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CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

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{D 000}	Initial Comments The Adult Care Licensure Section and the McDowell County Department of Social Services conducted a follow-up survey on 10/29/19-10/30/19.	{D 000}		
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: Based on observations, interviews and record reviews, the facility failed to assure the administration of medications by staff were in accordance with orders by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4) related to the administration of oxycodone/APAP and Symbicort. The findings are: Review of Resident #4's current FL2 dated 05/16/19 revealed diagnoses included chronic back pain, bronchial asthma, and osteoarthritis. a. Review of Resident #4's current FL2 dated 05/16/19 revealed there was a physician order for oxycodone/APAP (used to treat moderate pain) 5/325mg, one tablet three times daily. Review of Resident 4's electronic Medication	D 358		

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D 358	Continued From page 1 Administration Record (eMAR) for August 2019 revealed: -There was an entry for oxycodone/APAP 5/325mg three times daily at 8:00am, 2:00pm, and 8:00pm. -Oxycodone/APAP 5/325mg was documented as not administered on 08/31/19 at 2:00pm and 8:00pm. -There was documentation that the medication was a "new order, medication not at facility" on 08/31/19 at 1:13pm and 7:54pm. -There was no documentation that the pharmacy had been contacted on 08/31/19 regarding the medication being unavailable. Review of Resident 4's eMAR for September 2019 revealed: -There was an entry for oxycodone/APAP 5/325mg three times daily at 8:00am, 2:00pm, and 8:00pm. -Oxycodone/APAP 5/325mg was documented as not administered eight occurrences out of nine opportunities from 09/01/19 at 8:00am to 09/03/19 at 8:00pm. -Oxycodone/APAP 5/325mg was documented as administered on 09/02/19 at 8:00pm, when there was no medication available. -There was documentation that the medication was a "new order/medication not at facility" eight times from 09/01/19 at 7:17am to 09/03/19 at 7:48pm. -There was no documentation that the pharmacy had been contacted at any time from 09/01/19 to 09/03/19 regarding the medication being unavailable. Observation of Resident #4's medication on hand on 10/29/19 at 3:20pm revealed: -There was a bubble pack of oxycodone/APAP 5/325mg, with a dispensed quantity of 60, that	D 358		

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had 13 tablets remaining.
-The oxycodone/APAP was dispensed from the pharmacy on 10/03/19.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 10/30/19 at 8:40am revealed:
-The pharmacy was responsible for dispensing Resident #4's oxycodone/APAP.
-The pharmacy had dispensed a 30-day supply of oxycodone/APAP 5/325mg to Resident #4 on 07/30/19, 09/03/19, and 10/03/19.
-The facility was responsible for contacting the physician to get the medication refilled or call the pharmacy so they could refill and dispense the medication.

Interview with Resident #4 on 10/30/19 at 10:15am revealed:
-She had been out of her oxycodone/APAP from 08/31/19 to 09/03/19.
-The medication aide (MA) did not realize she was out of the medication until Saturday 08/31/19.
-The MAs forgot to request a refill for the medication before it ran out.
-The MAs could not call the physician assistant (PA) over the weekend, and 09/02/19 was a holiday, so they had to wait until 09/03/19 to call.
-She started back on the oxycodone/APAP on 09/04/19, when the medication became available.
-She "felt bad and just laid in bed" because she did not have her pain medication for several days.
-She was unable to rate her pain, but said it was not severe.
-She took the pain medication for arthritis, arm and back pain.
-She was aware that the medication was unavailable, and that staff were working to get it refilled.

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D 358	Continued From page 3 -She did not request her as needed (PRN) acetaminophen for her pain during that time. Interview with a MA on 10/30/19 at 10:50am revealed: -The MAs were responsible for requesting refills for Resident #4's oxycodone/APAP. -The MAs were responsible for assuring medications were available for administration. -MAs were to request refills when the remaining medications were "in the blue" on the bubble packs, which meant there were only 8-10 pills left. -Resident #4's PA was "hard to get in touch with." -Resident #4 had to see the PA every month in order to get a refill for oxycodone/APAP. -She did not call the PA prior to Resident #4 running out of the oxycodone/APAP on 08/31/19. -The PA's office was not available over the weekend, and Monday 09/02/19 was a holiday, so the MA had to wait until 09/03/19 to call. Interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:07pm revealed: -The MAs were responsible to call the pharmacy to request refills for oxycodone/APAP for Resident #4. -The pharmacy would then send refill requests to the physician and the facility for controlled medications. -She did not call the pharmacy or Resident #4's PA in August or September 2019 to request a refill of oxycodone/APAP. -She was not aware Resident #4 had missed eleven doses of oxycodone/APAP from 08/31/19 to 09/03/19 until 10/29/19. Interview with the Operations Manager (OM) on 10/30/19 at 2:40pm revealed: -The facility's policy was for the MAs to request refills when the medications left in the bubble	D 358		

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pack were in the blue strip (usually 8-10 tablets left).
-She was made aware that Resident #4 was out of her oxycodone/APAP on 09/03/19.
-She first called the pharmacy on 09/03/19, regarding Resident #4's oxycodone/APAP, and was told there was no prescription or refill available.
-She then reviewed Resident #4's physician's visit notes and realized there should be one prescription left to be filled for the oxycodone/APAP.
-She called back to the pharmacy later that day and was told there was a prescription available and that it would be filled that day and sent that evening on 09/03/19.
-There were no requests for refills for oxycodone/APAP prior to 09/03/19.

Interview with the Administrator on 10/30/19 at 3:15pm revealed:
-She was made aware of the need for a refill of the oxycodone/APAP for Resident #4 on 09/03/19.
-She and the OM were responsible to make sure Resident #4 had oxycodone/APAP available for administration.

Review of Resident #4's progress notes dated 09/03/19 at 4:03pm revealed:
-The pharmacy was contacted regarding the need for a refill of her pain medication.
-The pharmacy told the facility that no refills were available.
-After staff reviewed the physician visit notes, the facility contacted the pharmacy again and the pharmacy informed the facility they did have a refill, and that the oxycodone/APAP would be filled that night (09/03/19).

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D 358	Continued From page 5 Attempted telephone interview with Resident #4's PA on 10/30/19 at 8:59am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:07pm. Refer to the interview with the Administrator on 10/30/19 at 3:15pm. b. Review of Resident #4's record revealed there was a physician order dated 06/06/19 for Symbicort (an inhaled corticosteroid used for maintenance of asthma symptoms) 160mcg/4.5mcg per actuation, inhale 2 puffs twice daily. Review of Resident 4's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for Symbicort 160mcg/4.5mcg per actuation, inhale two puffs twice daily at 8:00am and 8:00pm. -Symbicort 160mcg/4.5mcg was documented as not administered seventeen occurrences out of sixty-two opportunities. -There was documentation that the medication was a "new order, medication not at facility" seventeen times from 08/15/19 to 08/28/19. -There was no documentation on the eMAR that the pharmacy had been contacted in August 2019 regarding the medication being unavailable. Review of Resident 4's eMAR for September 2019 revealed: -There was an entry for Symbicort 160mcg/4.5mcg per actuation, inhale two puffs twice daily at 8:00am and 8:00pm. -Symbicort 160mcg/4.5mcg was documented as not administered six occurrences out of sixty opportunities.	D 358		

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D 358	Continued From page 6 -There was documentation that the medication was a "new order, medication not at facility" or "withheld per DR orders" six times from 09/22/19 to 09/25/19. -There was no documentation on the eMAR that the pharmacy had been contacted in September 2019 regarding the medication being unavailable. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 10/30/19 at 8:40am revealed: -The pharmacy was responsible for dispensing Resident #4's Symbicort. -The pharmacy had dispensed a 30-day supply of Symbicort on 07/25/19, 08/27/19, 9/24/19 and 10/18/19. -Resident #4 "should have had enough" Symbicort for each month. -The facility was responsible for contacting the pharmacy for refills on Symbicort. Interview with Resident #4 on 10/30/19 at 10:15am revealed: -She was aware that she was prescribed Symbicort twice daily. -She had missed several doses of her Symbicort in September 2019. -She denied any respiratory issues during that time and was not hospitalized. -She could not recall if she had missed any doses in August 2019. Interview with a MA on 10/30/19 at 10:50am and 10:55am revealed: -The MAs were responsible for requesting refills for Resident #4's Symbicort. -The MAs were responsible for assuring medications were available for administration. -Resident #4 "probably" did not have the Symbicort, because of an insurance issue.	D 358		

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D 358	Continued From page 7 -There was no documentation related to an insurance issue in August and September 2019. Interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:07pm revealed: -The MAs were responsible to call the pharmacy to request refills for Symbicort for Resident #4. -She was not aware Resident #4 had not been administered seventeen doses of Symbicort in August 2019 and six doses in September 2019, until 10/30/19. -She did not call the pharmacy or Resident #4's physician assistant (PA) to request a refill. Telephone interview with Resident #4's PA on 10/30/19 at 1:35pm revealed: -Resident #4 was prescribed Symbicort for treatment of chronic obstructive pulmonary disease (COPD). -He expected Resident #4 to take the Symbicort daily. -The twenty-three missed doses could have resulted in an exacerbation of Resident #4's COPD. Interview with the Operations Manager (OM) on 10/30/19 at 2:40pm revealed: -The facility's policy was for the MAs to request refills when the medications left in the bubble pack were in the blue strip (usually 8-10 tablets left). -She was never made aware that Resident #4 was out of her Symbicort in August and September 2019. -The MAs were responsible to notify her and the RCC when Resident #4's Symbicort was unavailable for administration. -Upon review of the eMAR system, she found 4 requests for refills for Symbicort that were sent to the pharmacy on 08/09/19, 08/13/19, 08/27/19	D 358		

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and 09/24/19.
-She had no documented response from the pharmacy for the refill requests sent for Symbicort.

Observation of Resident #4's medication on hand on 10/30/19 at 2:42pm revealed:
-There was a hand-held inhaler of Symbicort 160mcg/4.5mcg, with a dispensed quantity of 120 inhalations, that had 28 inhalations remaining.
-The Symbicort was dispensed from the pharmacy on 10/18/19.

Interview with the Administrator on 10/30/19 at 3:15pm revealed:
-She was not aware of the missed doses of Symbicort in August and September 2019 for Resident #4.
-She and the OM were responsible to make sure Resident #4 had Symbicort available for administration.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:07pm.

Refer to the interview with the Administrator on 10/30/19 at 3:15pm.

Interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:07pm revealed:
-Medications were delivered from the pharmacy on third shift and the supervisor was responsible to check them in.
-The supervisor or the 3rd shift MAs put the medications on the carts.
-There was one overstock cart and two medication carts in the medication room.
-The MAs were responsible to check in the overstock cart when a medication was not on the

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D 358	Continued From page 9 regular medication cart. -The MAs should call the pharmacy, usually two days prior to running out of a medication. -She was responsible for completing medication cart to eMAR audits, and the audits "had not been done in a while." -Record audits were completed by the Operations Manager (OM) and the Administrator. -The MAs did not perform full medication cart counts, and only counted controlled medications each shift. -A medication error report was to be completed for missed medications. -"A resident should never be out of medications and should never miss one dose." Interview with the Administrator on 10/30/19 at 3:15pm revealed: -The facility's policy was for the MAs to request refills when the medications left in the bubble pack were in the blue line. -The MAs should notify the RCC when medications were unavailable.	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	{D 367}		

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{D 367}	Continued From page 10 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). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 5 sampled residents related to a medication used to treat opioid addiction (Resident #5) and a medication used to treat gastroesophageal reflux disease (Resident #3). The findings are: 1. Review of Resident #5's current FL-2 dated 07/18/19 revealed: -Diagnoses included depression and chronic use of opiates for therapeutic purpose. -There was a medication order for buprenorphine/naloxone (Suboxone) 2mg-0.5mg take one tablet sublingually every day (a medication used to treat opioid addiction).	{D 367}		

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{D 367}	Continued From page 11 Review of Resident #5's subsequent physician's orders dated 09/13/19 revealed: -There was a medication order for buprenorphine/naloxone (Suboxone) 2mg-0.5mg take one tablet sublingually every day. -There was a medication order for buprenorphine/naloxone (Suboxone) 2mg-0.5mg take one-half tablet sublingually every night. Review of orders faxed on 10/30/19 from Resident #5's pharmacy to the facility revealed medication orders dated 07/24/19, 08/21/19, 09/23/19 and 10/22/19 for Suboxone 12mg-3mg dissolve 1 film sublingually daily. Review of Resident #5's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for buprenorphine/naloxone (Suboxone) 2mg-0.5mg one tablet to be administered daily at 8:00am. -There was documentation Resident #5 was administered Suboxone 2mg-0.5mg one tablet at 8:00am for 31 of 31 opportunities. -There was an entry for buprenorphine/naloxone (Suboxone) 2mg-0.5mg one-half tablet to be administered at 8:00pm. -There was documentation Resident #5 was not administered Suboxone 2mg-0.5mg one-half tablet at 8:00pm for 29 of 31 opportunities due to "resident refused" and "leave of absence." -There was no documentation regarding administration of Suboxone 2mg-0.5mg one-half tablet at 8:00pm on 08/02/19 and 08/26/19. Review of Resident #5's September 2019 eMAR revealed: -There was an entry for buprenorphine/naloxone (Suboxone) 2mg-0.5mg one tablet to be administered daily at 8:00am.	{D 367}		

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{D 367}	Continued From page 12 -There was documentation Resident #5 was administered Suboxone 2mg-0.5mg one tablet at 8:00am for 28 of 30 opportunities. -There was documentation Resident #5 was not administered Suboxone 2mg-0.5mg one tablet at 8:00am on 09/22/19 an 09/23/19 due to "resident refused." -There was an entry for buprenorphine/naloxone (Suboxone) 2mg-0.5mg one-half tablet to be administered at 8:00pm. -There was documentation Resident #5 was not administered Suboxone 2mg-0.5mg one-half tablet at 8:00pm for 30 of 30 opportunities due to "resident refused" and "leave of absence." Review of Resident #5's October 2019 eMAR (10/01/19-10/28/19) revealed: -There was an entry for buprenorphine/naloxone (Suboxone) 2mg-0.5mg one tablet to be administered daily at 8:00am. -There was documentation Resident #5 was administered Suboxone 2mg-0.5mg one tablet at 8:00am for 29 of 29 opportunities. -There was an entry for buprenorphine/naloxone (Suboxone) 2mg-0.5mg one-half tablet to be administered at 8:00pm. -There was documentation Resident #5 was not administered Suboxone 2mg-0.5mg one-half tablet at 8:00pm for 28 of 28 opportunities due to "resident refused" and "leave of absence." Review of Resident #5's medications available for administration on 10/30/19 at 9:17am revealed: -There was no Suboxone 2mg-0.5mg tablets available for administration. -There was no Suboxone 2mg-0.5mg one-half tablets available for administration. -There was Suboxone 12mg-3mg dissolvable films with a dispense date of 10/22/19 and 22 of 30 films remaining and available for	{D 367}		

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{D 367}	Continued From page 13 administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/30/19 at 9:43am revealed: -The pharmacy did not dispense Suboxone for Resident #5. -The pharmacy entered orders into the eMAR system for all residents and someone at the facility would then approve the order so it would display for the MAs during medication administration times. -If the pharmacy did not dispense an ordered medication, it was the facility's responsibility to fax the order to the pharmacy so that it could be "profiled" and entered onto the resident's eMAR. -The pharmacy had a "profiled" order for Resident #5's Suboxone 2mg-0.5mg take one tablet sublingually every day and 2mg-0.5mg take one-half tablet sublingually every night until yesterday (10/29/19). -On 10/29/19, the pharmacy had received a fax from the facility asking them to correct Resident #5's eMAR by deleting the Suboxone tablet orders and adding the order for Suboxone 12mg-3mg dissolve 1 film every night. Telephone interview with a pharmaceutical technician at Resident #5's pharmacy on 10/30/19 at 10:10am revealed: -Resident #5's current order was for Suboxone 12mg-3mg dissolve one film under tongue daily. -The pharmacy had dispensed Suboxone 12mg-3mg 30 films for Resident #5 on 06/24/19, 07/24/19, 08/21/19, 09/23/19, and 10/22/19. -The pharmacy had been dispensing Suboxone 12mg-3mg films for Resident #5 since 2018. -The pharmacy never had an order for Suboxone 2mg-0.5mg tablets or Suboxone 2mg-0.5mg one-half tablets.	{D 367}		

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{D 367}	Continued From page 14 Interview with a medication aide (MA) on 10/31/19 at 11:02am revealed: -MAs were responsible for scanning the pharmacy codes on the medication label during administration of medications. -If the medication label scanned did not match the entry on the eMAR, the computer system would alert the MAs. -Resident #5's Suboxone was dispensed by a different pharmacy other than the facility's contracted pharmacy so it did not have a label for the MAs to scan. -The MAs were supposed to compare the medication label to the eMAR prior to administering medications. -As far as she could remember, Resident #5 had always taken Suboxone in film form, not tablets, and had taken it only once daily. -She had not realized the Suboxone entry on the eMAR did not match the medication label. -Resident #5 typically refused all nighttime medications so the MAs would ask him if he wanted to take his medications and if he refused, they did not pull the medications out of the medication cart; they would mark all medications as refused on the eMAR. Interview with a second MA on 10/31/19 at 11:15am revealed: -When Resident #5 was admitted to the facility (08/13/18), he brought tablets of Suboxone with him. -Once Resident #5 was able to get an appointment with his new physician, the physician began ordering Suboxone films to be taken once daily. -MAs were responsible for scanning the pharmacy codes on the medication label during administration of medications.	{D 367}		

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{D 367}	Continued From page 15 -If the medication label scanned did not match the medication entry on the eMAR, the computer system would alert the MAs. -Resident #5's Suboxone was dispensed by a different pharmacy other than the facility's contracted pharmacy so it did not have a label for the MAs to scan. -MAs were responsible for comparing the medication labels to the entries on the eMAR prior to administration, and she always did so. -She knew Resident #5's eMAR entries had not been accurate for Suboxone since shortly after he became a resident of the facility. -She had notified the Resident Care Coordinator (RCC) Resident #5's eMAR was inaccurate. -Resident #5 was transported by the facility to his physician's office every month, and his physician would send an electronic prescription directly to the pharmacy for his Suboxone. -The transporter would pick up the medication on the way back to the facility from Resident #5's physician appointment. -She thought Resident #5's eMAR had not been corrected because his physician would not provide any documentation to the facility. -She did not know why no one had contacted Resident #5's pharmacy to confirm his Suboxone order since they could not get the information directly from his physician. Interview with the RCC on 10/30/19 at 12:15pm revealed: -She did not know Resident #5's Suboxone order was entered incorrectly on the eMAR until the Operations Manager (OM) brought it to her attention on 10/29/19. -It was the responsibility of the MAs to compare the medication label to the entry on the eMAR prior to administering the medication. -If the MAs found discrepancies between the	{D 367}		

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{D 367}	Continued From page 16	{D 367}		

medication label and the eMAR, they should not administer the medication and should contact either the physician or pharmacy to clarify the order.
-If the MAs could not get the order clarified, they should notify her, the OM or the Administrator so they could obtain clarification.
-Cart audits were not routinely performed to ensure medications on the cart matched the orders and the entries on the eMAR.

Interview with the OM on 10/30/19 at 10:35am revealed:
-Resident #5's Suboxone was filled by a different pharmacy other than the facility's contracted pharmacy.
-Resident #5 had monthly appointments with his physician and would receive a refill order for Suboxone during each visit that was filled by the staff person transporting Residnet #5 to his appointment.
-She realized on 10/29/19 Resident #5's Suboxone order was entered incorrectly on the eMAR.
-She did not know why Resident #5 had entries on his eMAR for two administration times for Suboxone, tablets instead of films, and a different dose from what was ordered.
-Resident #5 had an order for Suboxone films since he had been a resident at the facility.
-For the eMAR to be correct, either she, the RCC, a MA or the Administrator would need to fax the correct order to the facility's contracted pharmacy.
-The MAs should compare the label on the medication to the entry on the eMAR prior to administering the medication.
-If the MAs found a discrepancy between the medication label and the eMAR, they should report it to her or the Administrator so they could

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{D 367}	Continued From page 17 get it corrected. -Medication cart audits to compare labels with the eMAR were not routinely performed by facility staff. -Any cart audit performed would be documented, and she would look for documentation of the last cart audit performed of Resident #5's medications. A second interview with the OM on 10/30/19 at 12:30pm revealed she was unable to locate documentation of any medication cart audit performed by facility staff of Resident #5's medications. Interview with the Administrator on 10/30/19 at 12:40pm revealed: -MAs were expected to compare the medication label to the eMAR prior to administering medications. -If the MAs found a discrepancy between the medication label and the eMAR, they were responsible for either contacting the physician or pharmacy themselves or notifying the RCC, the OM or herself so they could get the order clarified. -She did not know Resident #5's eMAR entries for Suboxone did not match his current order. -She and the RCC tried to perform chart audits and medication cart audits when they could. -Residents who had a hospitalization were prioritized for audits, and if a resident did not have a hospitalization, their record and medications might not get audited by facility staff until a later date. 2. Review of Resident #3's current FL-2 dated 08/20/19 revealed: -Diagnoses included chest pain, hypertension, hyperlipidemia and liver hemangioma.	{D 367}		

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{D 367}	Continued From page 18 -There was no medication order for Pepcid. Review of Resident #3's hospital FL-2 dated 07/16/19 revealed there was a medication order for Pepcid 20mg twice daily (a medication used to treat gastroesophageal reflux disease). Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Pepcid 20mg one tablet to be administered twice daily at 8:00am and 8:00pm with a start date of 07/30/19 and a stop date of 08/05/19. -There was documentation Pepcid 20mg had been administered 8 of 38 opportunities from 08/01/19-08/19/19. -There was documentation Pepcid 20mg had been administered from 08/01/19 at 8:00pm through 08/05/19 at 8:00am. Interview with Resident #3 on 10/30/19 at 8:56am revealed: -She did not currently take Pepcid. -Pepcid had been ordered for her during her hospitalization in July 2019 because she was having acid reflux. -She had not had any acid reflux since that hospitalization. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/30/19 at 9:43am revealed: -The pharmacy entered orders into the eMAR system for all residents and someone at the facility would then approve the order so it would display for the medication aides (MA) during medication administration times. -The pharmacy did not have a discontinue order for Resident #3's Pepcid.	{D 367}		

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{D 367}	Continued From page 19 -He did not realize Resident #3's Pepcid had been discontinued from the eMAR on 08/05/19 until the facility contacted the pharmacy yesterday (10/29/19). -He discovered one of the pharmacy's former pharmaceutical technicians had discontinued the Pepcid order from Resident #3's eMAR on 08/05/19 by mistake and without a physician's order to do so. -The facility would have had to approve the discontuation of the Pepcid for it to show on Resident #3's eMAR. Telephone interview with a night shift MA on 10/30/19 at 9:57am revealed: -Until one month ago, night shift MAs were responsible for checking the eMAR computer system for any orders entered by the pharmacy that needed to be approved. -All new medication orders received by the facility were kept in the order log notebook in the medication room. -MAs were responsible for consulting the order log notebook to find the original medication order prior to approving the order in the computer system. -She must have approved the discontinuation of Resident #3's Pepcid on 08/05/19 in error. -She remembered checking the order log for the discontinue order and did not find it. -She assumed, since the pharmacy had entered the Pepcid for Resident #3 as being discontinued, the pharmacy must have received an order for it. -She did not clarify the discontinue order for Resident #3's Pepcid with any other staff, Resident #3's physician or the pharmacy. Interview with the Resident Care Coordinator (RCC) on 10/30/19 at 12:15pm revealed: -She did not know Resident #3's Pepcid order	{D 367}		

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{D 367}	Continued From page 20 had been discontinued from her eMAR without a physician's order until the Operations Manager (OM) brought it to her attention on 10/29/19. -Until approximately one month ago, night shift MAs were responsible for approving orders entered by the pharmacy in the eMAR system. -Facility staff had found errors made by the night shift MAs, so currently only she, the OM, the Licensed Practical Nurse (LPN) and the Administrator could approve orders. -The night shift MAs were responsible for checking the computer system each night for any orders needing approval. -The MAs were to check the order log and the residents' medical records prior to approving to ensure the entry on the eMAR was correct. -If the MAs could not verify the entry was correct, they should not approve the entry and should notify her. -She would contact the pharmacy to obtain clarification of the order. -The order would not show up on the eMAR for MAs to see during medication administration times until the orders were approved. -The OM and the Administrator did chart audits and eMAR audits periodically, but she was not sure how often. Interview with the OM and the Administrator on 10/29/19 at 4:20pm revealed: -They did not know Resident #3's Pepcid had been discontinued from her eMAR on 08/05/19 without a discontinue order. -The OM contacted the facility's contracted pharmacy today (10/29/19) and was told one of their pharmaceutical technicians had mistakenly discontinued Resident #3's Pepcid from the eMAR. -A MA had approved the discontinue entry without having the order.	{D 367}		

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{D 367}	Continued From page 21 -Until about one month ago, third shift MAs were approving medication entries entered by the pharmacy. -MAs were supposed to locate the original order in the order log notebook prior to approving entries. -If the MAs could not locate the original order, they should not approve the order and should obtain clarification from the pharmacy or physician. -Because of errors found, MAs were no longer able to approve orders, only the RCC, the OM, the Administrator and an LPN could do so. -Both the OM and the Administrator attempted to do a full record and eMAR audit one time per quarter on every resident, but they sometimes were too busy to do so. -Residents who had a hospitalization were prioritized for audits, and if a resident did not have a hospitalization, their record, eMARs, and medications might not get audited by facility staff until a later date.	{D 367}		