 12:20

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pm revealed:
-She administered Resident #3's Alprazolam at 8:00 am; she was not aware Resident #3's Alprazolam had not been administered to Resident #3 on other shifts.
-Resident #3 had changes in her behavior that started "about July 2019."

Interview with Resident #3's primary care provider (PCP) on 09/09/19 at 10:35 am revealed:
-She did not have any specific concerns that Resident #3 had missed doses of Alprazolam.
-She expected Resident #3's Alprazolam to be administered as ordered and the facility staff to call her for clarification.

Interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm revealed MAs should have noticed duplicate orders and notified the Executive Director (ED), MCM, or Supervisor.

Interview with the DRC on 09/09/19 at 11:25 am revealed:
-He was not aware Resident #3 had missed doses of Alprazolam.
-Resident #3 could have had increased agitation without her Alprazolam being administered as ordered.

Interview with the ED on 09/06/19 at 10:45 am revealed the MAs should notify the MCM if there was a duplicate order in the eMAR.

Interview with the ED on 09/09/19 at 11:49 am revealed:
-She was not aware Resident #3 had received her Alprazolam as ordered due to medication not being available and confusion on administration times due to a duplicate order.
-The MAs needed to be more alert to what they

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D 358	Continued From page 66 were doing. -Resident #3 could have exhibited increased behaviors without her Alprazolam being administered correctly. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to confidential staff interviews. Refer to interview with a MA on 09/05/19 at 6:00 pm. Refer to interview with a MA on 09/06/19 at 7:15 am. Refer to interview with a MA on 09/09/19 at 10:41 am. Refer to interview with a MA on 09/06/19 at 2:13 pm. Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am. Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm. Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm. Refer to interview with the DRC on 09/06/19 at 11:15 am. Refer to interview with the ED on 09/05/19 at 5:04 pm.	D 358		

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Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

3. Review of Resident #4's current FL2 dated 05/07/19 revealed diagnoses included paroxysmal atrial fibrillation.

a. Review of Resident #4's current FL2 dated 05/07/19 revealed a physician's order for sertraline (a medication used to treat depression) 50 mg at bedtime.

Review of Resident #4's subsequent physician's order dated 07/09/19 revealed an order for sertraline 50 mg daily with 11 refills.

Review of Resident #4's subsequent physician's order dated 7/25/19 revealed an order to decrease sertraline to 25 mg daily x 1 week then discontinue.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for sertraline 50 mg at bedtime scheduled at 9:00 pm, with a start date of 03/11/19 and a discontinue date of 07/11/19.
-Staff documented sertraline 50 mg was not administered from 07/01/19 through 07/05/19 and 07/07/19 through 07/10/19.
-Staff documented "awaiting pharmacy" on 07/01/19.
-Staff documented "awaiting new script from doctor" on 07/02/19 through 07/04/19.

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-Staff documented "awaiting new script" on 07/05/19.
-Staff documented "drug/item unavailable" on 07/07/19 and 07/08/19.
-Staff documented "awaiting script from doctor" on 07/09/19 and 07/10/19.
-There was an entry for sertraline 50 mg daily scheduled at 9:00 am, with a start date of 07/10/19 and a discontinue date of 07/25/19.
-There was no documentation sertraline 50 mg was administered on 07/11/19, with no reason documented.
-There was an entry for sertraline 25 mg daily x 7 days scheduled at 9:00 am, with a start date of 07/26/19 and a discontinue date of 08/01/19.

Observation of Resident #4's medication on hand at 09/09/19 at 2:02 pm revealed:
-There were 30 tablets of sertraline 50 mg dispensed on 07/12/19.
-There were 14 of 30 tablets remaining.
-Staff had handwritten "break in half" on the sertraline 50 mg label.

Review of Resident #4's record revealed staff sent a refill request to Resident #4's Primary Care Physician (PCP) on 07/04/19 for sertraline 50 mg.

Interview with a representative from the facility's contracted pharmacy on 09/09/19 at 1:05 pm revealed:
-There was no current order for sertraline in the pharmacy system.
-On 05/17/19, there were 26 tablets of sertraline 50 mg dispensed.
-On 07/12/19, there were 30 tablets of sertraline 50 mg dispensed.
-On 07/25/19, sertraline 50 mg at bedtime was decreased to 25 mg daily x 1 week and then discontinue.

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-On 07/26/19, there were 7 tablets of sertraline 25 mg dispensed.

Interview with a medication aide (MA) on 09/09/19 at 12:02 pm revealed:
-She was the MCM until 08/12/19 and was responsible for the Memory Care Unit (MCU) and the Assisted Living (AL).
-She did not remember Resident #4 taking sertraline.
-If a medication was not available on the medication cart, she would document the medication was not available.
-She did not remember if she called the pharmacy regarding sertraline.

Interview with the Director of Resident Care (DRC) on 09/09/19 at 2:24 pm revealed he did not know sertraline was not administered as ordered in July 2019.

Interview with the Executive Director on 09/09/19 at 3:38 pm revealed:
-She did not know Resident #4 was not administered sertraline as ordered in July 2019 due to medication was not available.
-She would expect staff to make her aware if Resident #4 missed several doses of sertraline.

Interview with Resident #4's family member on 09/10/19 at 9:05 am revealed:
-Resident #4 experienced depression.
-Staff administered all medications.
-She had not noticed increased depression.

Interview with the PCP on 09/10/19 at 9:15 am revealed:
-Resident #4 was prescribed sertraline for depression.
-During weekly visits she had noted difficulty with

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depression.
-Staff did not make her aware sertraline was not administered or available in July 2019.
-She would expect staff to notify her if a medication was not available.
-Not receiving sertraline could cause an increase of symptoms of depression.
-She was not notified Resident #4 did not receive sertraline as ordered in July 2019.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

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Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

b. Review of Resident #4's current FL2 dated 05/07/19 revealed a physician's order for Systane eye drops 0.4-0.3% ophthalmic (a medication used to treat dry eyes), instill 2 drops into both eyes twice a day.

Review of Resident #4's subsequent physician's order dated 08/02/19 revealed an order for Systane eye drops 0.4-0.3% ophthalmic, instill 1-2 drops into both eyes as needed for up to every hour.

Review of Resident #4's subsequent physician's order dated 08/22/19 revealed an order for Systane eye drops 0.4-0.3% ophthalmic, instill 2 drops into both eyes three times a day.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Systane eye drops 0.4-0.3% ophthalmic, instill 2 drops into both eyes by ophthalmic route twice a day scheduled at 8:00 am and 8:00 pm (with a discontinue date of 07/02/19).
-There was no documentation Systane eye drops were administered from 07/02/19 through 07/31/19.

Review of Resident #4's August 2019 eMAR

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revealed:
-There was an entry for Systane eye drops 0.4-0.3% ophthalmic, instill 2 drops into both eyes three times a day for dry eye scheduled at 9:00 am, 1:00 pm, and 9:00 pm (with a start date of 08/28/19).
-There was no documentation Systane eye drops were administered from 08/01/19 through 08/28/19.

Observation of medications on hand for Resident #4 on 09/09/19 at 2:02 pm revealed:
-There was an opened bottle (15 ml) of Systane eye drops 0.3-0.4%, dispensed on 07/17/19, with instructions to instill 1 to 2 drops to both eyes as needed for up to every hour (dispensed by contracted pharmacy).
-There was an opened bottle (15 ml) of Systane eye drops 0.3-0.4%, dispensed on 08/22/19, with instructions to instill 2 drops in both eyes three times a day for dry eyes (dispensed by second contracted pharmacy).

Interview with a representative from the facility's contracted pharmacy on 09/09/19 at 1:05 pm revealed:
-There was an order received 04/19/19 for Systane eye drops, instill 2 drops into both eyes twice a day.
-The order dated 04/19/19 was discontinued on 08/25/19.
-The pharmacy did not have a record for a discontinue order on 07/02/19 for Systane eye drops.
-On 08/25/19, the pharmacy entered an order dated 08/22/19 for Systane eye drops, instill 2 drops into both eyes three times a day.
-The facility noted Resident #4 was "profile only".
-The pharmacy profiled Resident #4's Systane eye drops but were filled by another pharmacy.

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-On 06/21/19, 1 bottle (15ml) of Systane eye drops was dispensed.
-On 07/17/19, 1 bottle (15ml) of Systane eye drops was dispensed.
-On 08/26/19 the pharmacy changed Resident #4 to "profile only".

Interview with a representative from Resident #4's pharmacy on 09/09/19 at 1:43 pm revealed:
-The current and only order in their system was for Systane eye drops, instill 2 drops into both eyes three times a day.
-On 08/22/19, 1 bottle (15 ml) of Systane drops was dispensed.

Interview with a first shift medication aide (MA) on 09/09/19 at 10:41 am revealed:
-She remembered Resident #4 requesting eye drops in July 2019.
-Resident #4 questioned why she was not receiving the eye drops in July 2019.
-Resident #4 complained of dry eyes often.
-She noticed Systane eye drops dropped off the July eMAR abruptly.
-She informed the Memory Care Manager (MCM) the Systane eye drops dropped off the July eMAR.
-She assumed the error would be corrected and did not follow up after speaking with the MCM.
-The Systane eye drops were not on the eMAR to administer in July 2019.
-She only administered the medications due on the eMAR for her shift.

Interview with a MA on 09/09/19 at 12:02 pm revealed:
-She was the MCM until 08/12/19 and was responsible for the Memory Care Unit (MCU) and the Assisted Living (AL).
-She did not remember a MA speaking with her

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regarding Systane eye drops in July 2019 and August 2019.
-She did not know Resident #4 was not administered Systane eye drops as ordered in July 2019 and August 2019.

Interview with the Director of Resident Care (DRC) on 09/09/19 at 2:24 pm revealed he did not know Systane eye drops were not administered in July 2019 and August 2019.

Interview with the Executive Director on 09/09/19 at 3:38 pm revealed:
-She did not know Resident #4 missed Systane eye drops in July 2019 and August 2019.
-She would expect staff to make her aware if Systane eye drops was removed from Resident #4 eMARs.

Interview with Resident #4 on 09/09/19 at 1:00 pm revealed:
-She experienced dry eyes.
-She was ordered Systane eye drops three times a day and as needed.
-She remembered several occasions when she did not receive Systane eye drops as ordered.
-She told staff she was supposed to get drops scheduled.
-The MA told her there was no order for scheduled Systane eye drops.

Interview with the Primary Care Provider (PCP) on 09/10/19 at 9:15 am revealed:
-Resident #4 was prescribed Systane eye drops for dry eyes.
-She expected staff to administer Systane eye drops as ordered for Resident #4.
-Resident #4 complained of dry eyes during visits.
-She was not notified Resident #4 did not receive Systane eye drops as ordered in July 2019 and

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August 2019.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of

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Operations on 09/09/19 at 12:15 pm.

c. Review of Resident #4's current FL2 dated 05/07/19 revealed no order for omeprazole (a medication used to treat acid reflux) 20 mg daily.

Review of Resident #4's subsequent physician's order dated 07/19/19 revealed an order for omeprazole 20 mg daily.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for omeprazole 20 mg daily scheduled at 1:00 am.
-There was no documentation omeprazole was administered from 07/19/19 through 07/26/19.

Observation of medications on hand for Resident #4 on 09/09/19 at 2:02 pm revealed:
-There were 30 capsules of omeprazole 20 mg dispensed on 08/07/19.
-There were 17 capsules of omeprazole 20 mg remaining.

Interview with a representative from the facility's contracted pharmacy on 09/09/19 at 1:05 pm revealed:
-The pharmacy had an order dated 07/19/19 for omeprazole 20 mg daily.
-On 07/20/19, 22 tablets of omeprazole 20 mg were dispensed.
-On 08/07/19, 30 tablets of omeprazole 20 mg were dispensed.

Interview with a representative from Resident #4's pharmacy on 09/09/19 at 1:43 pm revealed they had no order for omeprazole and had never dispensed omeprazole for Resident #4.

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Interview with a first shift medication aide (MA) on 09/09/19 at 10:41 am revealed:
-She knew Resident #4 was ordered omeprazole.
-The omeprazole should have been scheduled at 6:00 am but the pharmacy entered the omeprazole at 1:00 am.
-She mentioned changing the time omeprazole was scheduled on the July 2019 eMAR to a Memory Care Manager (MCM).
-She did not follow up with the MCM after speaking with her regarding the scheduled time for omeprazole.
-The MCM was capable of changing medication orders in the eMAR system, including the scheduled time.

Interview with a MA on 09/09/19 at 12:02 pm revealed:
-She was the MCM until 08/12/19 and was responsible for the Memory Care Unit (MCU) and the Assisted Living (AL).
-She did not remember omeprazole not being administered for several days in July 2019 for Resident #4.
-She did not remember a MA speaking with her regarding the scheduled time for omeprazole, but it was possible a MA spoke with her and she did not have the time to correct the issue.
-The pharmacy scheduled the omeprazole to be administered at 1:00 am daily.
-She had access to make changes to medications within the eMAR system.

Interview with the Director of Resident Care (DRC) on 09/09/19 at 2:24 pm revealed he did not know omeprazole was not administered for 8 doses in July 2019.

Interview with the Executive Director on 09/09/19 at 3:38 pm revealed:

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-She did not know Resident #4 was not administered several doses of omeprazole in July 2019.
-She would expect staff to make her aware if the scheduled time for omeprazole needed to be changed.

Interview with Resident #4 on 09/09/19 at 1:00 pm revealed:
-She experienced acid reflux and omeprazole helped with the symptoms.
-She did not know if she missed any doses of omeprazole.
-She did not remember experiencing increased symptoms in July 2019 or August 2019.

Interview with the Primary Care Provider (PCP) on 09/10/19 at 9:15 am revealed:
-Resident #4 was prescribed omeprazole for gastroesophageal reflux disease (GERD).
-She expected staff to administer omeprazole as ordered for Resident #4.
-Not receiving omeprazole as ordered could increase GERD symptoms, including heartburn and nausea.
-Resident #4 complained of GERD frequently during visits.
-She was not notified Resident #4 did not receive omeprazole as ordered in July 2019.

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

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Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to interview with Area Director of Operations on 09/09/19 at 12:15 pm.

d. Review of Resident #4's current FL2 dated 05/07/19 revealed no order for menthol patch.

Review of Resident #4's subsequent physician's order dated 08/02/19 revealed an order for menthol patch (a medication used to treat pain) 5 %, one patch to skin three times a day as needed.

Review of Resident #4's August 2019 electronic

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Medication Administration Record (eMAR) revealed there was no entry for a menthol patch.

Review of Resident #4's September 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for a menthol patch.

Observation of medications on hand for Resident #4 on 09/09/19 at 2:02 pm revealed there were no menthol patches available to be administered.

Interview with a representative from the facility's contracted pharmacy on 09/09/19 at 1:05 pm revealed:
-The pharmacy did not receive the order dated 08/02/19 for a menthol patch 5%.
-The pharmacy had never dispensed a menthol patch for Resident #4.

Interview with a representative from Resident #4's pharmacy on 09/09/19 at 1:43 pm revealed they had no order for a menthol patch and had never dispensed menthol patches for Resident #4.

Interview with a first shift medication aide (MA) on 09/09/19 at 10:41 am revealed:
-She did not know there was an order for a menthol patch.
-She had never administered a menthol patch for Resident #4.
-Resident #4 complained of generalized pain daily.

Interview with a MA on 09/09/19 at 12:02 pm revealed:
-She was the MCM until 08/12/19 and was responsible for the Memory Care Unit (MCU) and the Assisted Living (AL).
-She did not know Resident #4 had an order for a

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menthol patch.
-She had never administered Resident #4 a menthol patch.
-Resident #4 complained of pain several times a day.
-She did not know if Resident #4's Primary Care Physician (PCP) was notified regarding complaints of pain.

Interview with the Director of Resident Care (DRC) on 09/09/19 at 2:24 pm revealed he did not know Resident #4 had an order for a menthol patch for pain.

Interview with the Executive Director on 09/09/19 at 3:38 pm revealed:
-She did not know Resident #4 had an order for a menthol patch in August 2019.
-She did not know Resident #4 was experiencing pain.

Interview with Resident #4 on 09/09/19 at 1:00 pm revealed:
-She experienced chronic pain in her arms, legs, and head on a daily basis.
-She complained of generalized pain 8/10 on 09/09/19.

Interview with the Primary Care Provider (PCP) on 09/10/19 at 9:15 am revealed:
-Resident #4 was prescribed the menthol patch on 08/02/19 for chronic pain.
-She expected staff to administer the menthol patch as ordered for Resident #4.
-Not receiving the menthol patch as ordered could result in continued pain.
-Resident #4 complained of generalized chronic pain frequently during weekly visits.
-She was not notified Resident #4 did not receive the menthol patch as ordered on 08/02/19.

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4. Review of Resident #1's current hospital FL2 dated 01/08/19 revealed diagnoses included behavioral disturbances, anxiety, atrial fibrillation, insomnia, and lower extremity neuropathy.

a. Review of Resident #1's current FL2 dated 01/08/19 revealed there was an order for quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime. (Quetiapine is an antipsychotic used to treat mental illness).

Review of Resident #1's mental health provider's order dated 07/23/19 revealed:
-The first order was to discontinue the current dose of quetiapine.
-The second order was for quetiapine 12.5 mg two times a day.
-The third order was to call if there was an increase in falls or if over sedation occurred.

Review of Resident #1's physician's order dated 08/06/19 revealed there was an order for quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime and an order for quetiapine 25 mg take 0.5 tablet (12.5 mg) twice daily.

Review of Resident #1's Primary Care Provider's (PCP) order dated 08/20/19 revealed there was an order for quetiapine 25 mg take one tablet nightly.

Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019 revealed:
-There was an entry for quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime scheduled to be administered at 9:00 pm from 07/01/19 to 07/31/19.
-There was an entry for quetiapine 25mg take 0.5

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tablet (12.5 mg) twice daily scheduled to be administered at 8:00 am and 8:00 pm from 07/25/19 to 07/31/19.
-From 07/25/19 to 07/31/19, there were 7 out of 7 doses of quetiapine 0.5 tablet (12.5 mg) documented as administered for the 8:00 pm (twice daily) dose and the 9:00 pm (bedtime) dose.

Review of Resident #1's eMAR for August 2019 revealed:
-There was an entry for quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime scheduled to be administered at 9:00 pm from 08/01/19 to 08/19/19.
-There was an entry for quetiapine 25 mg take 0.5 tablet (12.5 mg) twice daily scheduled to be administered at 8:00 am and 8:00 pm from 08/01/19 to 08/21/19.
-There was an entry for quetiapine 25 mg take 1 tablet (25 mg mg) at bedtime scheduled to be administered at 8:00 pm from 08/21/19 to 08/31/19.
-From 08/01/19 to 08/21/19, there were 8 out of 21 doses of quetiapine 0.5 tablet (12.5 mg) documented as administered for both the 8:00 pm (twice daily) dose and the 9:00 pm (bedtime) dose.
-From 08/01/19 to 08/21/19, there were 11 out of 21 doses of quetiapine 0.5 tablet (12.5 mg) at 9:00 pm (bedtime) documented as "not administered: duplicate".
-From 08/22/19 to 08/31/19, there were 10 out of 11 doses of quetiapine 25 mg take 1 tablet (25 mg) at bedtime documented as administered at 08:00 pm.
-Quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime had a discontinue date of 08/20/19.
-Quetiapine 25 mg take 0.5 tablet (12.5 mg) twice daily had a discontinue date of 08/21/19.

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Observation of Resident #1's medications on hand on 09/05/19 at 4:50 pm revealed 20 tablets of quetiapine 25mg were dispensed on 08/21/19 with 5 tablets remaining and available for administration.

Interview with a representative from the contracted pharmacy on 09/05/19 at 3:34 pm and 09/06/19 at 8:38 am revealed:
-The pharmacy received the mental health provider's order dated 07/23/19 for Resident #1.
-The order for Resident #1 dated 07/23/19 was to discontinue previous quetiapine orders and add quetiapine 12.5 mg twice daily.
-Quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime was discontinued 07/23/19 and not on 08/20/19.
-Quetiapine 25 mg take 0.5 tablet (12.5 mg) at bedtime was not supposed to be on the eMAR past 07/23/19.
-Quetiapine 25 mg one tablet at night was the current order for Resident #1 and was dated 08/21/19.
-On 07/09/19, there were 15 capsules of quetiapine 12.5 mg at bedtime dispensed.
-On 07/24/19, there were 18 capsules of quetiapine 12.5 mg twice daily dispensed.
-On 08/21/19, there were 20 capsules of quetiapine 25 mg dispensed.

Interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm revealed the medication aide (MA) should have noticed the duplicate order for quetiapine and notified the Executive Director (ED), Memory Care Manager (MCM), or Supervisor.

Interview with a medication aide (MA) on 09/05/19 at 5:25 pm revealed:

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-She administered both doses of quetiapine, the 8:00 pm 12.5 mg dose and the 9:00 pm 12.5 mg dose, to Resident #1 at the end of July 2019 and the beginning of August 2019.
-She did not notice the duplicate order for quetiapine and administered the doses scheduled in the eMAR.
-She did not see an increase in sleepiness in Resident #1 in July 2019 or August 2019.

Interview with a second MA on 09/06/19 at 7:37 am revealed:
-She did not remember an order for Quetiapine on 07/23/19.
-She did not notice an increase in sedation in Resident #1 in July 2019 or August 2019.
-Resident #1 fell one time at the end of July 2019 when he had a urinary tract infection.

Interview with Resident #1's family member on 09/06/19 at 9:08 am revealed:
-She was Resident #1's family member and would visit once a month.
-She did not know of any issues with medications.
-She received a call one time (date unknown) that Resident #1 had an unwitnessed fall.
-She did not see Resident #1 over sedated and he was not sleepy.

Interview with the Primary Care Provider (PCP) on 09/06/19 at 9:25 am revealed:
-Quetiapine was ordered for behavior issues and sleep problems.
-Resident #1 had Alzheimer's disease and Resident #1 had issues with anxiety, dementia, insomnia, and confusion.
-The order on 07/23/19 was prescribed by Resident #1's mental health provider.
-She did not know Resident #1 received the 8:00 am 12.5 mg, the 8:00 pm 12.5 mg dose, and the

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9:00 pm 12.5 mg dose of quetiapine at the end of July 2019 and the beginning of August 2019.
-She did not know quetiapine 12.5 mg at bedtime was not discontinued in July 2019.
-The extra dose of quetiapine in the evening in July and August 2019 would not harm Resident #1 because Resident #1 received a small dose during that time.
-On 08/20/19, she ordered the quetiapine 25 mg one tablet at night.
-The last time she saw Resident #1 was 09/03/19 and he was active, alert, and pacing the unit.
-She expected medications to be administered as ordered, and if there was an issue, to contact her.

Interview with the Executive Director (ED) on 09/06/19 at 10:45 am revealed:
-The MAs were responsible for medication administration.
-She did not know about the quetiapine orders on 07/23/19.
-She did not know quetiapine was not administered as ordered.
-The MA should have notified the MCM if there was a duplicate order in the eMAR.
-The physician should have been contacted to clarify the quetiapine orders on 07/23/19.

Interview with the ED on 09/06/19 at 11:55 am revealed she was not made aware of duplicate orders in July 2019.

Interview with the Mental Health Provider on 09/06/19 at 3:45 pm revealed:
-Quetiapine was ordered for anxiety and sleep.
-On 07/23/19, she discontinued previous orders of quetiapine and ordered quetiapine 12.5 mg twice daily.
-She did not know the quetiapine 12.5 mg at bedtime was not discontinued on 07/23/19.

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-She did not know Resident #1 received quetiapine 12.5 mg twice daily (8:00 am and 8:00 pm) and 12.5 mg at bedtime (9:00 pm) in July 2019 and August 2019.
-The last time she saw Resident #1 was 07/23/19.
-Resident #1 received a low dose of quetiapine in July 2019 and August 2019 and there was no negative outcome or harm to Resident #1 with the doses administered.
-If not administered as ordered, quetiapine can cause sedation.

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

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident

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Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to the interview with Area Director of Operations on 09/09/19 at 12:15 pm.

b. Review of Resident #1's hospital provider's order dated 07/23/19 revealed there was an order for cephalic 500 mg take 1 capsule (500 mg total) four times daily for seven days. (Cephalic is an antibiotic used to treat bacterial infections).

Review of Resident #1's electronic medication administration record (eMAR) for July 2019 revealed:
-There was an entry for cephalic 500 mg take one capsule four times daily for 7 days, scheduled to be administered at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.
-From 07/25/19 to 07/31/19, there were 24 out of 28 doses of cephalic 500mg documented as administered at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.
-The dates of 07/31/19 were electronically marked out with an "X" for cephalic 500mg at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.
-Resident #1 missed 4 doses (1 day) of cephalic.

Observation of Resident #1's medications on

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hand on 09/05/19 at 4:50 pm revealed cephalic was not available for administration.

Interview with a medication aide (MA) on 09/06/19 at 7:37 am revealed:
-At the end of July 2019, Resident #1 went to the local hospital emergency department for painful urination and was diagnosed with a urinary tract infection (UTI).
-Resident #1 was ordered an antibiotic for the UTI in July 2019.
-She was not aware the resident missed 4 doses (1 day) of cephalic.
-As the Memory Care Manager (MCM), she was not made aware of missed doses of cephalic or disposal of cephalic medication at the end of July 2019.
-Resident #1 had no complaints of painful urination after the antibiotics were administered.
-The primary care provider was not notified of the 4 doses of cephalic missed.

Interview with a representative from the contracted pharmacy on 09/06/19 at 8:38 am revealed:
-The pharmacy received the order for cephalic 500 mg dated 07/23/19.
-On 07/24/19, there were 28 capsules dispensed to the facility.
-The pharmacy received the cephalic order as stat and the order was sent to the backup pharmacy.
-Four doses of cephalic 500 mg were sent from the backup pharmacy in order to start Resident #1's treatment.
-The remaining cephalic capsules were sent to the facility on the regular daily medication delivery to the facility.
-Medications sent from the backup pharmacy were delivered by a driver from the contracted

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pharmacy the same day as ordered.
-Cephalic was not returned to the contracted pharmacy.

Interview with Resident #1's family member on 09/06/19 at 9:08 am revealed:
-She was Resident #1's family member and would visit once a month.
-Resident #1 had a UTI and was sent to the emergency department at the end of July 2019.
-Once Resident #1 completed the antibiotics, the family member contacted the MCM and requested for Resident #1 to be tested for a UTI again because Resident #1 was still very confused.

Interview with the Primary Care Provider (PCP) on 09/06/19 at 9:25 am revealed:
-Cephalic was ordered by a hospital provider for a UTI.
-She did not know 4 out of 28 doses of cephalic were not administered to Resident #1 in July 2019.
-The last time she saw Resident #1 was 09/03/19 and he was active and alert.
-Resident #1 did not display signs of a UTI, painful urination, confusion, or falls, in August 2019.
-She expected medications to be administered as ordered, and if there was an issue, to contact the PCP.

Interview with the Executive Director (ED) on 09/06/19 at 10:45 am revealed:
-The MAs were responsible for medication administration.
-She did not know 4 out of 28 doses of cephalic were not administered to Resident #1 in July 2019.
-She did not know why it was not administered for

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one day.
-Resident #1 did not report pain or have an increase in painful urination in August 2019.
-Resident #1's responsible person requested a repeat urinary analysis in August 2019 and the test was negative.

Review of Resident #1's lab report dated 08/21/19 revealed urinalysis results were within normal limits.

Interview with the Director of Resident Care (DRC) on 09/06/19 at 11:15 am revealed:
-He did not know Resident #1 did not receive his antibiotics as ordered in July 2019.
-If cephalic was ordered and delivered by the pharmacy, the Supervisor, MCM, and DRC must approve the order in the eMAR so the medication can be administered.
-Resident #1 did not have painful urination, was not agitated, and did not have an increase in frequency of urination in August 2019.
-He was concerned the antibiotics were not administered as ordered because the resident could have become septic. (Sepsis in an immune response characterized by fever, difficulty breathing, low blood pressure, and can be potentially life threatening).
-He expected cephalic to be administered as ordered.

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

Refer to confidential staff interviews.

Refer to interview with a MA on 09/05/19 at 6:00 pm.

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Refer to interview with a MA on 09/06/19 at 7:15 am.

Refer to interview with a MA on 09/09/19 at 10:41 am.

Refer to interview with a MA on 09/06/19 at 2:13 pm.

Refer to telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am.

Refer to telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm.

Refer to interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm.

Refer to interview with the DRC on 09/06/19 at 11:15 am.

Refer to interview with the ED on 09/05/19 at 5:04 pm.

Refer to interview with the ED on 09/06/19 at 11:55 am.

Refer to interview with the ED on 09/09/19 at 3:36 pm.

Refer to the interview with Area Director of Operations on 09/09/19 at 12:15 pm.

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Confidential staff interviews revealed:
-There were medication aides (MAs) who did not administer the resident's medications but would document the medication had been administered.
-Several residents had not received their full

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doses of antibiotics.
-The Executive Director (ED) was made aware of antibiotics not being administered as ordered in July 2019 and August 2019.
-Staff observed all medications, specifically large amounts of antibiotics, had leftover doses at the end of the administration period.
-The ED was made aware of the leftover medications and medications, specifically antibiotics, were stored in the Supervisor's office for additional monitoring in July 2019 and August 2019.

Interview with a MA on 09/05/19 at 6:00 pm revealed:
-She administered medications, and assisted residents with bathing and dressing as needed.
-She was not responsible for adding, changing, or discontinuing orders in the electronic medication administration record (eMAR) system.
-The MAs, Director of Resident Care (DRC) and the ED were responsible for faxing orders to the pharmacy.
-When a medication arrived at the facility and the medication was not entered into the eMAR system, she would make the DRC or ED aware so they could enter the order into the system.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-She worked as the Memory Care Manager (MCM) from 03/03/19 to 08/12/19.
-She would receive a daily report of duplicate orders when she worked as the MCM.
-As the MCM, she processed orders and delegated tasks to personnel.
-The MCM and Supervisors were responsible for ensuring the implementation of orders.
-She manually put orders in the eMAR or she sent the order to the contracted pharmacy and

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the pharmacy would then put the order into the eMAR.
-Only the MCM and Supervisors could add orders into the eMAR.
-MAs should have followed orders from the eMAR, and if there was a discrepancy, the Supervisors should have been notified.
-She was not able to keep up with cart audits because of so many other responsibilities; she was on the floor a lot working.
-When a resident had 5 doses of medication remaining the MA should fax the sticker to the pharmacy and call to make sure the fax was received.
-She implemented a documentation notebook; MAs documented when a medication was ordered and when the medication was received.
-She did not know where this notebook was; it was thinned every month, but the documentation was maintained for records.

Interview with a MA on 09/09/19 at 10:41 am revealed:
-The ED, DRC, and MCM could change orders in the eMAR system.
-Recently, the Supervisors had been given access to change orders in the system.
-Prior to August 2019, she was responsible for orders in the Memory Care Unit (MCU) and Assisted Living (AL), resident care, clinical paperwork, family and physician notification, and she was working different shifts.
-When the pharmacy entered an order, the time would often default to 1:00 am.
-The facility had reported the problems to the pharmacy representative, but the problems continued.
-It could take days for an order to be entered into the eMAR system and even longer if the medication order required clarification.

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D 358	Continued From page 96 -The staff sent the order to the pharmacy, the pharmacy entered the order into the eMAR system, once the medication was delivered to the facility, the Supervisors or DRC would approve the order in the eMAR system, and the medication would appear in the eMAR system available to administer. -The first and second shift MAs in the Assisted Living Unit were responsible for eMAR and medication cart audits. -The third shift MAs in the MCU were responsible for eMAR and medication cart audits. -The audits were completed Monday through Thursday and by the end of the week all residents in the facility would have been audited. -When a resident refused a medication, the MAs were expected to document the refusal in the eMAR system. -The MA should notify the physician after 3 consecutive refusals. -The MA should report consecutive refusals to the Supervisors. -The Supervisors, MCM and DRC were responsible for physician notification. Interview with a MA on 09/06/19 at 2:13 pm revealed: -She looked on the eMAR and would pull medications out one by one based on the eMAR, put the medication in a cup and hit the "prep" button. -She would have all the medications in a cup, administer to the resident and then document all "prepped" or would do individually if a resident did not take medication. -If a medication was not stored with the resident's other medications, she would look in the over-flow or in other residents' medications to see if it had been stored improperly. -If a resident did not have a medication to be	D 358		

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administered, she would click on not given.
-She would fax a note to the pharmacy asking for a short supply (a short supply meant requesting for some medication until the next cycle).
-She filed the copy of the faxed request in the pharmacy notebook.
-She would not document she had administered a medication if she had not administered.

Telephone interview with a representative from the facility's contracted pharmacy on 09/05/19 at 11:45 am revealed:
-The residents' medications were on cycle fill system.
-If a medication was requested to be refilled before the allotted time, it would not be refilled.
-Sometimes medications were refilled for a smaller amount until the next dispensing date.
-New orders for medications were faxed into the pharmacy by the facility or provider; providers also sent prescriptions electronically.

Telephone interview with a representative from the contracted pharmacy on 09/09/19 at 1:05 pm revealed once the pharmacy discontinued an order the facility staff were required to approve the change in the eMAR system.

Interview with the Director of Resident Care (DRC) on 09/05/19 at 4:11 pm revealed:
-When a new or changed order was received the DRC or MA were responsible for faxing the order to the pharmacy.
-The pharmacy would send the medication to the facility and then enter the order into the eMAR system.
-After the medication was entered into the eMAR system the facility staff was required to approve the order.
-The DRC, ED, MCM, and Supervisors could add,

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remove, change, or discontinue orders.
-If new or changed orders were sent to the pharmacy by 12:00pm, the pharmacy should deliver the medication to the facility by 11:00 pm.
-If new/changed orders were sent to the pharmacy after 12:00pm, the pharmacy should deliver the medication to the facility by 3:00 am.
-The pharmacy provided a delivery receipt for all medications delivered to the facility.
-The AL MAs on first and second shift were expected to check the medications on hand for all AL residents at least once a week.
-The MCU MAs on third shift were expected to check the medications on hand for all MCU residents at least once a week.
-He was concerned medications were being documented as administered when the medication had not been administered.
-He expected MAs to call the pharmacy if they had any questions about a medication being available or discrepancy in medications.
-The facility used a back-up pharmacy if medication could not be delivered; use of the back-up pharmacy had to be cleared by management.

Interview with the DRC on 09/06/19 at 11:15 am revealed:
-The MAs were responsible for medication administration.
-The MAs were ultimately responsible for administering medications as ordered, and if there was an issue, report the concern to the Supervisor, clarify the order with the provider, and then notify the DRC.
-He expected medications to be administered as ordered.
-If the pharmacy said medication had been delivered and it was too soon to be refilled, he expected the MAs to then look harder for the

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medication in the facility.

Interview with the ED on 09/05/19 at 5:04 pm revealed:
-She implemented the "bucket list" one month ago.
-The staff were expected to fax the order to the pharmacy, wait for the fax confirmation and attach to the order, place the order in the designated folder, call pharmacy to get an expected time of arrival for the medication, place the order in the designated orange folder, once the medication arrived at the facility the DRC or ED was expected to approve the order in the eMAR system and then place the order in the designated green folder to be filed in the resident record.
-There was a red folder designated for orders requiring order clarification.
-The DRC or ED was responsible for order clarification.
-Medications were expected to be delivered within 24 hours, but medications were not delivered in the expected time frame.
-The pharmacy did not always deliver medications as expected.
-The facility had a designated back up pharmacy for "stat" orders and new admissions.
-When a medication was not to be delivered within 6 hours staff were expected to use the back up pharmacy.

Interview with the ED on 09/06/19 at 11:55 am revealed:
-The MAs were responsible for medication administration.
-She was concerned residents had missed medications being administered; missed medications could result in a change in the resident's conditions.

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-She was concerned there was a communication problem; she "preached to the staff" constantly for the MAs to communicate.
-They had implemented a group text message with the MAs about 2 months ago for communication; she thought it had improved overall communication.
-She expected MAs to administer medications as prescribed, and if the MAs had concerns, they should have notified the Supervisor and provider.

Interview with the ED on 09/09/19 at 3:36 pm revealed:
-MAs did cart audits.
-Physicians orders were used to do cart audits.
-The MAs did not use the eMARs to do audits; no one had audited the eMARs.

Interview with Area Director of Operations on 09/09/19 at 12:15 pm revealed the facility followed the contracted pharmacy's policy for communication of orders and medication orders.

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The facility failed to administer medications as ordered for 4 of 5 residents (#1, #2, #3, #4), including an anti-psychotic placing the residents at increased risk for mood instability and sedation (#1, #2, #3); an antibiotic resulting in an increased risk of infection (#1, #2); antihypertensives and an antidepressant resulting in increased blood pressure and sleep deprivation (#2); an antidepressant, an anti-anxiety medication resulting in increased anxiety (#3), and a topical analgesic patch resulting in continued chronic pain (#4).
This failure was detrimental to the health, welfare, 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 358	Continued From page 101 accordance with G.S. 131D-34 on 09/06/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2019.	D 358		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	{D 367}	Pharmacy Foundations Training conducted with Beth Wilson(omnicare) including med administration process, as it relates to meds not in facility, duplicate orders, administration of medications per pcp orders,proper documentation, and notify management immediately regarding issues related to medications not being available. ED, DRC and MCM will conduct resident chart audits and cart audits. Any identified issues will be addressed immediately. ED, DRC, MCM will conduct training to MAs regarding medication administration and accuracy of MARs. MAs will notify DRC and/or MCM regarding identified issues with MARs. DRC and/or MCM will contact PCP regarding any issues related to resident orders. DRC and MCM will conduct weekly chart audits and audits of MARs to ensure medication administration compliance. ED will monitor compliance through random audits and observations.	

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure medication administration records (MARs) were accurate and complete for 2 of 5 sampled residents (#2 and #5) including inaccurate documentation of antihypertensive medications, an antidepressant medication, a sleep aid medication and medication used to treat reflux (Resident #2) and inaccurate documentation of fingerstick blood sugar (FSBS) and sliding scale insulin (SSI) administration (#5).

The findings are:

1. Review of Resident #2's current FL-2 dated 01/09/19 revealed diagnoses included dementia, cerebral infarction, type 2 diabetes, epilepsy, recurrent seizures, hernia, hx right femur fracture, major depressive disorder, calculus of kidney and gastro-esophageal reflux disease (GERD) with esophagitis.

a. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Carvedilol 3.125 mg twice daily. (Carvedilol is used to treat high blood pressure and heart disease).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Carvedilol 3.125 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm.
-Carvedilol was documented as administered 07/01/19-07/12/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as unavailable on 07/13/19 at 8:00 am.
-Carvedilol was documented as administered on

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07/13/19 at 8:00 pm.
-Carvedilol was documented as administered 07/14/19-07/28/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as unavailable on 07/29/19 and 07/30/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as unavailable on 07/31/19 at 8:00 am.
-Carvedilol was documented as administered 07/31/19 at 8:00 pm.
-It was documented Resident #2 received 57 doses of Carvedilol out of 63 opportunities.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Carvedilol 3.125 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm.
-Carvedilol was documented as unavailable 08/01/19 at 8:00 am.
-Carvedilol was documented as administered on 08/01/19 at 8:00 pm.
-Carvedilol was documented as unavailable 08/02/19 at 8:00 am.
-Carvedilol was documented as administered on 08/02/19 at 8:00 pm.
-Carvedilol was documented as unavailable 08/03/19 at 8:00am and 8:00 pm.
-Carvedilol was documented as administered on 08/04/19 at 8:00 am.
-Carvedilol was documented as unavailable on 08/04/19 at 8:00 pm.
-Carvedilol was documented as unavailable 08/05/19-06/06/19 at 8:00 am and 8:00 pm.
-Carvedilol was documented as administered on 08/07/19-08/31/19 at 8:00 am and 8:00 pm.
-It was documented Resident #2 received 54 doses of Carvedilol out of 63 opportunities.

Review of Resident #2's September 2019 eMAR revealed:

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-There was an entry for Carvedilol 3.125 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm.
-Carvedilol was documented as administered on 09/01/19-09/05/19 at 8:00 am.
-Carvedilol was documented as administered on 09/01/19-09/04/19 at 8:00 pm.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There were two bubble packs of thirty Carvedilol dispensed on 08/10/19.
-Nine tablets had been administered; twenty-one tablets were available to be administered in one of the bubble packs.
-Fourteen tablets had been administered; sixteen tablets were available to be administered on the second bubble pack.
-There was a total of 36 tablets available to be administered.

Review of pharmacy dispensing records for Resident #2's Carvedilol revealed:
-Sixty tablets were dispensed on 07/09/19.
-Eight tablets were dispensed on 08/07/19.
-Sixty tablets were dispensed on 08/10/19.

Based on staff documentation and medications on hand between August and September 2019, there should have been 9 Carvedilol tablets remaining, but there were 36 tablets remaining.

Confidential interview with staff revealed there were medication aides (MAs) who did not administer the resident's medications but would document the medication had been administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-MAs should not document they had administered

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a resident's medication if they did not administer the medication.
-She had never documented administering medication if she had not administered the medication.

Interview with another MA on 09/06/19 at 2:13 pm revealed:
-She would not document she had administered a medication if she had not administered the medication.
-She did not know why there were residents who had extra pills available.

Interview with the Director of Resident Care (RCD) on 09/06/19 at 12:59 pm revealed:
-He did not know why there were more Carvedilol tablets on hand than should be based on dispensing records and medication documented as administered.
-He was concerned medications were being documented as administered when the medication had not been administered.
-He expected MAs to document when medications were administered or if there were exceptions.

Interview with the Executive Director (ED) on 09/06/19 at 10:52 am revealed:
-She did not know why there were more Carvedilol tablets on hand than should be based on dispensing records and medication documented as administered.
-MAs should not document they had administered a medication unless they had administered that medication.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

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b. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Lisinopril 20mg daily. (Lisinopril is used to treat high blood pressure and heart disease).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lisinopril 20 mg daily with a scheduled administration time at 8:00 am.
-Lisinopril was documented as administered on 07/01/19 through 07/25/19 at 8:00 am.
-Lisinopril was documented as unavailable on 07/26/19-07/31/19 at 8:00 am.
-It was documented Resident #2 received 25 doses of Lisinopril out of 31 opportunities.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Lisinopril 20 mg daily with a scheduled administration time at 8:00 am.
-Lisinopril was documented as unavailable on 08/01/19 through 08/06/19 at 8:00 am.
-Lisinopril was documented as administered on 08/07/19 through 08/31/19 at 8:00 am.
-It was documented Resident #2 received 25 doses of Lisinopril out of 31 opportunities.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Lisinopril 20 mg daily with a scheduled administration time at 8:00 am.
-Lisinopril was documented as administered on 09/01/19 through 09/05/19 at 8:00 am.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of thirty Lisinopril dispensed on 08/07/19.

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-No tablets had been administered; thirty tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Lisinopril revealed:
-Thirty tablets were dispensed on 07/09/19.
-Thirty tablets were dispensed on 08/07/19.
-Nine tablets were dispensed on 09/01/19.

Based on staff documentation and medications on hand between August and September 2019, there should have been 1 tablet of Lisinopril remaining, but there were 30 tablets remaining.

Confidential staff interview revealed there were medication aides (MAs) who did not administer the resident's medications but would document the medication had been administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-MAs should not document they had administered a resident's medication if they did not administer the medication.
-She had never documented administering medication if she had not administered the medication.

Interview with another MA on 09/06/19 at 2:13 pm revealed:
-She would not document she had administered a medication if she had not administered the medication.
-She did not know why there were residents who had extra pills available.

Interview with the Director of Resident Care (RCD) on 09/06/19 at 12:59 pm revealed:
-He did not know why there were more tablets of Lisinopril on hand than should be based on

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dispensing records and medication documented as administered.
-He was concerned medications were being documented as administered when the medication had not been administered.
-He expected MAs to document when medications were administered or if there were exceptions.

Interview with the Executive Director (ED) on 09/06/19 at 10:52 am revealed:
-She did not know why there were more tablets of Lisinopril on hand than should be based on dispensing records and medication documented as administered.
-MAs should not document they had administered a medication unless they had administered that medication.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

c. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Mirtazapine 30 mg daily. (Mirtazapine is an antidepressant).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Mirtazapine 30 mg daily with a scheduled administration time at 8:00 pm.
-Mirtazapine was documented as administered on 07/01/19 through 07/06/19 at 8:00 pm.
-Mirtazapine was documented as unavailable on 07/07/19-07/17/19 at 8:00 pm.
-Mirtazapine was documented as administered on 07/18/19 through 07/31/19.
-It was documented Resident #2 received 20 doses of Mirtazapine out of 31 opportunities.

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Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Mirtazapine 30 mg daily with a scheduled administration time at 8:00 pm.
-Mirtazapine was documented as administered on 08/01/19 through 08/07/19 at 8:00 pm.
-The dates of 08/08/19-08/31/19 electronically marked out with an "X" for Mirtazapine 30 mg at 8:00 pm.
-There was a second entry for Mirtazapine 30 mg daily with a scheduled administration time as 9:00 pm.
-The dates of 08/01/19-08/08/19 were electronically marked out with an "X" for Mirtazapine 30 mg at 9:00 pm.
-Mirtazapine was documented as administered on 08/09/19 through 08/19/19 at 9:00 pm.
-Mirtazapine was documented as unavailable on 08/20/19 through 08/23/19 at 9:00 pm.
-Mirtazapine was documented as administered on 08/24/19 through 08/30/19 at 9:00 pm.
-Mirtazapine was documented as unavailable on 08/31/19.
-It was documented Resident #2 received 26 doses of Mirtazapine out of 31 opportunities.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Mirtazapine 30 mg daily with a scheduled administration time at 9:00 pm.
-Mirtazapine was documented as unavailable on 09/01/19 and 09/02/19.
-Mirtazapine was documented as administered on 09/03/19 and 09/04/19.
-It was documented Resident #2 missed 2 doses of Mirtazapine out of 4 opportunities.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:

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-There was a bubble pack of thirty Mirtazapine dispensed on 08/07/19.
-Nine tablets had been administered; twenty-one tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Mirtazapine revealed:
-Thirty tablets were dispensed on 07/09/19.
-Thirty tablets were dispensed on 08/07/19.

Based on staff documentation and medications on hand between August and September 2019, there should have been 15 tablets remaining, but there were 21 tablets remaining.

Confidential staff interview revealed there were medication aides (MAs) who did not administer the resident's medications but would document the medication had been administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-MAs should not document they had administered a resident's medication if they did not administer the medication.
-She had never documented administering medication if she had not administered the medication.

Interview with another MA on 09/06/19 at 2:13 pm revealed:
-She would not document she had administered a medication if she had not administered the medication.
-She did not know why there were residents who had extra pills available.

Interview with the Resident Care Director (RCD) on 09/06/19 at 12:59 pm revealed:
-He did not know why there were more tablets of

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Mirtazapine on hand than should be based on dispensing records and medication documented as administered.
-He was concerned medications were being documented as administered when the medication had not been administered.
-He expected MAs to document when medications were administered or if there were exceptions.

Interview with the Executive Director (ED) on 09/06/19 at 10:52 am revealed:
-She did not know why there were more tablets of Mirtazapine on hand than should be based on dispensing records and medication documented as administered.
-MAs should not document they had administered a medication unless they had administered that medication.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

d. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Melatonin 3 mg at bedtime (Melatonin is an antidepressant).

Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Melatonin 3 mg daily with a scheduled administration time at 8:00 pm.
-Melatonin was documented as administered on 07/01/19 through 07/31/19 at 8:00 pm.

Review of Resident #2's August 2019 eMAR revealed:
-There was an entry for Melatonin 3 mg daily with a scheduled administration time at 8:00 pm.

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-Melatonin was documented as administered on 08/01/19 through 08/16/19 at 8:00 pm.
-Melatonin was documented as unavailable on 08/17/19 through 08/22/19.
-Melatonin was documented as administered on 08/23/19 through 08/30/19.
-Melatonin was documented as unavailable on 08/31/19.
-It was documented Resident #2 received 25 doses of Melatonin out of 31 opportunities.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Melatonin 3 mg daily with a scheduled administration time at 8:00 pm.
-Melatonin was documented as unavailable on 09/01/19 and 09/02/19.
-Melatonin was documented as administered on 09/03/19 and 09/04/19.
-It was documented Resident #2 received 2 doses of Melatonin out of 4 opportunities.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of eighteen Melatonin dispensed on 08/23/19.
-Nine tablets had been administered; nine tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Melatonin revealed:
-Thirty tablets were dispensed on 07/09/19.
-Eighteen tablets were dispensed on 08/23/19.

Based on staff documentation and medications on hand between August and September 2019, there should have been 6 tablets remaining, but there were 9 tablets remaining.

Confidential staff interview revealed there were

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medication aides (MAs) who did not administer the resident's medications but would document the medication had been administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-MAs should not document they had administered a resident's medication if they did not administer the medication.
-She had never documented administering medication if she had not administered the medication.

Interview with another MA on 09/06/19 at 2:13 pm revealed:
-She would not document she had administered a medication if she had not administered the medication.
-She did not know why there were residents who had extra pills available.

Interview with the Director of Resident Care (DRC) on 09/06/19 at 12:59 pm revealed:
-He did not know why there were more tablets of Melatonin on hand than should be based on dispensing records and medication documented as administered.
-He was concerned medications were being documented as administered when the medication had not been administered.
-He expected MAs to document when medications were administered or if there were exceptions.

Interview with the Executive Director (ED) on 09/06/19 at 10:52 am revealed:
-She did not know why there were more tablets of Melatonin on hand than should be based on dispensing records and medication documented as administered.

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{D 367}	Continued From page 114 -MAs should not document they had administered a medication unless they had administered that medication. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. e. Review of Resident #2's physician's orders dated 01/09/19 revealed an order for Pantoprazole 40 mg daily (Pantoprazole is used to treat reflux). Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Pantoprazole 40 mg daily with a scheduled administration time at 6:00 am. -Pantoprazole was documented as administered on 07/01/19 through 07/25/19 at 6:00 am. -Pantoprazole was documented as unavailable on 07/26/19 through 07/30/19. -Pantoprazole was documented as administered on 07/31/19. -It was documented Resident #2 received 25 doses of Pantoprazole out of 31 opportunities. Review of Resident #2's August 2019 eMAR revealed: -There was an entry for Pantoprazole 40 mg daily with a scheduled administration time at 6:00 am. -Pantoprazole was documented as unavailable on 08/01/19. -Pantoprazole was documented as administered 08/02/19 through 08/31/19. -It was documented Resident #2 received 30 doses of Pantoprazole out of 31 opportunities. Review of Resident #2's September 2019 eMAR revealed:	{D 367}		

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-There was an entry for Pantoprazole 40 mg daily with a scheduled administration time as 6:00 am.
-Pantoprazole was documented as administered 09/01/19 through 09/04/19.

Observation of Resident #2's medications on hand on 09/05/19 at 2:51 pm revealed:
-There was a bubble pack of thirty Pantoprazole dispensed on 07/09/19; there were eight tablets available to be administered.
-There was a second bubble pack of thirty Pantoprazole dispensed on 08/08/19; no tablets had been administered.
-There was a total of 38 tablets were available to be administered.

Review of pharmacy dispensing records for Resident #2's Pantoprazole revealed:
-Thirty tablets were dispensed on 07/09/19.
-Thirty tablets were dispensed on 08/07/19.

Based on staff documentation and medications on hand between August and September 2019, there should have been 7 tablets remaining, but there were 38 tablets remaining.

Confidential staff interview revealed there were medication aides (MAs) who did not administer the resident's medications but would document the medication had been administered.

Interview with a MA on 09/06/19 at 7:15 am revealed:
-MAs should not document they had administered a resident's medication if they did not administer the medication.
-She had never documented administering medication if she had not administered the medication.

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Interview with another MA on 09/06/19 at 2:13 pm revealed:
-She would not document she had administered a medication if she had not administered it.
-She did not know why there were residents who had extra pills available.

Interview with the Resident Care Director (RCD) on 09/06/19 at 12:59 pm revealed:
-He did not know why there were more tablets of Pantoprazole on hand than should be based on dispensing records and medication documented as administered.
-He was concerned medications were being documented as administered when the medication had not been administered.
-He expected MAs to document when medications were administered or if there were exceptions.

Interview with the Executive Director (ED) on 09/06/19 at 10:52 am revealed MA's should not document they had administered a medication unless they had administered that medication.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

2. Review of Resident #5's current FL-2 dated 07/16/19 revealed diagnoses included diabetes mellitus and diabetic retinopathy.

a. Review of Resident #5's subsequent physician's orders dated 08/02/19 revealed FSBS twice a day.

Review of subsequent physician's order dated 08/27/19 revealed an order for FSBS every morning, 11:00 am, 4:00 pm, and 9:00 pm.

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Review of Resident #5's July 2019 electronic medication administration record (eMAR) revealed:
-There was an entry to check Resident #5's blood sugar before meals twice a day scheduled at 11:00 am and 4:00 pm.
-Staff documented FSBS checks from 07/23/19 through 07/31/19.
-There was no FSBS readings documented.

Review of Resident #5's August 2019 eMAR revealed:
-There was an entry to check Resident #5's FSBS before meals twice a day scheduled at 11:00 am and 4:00 pm.
-Staff documented Resident #5's FSBS for 56 of 62 opportunities.
-There was an entry for FSBS four times a day (start date 08/28/19) scheduled at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.
-On 08/31/19 at 1:00 pm and 5:00 pm, staff documented "not administered" due to order not approved in time to administer.
-On 08/31/19 at 9:00 pm, staff documented the FSBS as "done".
-There was no FSBS readings documented.

Review of Resident #5's September 2019 eMAR revealed:
-There was an entry for FSBS before meals twice a day scheduled at 11:00 am and 4:00 pm.
-Staff documented Resident #5's FSBS from 09/01/19 through 09/04/19.
-The FSBS ranged from 108-245.
-There was an entry for FSBS four times a day scheduled at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.
-Staff documented Resident #5's FSBS from 09/01/19 through 09/05/19 (at 9:00 am).

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-On 09/01/19, staff documented Resident #5's FSBS was checked at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.
-On 09/02/19, staff documented Resident #5's FSBS was checked at 9:00 am.
-On 09/02/19, staff documented Resident #5's FSBS was not checked at 1:00 pm, 5:00 pm, and 9:00 pm due to "duplicate" or "wrong time".
-On 09/03/19, staff documented Resident #5's FSBS was checked at 9:00 am.
-On 09/03/19, staff documented Resident #5's FSBS was not checked at 1:00 pm, 5:00 pm, and 9:00 pm due to "duplicate" or "wrong time".
-On 09/04/19, staff documented Resident #5's FSBS was checked at 9:00 am.
-On 09/04/19, staff documented Resident #5's FSBS was not checked at 1:00 pm, 5:00 pm, and 9:00 pm due to "wrong time".

Interview with Resident #5 on 09/09/19 12:44 pm revealed staff monitored his FSBS 3-4 times every day.

Interview with a medication aide (MA) on 09/05/19 at 6:00 pm revealed:
-The MAs were responsible for obtaining FSBS.
-The MAs should be documenting the FSBS result.
-The FSBS would not be documented anywhere other than the eMAR.
-She told the Memory Care Manager (MCM) in August 2019 that there was no space to document the FSBS result on the eMAR.
-The MCM told her she would "take care of it".
-In August 2019, she noticed the FSBS result appeared on the eMAR.

Interview with a MA on 09/06/19 at 7:37 pm revealed:
-She was a the MCM prior to early August 2019.

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-She did not remember discussing the FSBS eMAR entry for Resident #5.
-She was too busy to complete the tasks she was assigned.

Interview with the Director of Resident Care (DRC) on 09/05/19 at 11:00 am revealed:
-The MAs were responsible for obtaining FSBS.
-The MAs were responsible for assuring documentation of FSBS and result was complete.
-Without documentation of the FSBS result there was no way to review the previous results.
-The FSBS documentation should include the FSBS result.
-He knew the entry on the eMAR did not include a space for the FSBS result and was currently working to correct the issue.
-He did not know if Resident #5's eMAR had been corrected.
-The Executive Director (ED)/DRC/Supervisor can make changes to the eMAR formatting.
-There was no one conducting eMAR audits.

Interview with the ED on 09/05/19 at 5:04 pm revealed:
-The MAs were responsible for obtaining FSBS as ordered and documenting the FSBS result on the eMAR.
-She expected the FSBS entry to have a designated area to document the result and did not know there was no space to document the result on the eMAR.

b. Review of Resident #5's current FL2 dated 07/16/19 revealed there was an order for Humalog kwik pen (a short-acting insulin used to lower elevated blood sugar levels) 100 unit/ml, inject 4 to 10 units subcutaneously three times a day before meals: 80-199= 4 unit, 200-299=6 units, 300-399=8 units, 400 of higher=10 units.

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Review of Resident #5's July 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog 100 unit/ml, inject subcutaneously three times daily before meals using sliding scale: 80-199= 4 unit, 200-299=6 units, 300-399=8 units, 400 of higher=10 units scheduled at 8:000 am, 11:00 am, and 4:00 pm (start date 07/22/19).
-There was documentation SSI was administered for 24 of 27 opportunities.
-There was documentation SSI was not administered due to FSBS less than 80.
-There was no FSBS result documented for 24 of 27 opportunities.

Review of Resident #5's August 2019 eMAR revealed:
-There was an entry for Humalog 100 unit/ml, inject subcutaneously three times daily before meals using sliding scale: 80-199= 4 unit, 200-299=6 units, 300-399=8 units, 400 of higher=10 units scheduled at 8:000 am, 11:00 am, and 4:00 pm.
-There was no SSI amount documented from 08/01/19 through 08/15/19.

Observation of Resident #5's medications on hand on 09/05/19 at 3:40 pm revealed Humalog Insulin was available to be administered.

Interview with Resident #5 on 09/09/19 12:44 pm revealed he received insulin 3-4 times every day.

Interview with a medication aide (MA) on 09/06/19 at 7:37 pm revealed:
-The MA was responsible for obtaining FSBS and administering SSI as ordered.
-She administered the SSI ordered according to

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the FSBS results.
-She knew there was no space to document the SSI administered in July 2019 and August 2019.
-The eMAR should have a designated area to document the SSI amount administered.
-She discussed her concerns with the Memory Care Manager (MCM) in July 2019.

Interview with a MA on 09/06/19 at 7:37 pm revealed:
-She was the MCM prior to early August 2019.
-She did not remember discussing the FSBS entries on the eMAR.

Interview with the Director of Resident Care (DRC) on 09/05/19 at 11:00 am revealed:
-The MAs were responsible for obtaining FSBS.
-The MAs were responsible for insulin administration and assuring documentation was complete.
-Without correct documentation of SSI administered, he did not know if SSI was administered correctly.
-He knew there were issues with SSI documentation and he was working to correct the issue but was unsure if Resident #5's eMAR had been corrected.
-There was no one conducting eMAR audits.

Interview with the ED on 09/05/19 at 5:04 pm revealed:
-The MAs were responsible for administering SSI as ordered and documenting the amount administered on the eMAR.
-She did not know there was no space provided on the eMAR to document the amount of insulin administered.

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{D912}	Continued From page 122	{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 reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and medication aide competency. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 4 of 5 residents sampled for record review (#1, #2, #3, #4) including errors with an antipsychotic medication and an antibiotic (#1), an antibiotic, an antihypertensive medications, an anti-psychotic medication, an antidepressant medication, a sleep aid medication and a medication used to treat reflux (#2), an antipsychotic, an antidepressant, a thyroid medication, and an anti-anxiety medication (#3), and an anti-depressant, lubricant eye drops, a proton-pump inhibitor, and a topical analgesic	{D912}	Residents will have the right to receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws, rules and regulation. Ombudsmen to complete Resident Rights Training to staff. Hospice Agency to complete Resident Rights Training. Staff received a copy of the "Declaration of Resident Rights." Staff signed acknowledging receipt and understanding. Business Office Manager (BOM) will utilize a perpetual staff log to ensure all staff complete Resident Rights Training upon hire and annually. ED will monitor ongoing compliance through observations and resident council meetings.	

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{D912}	Continued From page 123 patch (#4). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled medication aides (Staff E) completed the 5, 10 or 15 hour state approved medication aide training, an employment verification, and completed the written medication aide exam prior to administering medications. [Refer to Tag 0935 10A NCAC 13F G.S. § 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)].	{D912}		
{D935}	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which	{D935}	ED and BOM will audit staff files to ensure MAs have completed the 5/10 or 15 hour MA training. Any MA that has not completed the training as required will be removed from med cart until training is completed and LHPS RN validates competency. BOM will utilize perpetual staff log to ensure all MAs have met requirements. BOM will notify ED immediately regarding any identified issues. ED will complete random weekly staff file audits to ensure compliance related to med aide competency.	

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bleeding occurs or the potential for bleeding exists.
(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.
(3) Within 60 days from the date of hire, the individual must have completed the following:
a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled medication aides (Staff E) completed the 5, 10 or 15 hour state approved medication aide training, an employment verification, and completed the written medication aide exam prior to administering medications.

The findings are:

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Review of Staff E's, Medication Aide (MA) personnel record on revealed:
-Staff E was hired on 02/15/18.
-There was no documentation that Staff E completed the 5, 10, or 15 hour MA training.
-There was no documentation of employment verification showing Staff E worked as a medication aide within the last 24 months.
-There was no documentation Staff E passed the written medication examination.
-There was documentation Staff E completed the clinical skills competency validation checklist on 03/30/18 and 09/06/19.

Review of a residents' August 2019 electronic medication administration record (eMAR) revealed Staff E documented administration of medications 9 out of 31 days from 08/01/19 to 08/31/19.

Interview with Area Director of Operations on 09/06/19 at 5:00 pm revealed:
-Staff E completed the 5 hour MA training on 09/06/19.
-Staff E transferred from a sister facility and Staff E completed part of the 5 hour and all of the 10 hour MA training at that facility.
-She was unable to provide documentation of the MA training, written medication exam, and employment verification from the sister facility Staff E transferred from.

Interview with the Director of Resident Care (DRC) on 09/09/19 at 10:30 am revealed:
-Staff E worked as a medication aide and was responsible for administering medications to residents.
-He did not know MAs were required to have the 5, 10, or 15 hour MA training, employment

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verification, and proof of passing the state written medication exam.
-He did not know Staff E had not completed the required MA training, employment verification, and written medication exam.
-He did not know who was responsible for auditing personnel records.

Interview with the Executive Director on 09/09/19 at 10:35 am revealed:
-Staff E worked as a medication aide and was responsible for administering medications to residents.
-She knew MAs were required to complete the written medication exam and complete the 5, 10, or 15 hour MA training or have employment verification.
-She did not know Staff E had not completed the MA training, employment verification, and written medication exam.
-The Business Office Manager (BOM) was responsible for personnel records and ensuring the required training was complete.
-The BOM was responsible for auditing personnel records.

Interview with the BOM on 09/09/19 at 10:40 am revealed:
-She knew MAs were required to complete the written medication exam and complete the 5, 10, or 15 hour MA training or have employment verification.
-She did not know Staff E had not completed the MA training, employment verification, and written medication exam.
-She was responsible for auditing personnel records.
-She had not audited Staff E's personnel record.
-She was responsible for ensuring MA training was completed.

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-She was aware Staff E was passing medications.
-She was aware Staff E needed to complete the 5 hour training prior to passing medications.

Interview with Staff E on 09/09/19 at 11:00 am revealed:
-She was hired as a MA and was responsible for administering medications.
-She administered oral medications, topical medications (creams), eye drops, and medications by injection.
-She did not know about the required written medication exam and the 5, 10, or 15 hour MA training or employment verification.
-She started the 5 hour MA training in 2017 at the facility she transferred from, but she did not complete the 10 hour training because she did not think it was mandatory.
-She did not know who was responsible for personnel requirements and records.
-The ED told her she needed to complete the 5 hour training on 09/06/19.

____

The facility failed to assure Staff E, who administered medications to the residents, had obtained the required training and qualifications and had passed the state written medication aide exam. This failure placed the residents at risk of medication errors which was detrimental to the health, safety, and welfare 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 09/09/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2019.

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