Vogel, Abigail L

From: debra talmadge <dtalmadge19563@yahoo.com>
Sent: Monday, February 1, 2021 4:33 PM
To: Vogel, Abigail L
Subject: [External] Fw: PANTEGO POP
Attachments: pantego POP 2021.pdf

----- Forwarded Message -----
From: becky flood <hertfordmanor464@yahoo.com>
To: vogelabigail@dhhsnc.gov <vogelabigail@dhhsnc.gov>; Debra Talmadge <dtalmadge19563@yahoo.com>
Sent: Monday, February 1, 2021, 03:43:03 PM EST
Subject: PANTEGO POP

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
	HAL007015	A. BUILDING: _____ B. WING _____	R 12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANTEGO REST HOME	143 SWAMP ROAD PANTEGO, NC 27860

(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 and COVID-19 focused Infection Control survey on December 8, 2020 to December 9, 2020.	{D 000}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to meal service when residents were not provided tables for in-room dining after stopping communal dining. The findings are: Review of the facility's resident roster revealed the facility's current census was 19 residents. Observation of the dining room on 12/08/20 at 10:34am revealed snack being served to 5 residents, who were seated one resident per table with at least 6 feet of distance between them. Interview with resident in the dining room on 12/08/20 at 10:36am revealed most of the	{D 338}	On December 10, 2020 residents returned to communal dining following 6 feet apart as followed CDC guidelines. Shall a resident be in isolation a table will be provided for meal placement.	12/10/2020

Reviewed and Accepted — Abigail L. Vogel, RN 02.02.21.

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{D 338}	Continued From page 1 residents eat in their room but he preferred to eat in the dining room. Observation of two residents in room #9 on 12/08/20 at 12:15pm revealed: -Both residents were sitting on the side of their beds with black metal chairs with plastic cushioned backs and seats. -The seats of the chairs were slightly slanted down from the front of the seat to the back of the chair. -The residents' lunch meal plates and drinks were sitting on the seats of the chairs. -One of the residents was sitting upright eating a snack cake. -The other resident was hunched over and leaning forward with his head down while eating his meal. Interview with a resident in room #9 on 12/08/20 at 12:15pm revealed: -He ate all 3 meals in his room each day and he did not have an over-the bed table. -He used the chair as a table but it was inconvenient because the chair was unlevel and he sometimes spilled his drink. Interview with the second resident in room #9 on 12/08/20 at 12:17pm revealed: -He ate all of his meals in his room and he did not have an over-the-bed table. -It did not hurt his back to lean over to reach his meal plate in the chair. -He "made do" with what they had. Observation of a resident in room #8 on 12/08/20 at 12:20pm revealed: -The resident was sitting on the side of his bed holding his lunch plate in one hand while eating with the other hand.	{D 338}		

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{D 338}	Continued From page 2 -There was a piece of bread laying on top of the resident's right leg. -There were 3 styrofoam drinking cups sitting on top of a chest of drawers across the room, not within reach of the resident. Interview with the resident in room #8 on 12/08/20 at 12:20pm revealed: -He ate all 3 meals in his room and he did not have an over-the bed table. -The residents "eat where we can". -He thought it would be "nice" to have a table that he could place his lunch plate and his drinks on while eating. Observation of a resident in room #3 on 12/09/20 at 8:15am revealed: -Staff put a breakfast plate and 3 cups with juice, coffee, and milk on the resident's dresser on the other side of the resident's night stand. -The resident sat on his bed and held his plate while eating his breakfast. Interview with the resident in room #3 on 12/09/20 at 8:30am revealed: -He ate all 3 meals in his room and he did not have an over-the-bed table. -He usually sat on his bed to eat and he would put the plate either on top of the bed or on his lap. -He sometimes spilled his food. -He would like to have an over-the-bed table to sit his food and drinks on. Observation of a resident in room #14 on 12/09/20 at 8:16am revealed: -The resident was sitting in a chair pulled up to his dresser with his legs touching the dresser. -The resident's breakfast plate and drink cups were sitting on the dresser and he was eating.	{D 338}		

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{D 338}	Continued From page 3 Interview with the resident in room #14 on 12/09/20 at 8:16am revealed: -He ate all 3 meals in his room and he did not have an over-the-bed table to eat on. -He had been eating that way since May 2020. -It did not bother him much to eat this way but he would like to have a table to eat on. Observation of a resident in room #4 on 12/09/20 at 8:20am revealed: -The resident was sitting in a chair at the end of her dresser with her body turned sideways toward the dresser where her breakfast plate was sitting. -There were 3 styrofoam drinking cups sitting near the middle of the dresser on the other side of the plate. Interview with the resident in room #4 on 12/09/20 at 8:20am revealed: -She ate all 3 meals in her room and she did not have an over-the-bed table to eat on. -It was hard for her to get in a position where she could reach the plate and the cups at the same time on her dresser. -It would be "nice" to have an over-the-bed table so it would be easier to reach her meals and drinks. Observation of a resident in Room #9 during the breakfast meal service on 12/09/10 at 8:18am revealed: -The resident received a cup of coffee, a cup of water, and a cup of apple juice. -The resident placed his beverages in a black chair in his room. -The resident received a breakfast plate, that he also placed in the black chair with his beverages. -The resident then sat down on bed and moved the black chair in front of him. -The resident ate his breakfast using the black	{D 338}		

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{D 338}	Continued From page 4 chair to hold his breakfast items. Interview with the resident in Room #9 on 12/09/20 at 8:23am revealed: -The resident had been using his chair to eat his breakfast for a few months. -The resident often dropped his food and beverages because the chair did not have an even, flat surface. -It was hard for him to eat his breakfast in his room and he did not like it. Observation of the dining room on 12/08/20 at 8:10am revealed breakfast being served to 5 residents, who were seated one resident per table with at least 6 feet of distance between them. Interview with facility's Manager on 12/09/20 at 8:02am revealed: -They stopped communal dining because of COVID-19. -Before they stopped communal dining, all 19 residents were served meals in the dining room. -She was unsure of the date that they started serving all the residents in the dining room. -She had not spoken with the local health department related to resuming communal dining since the facility COVID-19 outbreak was over at the end of September 2020. -There is a handful of residents that eat in the dining room at individual tables because they needed extra supervision or help getting their meals set up. Interview with the Administrator on 12/09/20 at 10:33am revealed: -The facility stopped communal dining when COVID-19 started in the spring of 2020. -No residents had complained about eating in	{D 338}		

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{D 338}	Continued From page 5 their room to her or the facility's Manager. -One resident was moved into the dining room about a month ago because he was having difficulty eating his meal in his room. -There were a few residents that need extra help with meals that get served meals in the dining room.	{D 338}		
{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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 12 residents (#3, #4, #5, #6) observed during the medication passes including errors with insulin (#3), medications for acid reflux (#4, #5), and a medication for constipation (#6). The findings are: 1. The medication error rate was 11% as	{D 358}	Administrator set up medication refresher class with Express Pharmacy date set as 2/19/2021-2/20/2021 for all medtechs to include diabetic training and medication pass times. Manager will monitor alternating shifts that meal times are ontime to meet requirements of physician orders for medication passes. Shall meal not be ready staff will offer diabetic snack to diabetic while waiting for meal to prepare.	2/20/2021

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{D 358}	Continued From page 6 evidenced by the observation of 4 errors out of 35 opportunities during the 11:30am/12:00pm medication pass on 12/08/20 and the 7:30am/8:00am medication pass on 12/09/20. a. Review of Resident #3's current FL-2 dated 01/02/20 revealed: -Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, gastroesophageal reflux disease, schizophrenia, and chronic constipation. -There was an order to check the resident's fingerstick blood sugar (FSBS) 3 times daily with meals and administer Humalog insulin according to the following scale: 201 - 250 = 5 units; 251 - 300 = 10 units; 301 - 350 = 15 units; and greater than 350 = 20 units and call physician. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before or right after a meal.) Interview with the medication aide (MA) on 12/08/20 at 11:02am revealed the lunch meal was usually served at 12:00pm. Observation of the 12:00pm medication pass on 12/08/20 revealed: -Resident #3's blood sugar was 249 at 11:14am. -The resident was administered 5 units of Humalog insulin at 11:17am. Observation on 12/08/20 revealed Resident #3's lunch plate was delivered to his room at 12:12pm and the resident returned to his room and started eating lunch at 12:20pm. (1 hour and 3 minutes after being administered Humalog insulin.) Review of Resident #3's December 2020 medication administration record (MAR) revealed:	{D 358}		

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{D 358}	Continued From page 7 -There was an entry to check FSBS 3 times a day with meals and administer Humalog insulin: 201 - 250 = 5 units; 251 - 300 = 10 units; 301 - 350 = 15 units; and greater than 350 = 20 units and call physician. -Humalog sliding scale insulin and FSBSs were scheduled for 6:30am, 11:30am, and 4:30pm. -The resident's FSBS ranged from 96 - 391 from 12/01/20 - 12/08/20. Interview with the MA on 12/08/20 at 2:31pm revealed: -If the order was to administer insulin with a meal, it should be administered with the meal. -She usually gave Resident #3's insulin before meals and if his sugar was high and she had to administer 10 or more units of insulin, she would wait until about 30 minutes before the resident ate to administer his insulin. -If the resident only needed 5 units of insulin, she would administer it about an hour before the meal. -She could not explain why she did not follow the order and administer the insulin with the meal but she stated that she was diabetic and she used her "basic common sense". Interview with Resident #3 on 12/08/20 at 12:20pm revealed: -He usually had his blood sugar checked and received insulin about an hour before meals. -For lunch, he usually received insulin at 11:00am and his lunch meal was delivered around 12:00pm. -He usually felt weak if is blood sugar was low but he felt okay today (12/08/20) while waiting to get his lunch meal. -He did not usually feel any symptoms of low blood sugar while waiting for his meals after receiving insulin.	{D 358}		

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{D 358}	Continued From page 8 Interview with the facility's Manager on 12/08/20 at 2:51pm revealed: -She was not aware Resident #3 was receiving insulin about an hour before he received his meals. -The MAs should administer insulin no more than 30 minutes prior to a meal. -Waiting too long to eat after receiving insulin could cause the resident to "bottom out" and drop the blood sugar too low. -If it was going to be a while before a resident was served a meal after receiving insulin, the MAs could give the resident a snack like peanut butter. Attempted telephone interview with Resident #3's primary care provider (PCP) on 12/09/20 at 1:40pm was unsuccessful. b. Review of Resident #4's current FL-2 dated 10/29/20 revealed: -Diagnoses included gastroesophageal reflux disease, diabetes mellitus, chronic obstructive pulmonary disease, hyponatremia, anoxic encephalopathy, confusion, and reflex sympathetic dystrophy. -There was an order for Metoclopramide 10mg 1 tablet 4 times a day before meals and at bedtime. (Metoclopramide is used to treat acid reflux.) Review of Resident #4's December 2020 medication administration record (MAR) revealed: -There was an entry for Metoclopramide 10mg 1 tablet 4 times a day before meals and at bedtime. -Metoclopramide was scheduled to be administered at 8:00am, 12:00pm, 5:00pm, and 8:00pm. Observation of the 12:00pm medication pass on	{D 358}		

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{D 358}	Continued From page 9 12/08/20 revealed: -The medication aide (MA) prepared and administered two medications to Resident #4 at 11:33am. -Metoclopramide was not offered or prepared and administered to the resident when he received his other medications. Interview with the MA on 12/08/20 at 2:42pm revealed: -She forgot to administer the Metoclopramide to Resident #4 when she prepared and administered his other medications. -She usually gave the Metoclopramide at the same time as the other two medications because it had to be administered before meals. -She realized after the medication pass that she had forgotten to administer the Metoclopramide so she went back and administered it before the resident ate lunch. Interview with the facility's Manager on 12/08/20 at 2:51pm revealed: -The MAs should read the MARs and follow the instructions when administering medications. -The MAs should administer medications when they were scheduled to be administered. Interview with Resident #4 on 12/09/20 at 12:16pm revealed: -He did not know what medications he took or if he took any medications at lunch. -He did not have any symptoms of acid reflux. Attempted telephone interview with Resident #4's primary care provider (PCP) on 12/09/20 at 1:40pm was unsuccessful. c. Review of Resident #5's current FL-2 dated 06/30/20 revealed:	{D 358}		

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{D 358}	Continued From page 10 -Diagnosis included intermittent explosive disorder. -There was an order for Protonix 40mg 1 tablet daily every morning. (Protonix is used to treat acid reflux.) Review of Resident #5's December 2020 medication administration record (MAR) revealed: -There was an entry for Protonix 40mg 1 tablet daily every morning. -Protonix was scheduled to be administered at 8:00am. Observation of the 8:00am medication pass on 12/09/20 revealed: -The medication aide (MA) punched 5 different medications into a paper souffle medication cup for Resident #5. -The MA pulled a sixth bubble card from the medication cart with Protonix 40mg tablets. -The MA pushed the front of the bubble with a Protonix tablet and held it over the medication cup. -The Protonix tablet did not release from the bubble card. -There were 5 tablets in the medication cup instead of 6 tablets. -The MA placed the Protonix bubble card back into the medication cart. -The MA continued with the medication pass and started to hand the medication cup to the resident. -When the MA was stopped and asked how many tablets were in the medication cup, she counted 5 tablets. -When the MA was told there was 1 tablet missing, she pulled the bubble cards from the medication cart and found the Protonix 40mg tablet was stuck on the paper on the back of the bubble card.	{D 358}		

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{D 358}	Continued From page 11 -She then removed the Protonix tablet from the bubble card and put it in the medication cup with the resident's other medications and administered them at 8:03am. Interview with the MA on 12/09/20 at 8:03am revealed: -The tablets sometimes got stuck on the paper on the back of the bubble cards when she tried to push the medications from the bubble card into the medication cup. -She did not realize Resident #5's Protonix tablet did not fall into the medication cup when she pushed on the bubble earlier. Interview with the facility's Manager on 12/09/20 at 12:09pm revealed the MAs should check the medication cup and the back of the bubble cards to make sure the tablets fell into the medication cup and were administered. Interview with Resident #5 on 12/09/20 at 12:16pm revealed: -He usually got all of his lunch medications at the same time. -He had no acid reflux since he started taking Protonix. Attempted telephone interview with Resident #5's primary care provider (PCP) on 12/09/20 at 1:40pm was unsuccessful. d. Review of Resident #6's current FL-2 dated 11/27/20 revealed: -Diagnoses included diabetes, schizoaffective disorder, and hypertension. -There was an order for Miralax powder, mix 17 grams in 8 ounces of liquid and drink daily. (Miralax is a used to treat and prevent constipation.)	{D 358}		

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{D 358}	Continued From page 12 Review of Resident #6's December 2020 medication administration record (MAR) revealed: -There was an entry for Miralax powder mix 17 grams in 8 ounces of liquid and drink once daily for constipation. -Miralax was scheduled to be administered at 8:00am. Observation of the 8:00am medication pass on 12/09/20 revealed: -The medication aide (MA) prepared and administered five medications to Resident #6 at 8:39am. -Miralax was not offered or prepared and administered to the resident when he received his other medications. Observation of Resident #6's medications on hand on 12/09/20 at 11:35am revealed: -There was a bottle of Miralax powder (510 grams or a 30-day supply) dispensed on 11/27/20 with instructions to mix 17 grams in 8 ounces of liquid and drink daily. -The bottle had been opened and it was approximately 3/4th full of Miralax powder. Interview with the MA on 12/09/20 at 11:35am revealed: -She was aware Resident #6's Miralax was scheduled to be administered at 8:00am. -The resident usually asked for the Miralax later in the day so she did not prepare or offer it during the 8:00am medication pass. -She had not notified the primary care provider (PCP) that the resident requested Miralax later in the day. -The resident had not complained of any issues with constipation.	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 13 Interview with Resident #6 on 12/09/20 at 11:31am revealed: -She was taking Miralax mixed in her water in the mornings. -She did not receive any Miralax that morning (12/09/20) during the morning medication pass. -She did not have to ask for Miralax because she usually got it in the mornings. -She could not recall when she last received Miralax. -She was not having any current issues with constipation. Interview with the facility's Manager on 12/08/20 at 2:51pm revealed: -She was not aware of Resident #6 requesting to take Miralax later in the day. -The MAs were expected to administer medications at the time they were scheduled on the MARs. -If there needed to be changes with the times of administration, the MA should contact the PCP. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/09/20 at 1:40pm was unsuccessful.	{D 358}		
{D 366}	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's	{D 366}		

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	HAL007015	A. BUILDING: _____ B. WING _____	R 12/09/2020

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{D 366}	Continued From page 14 medication. Pre-charting is prohibited. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 2 medication aides (MAs) observed during medication passes on 12/08/20 and 12/09/20 documented the administration of medications immediately following the administration and observation of the residents actually taking the medications, including a MA who precharted medications for all residents on 12/08/20. The findings are: 1. Observation of the 11:30am/12:00pm medication pass on 12/08/20 from 11:02am - 11:33am revealed: -The medication aide (MA) administered medications to 8 residents during the time period observed. -Five of the 8 residents were administered oral medications while the other 3 residents had fingerstick blood sugar checks and/or insulin administered. -The MA administered 4 oral medications to the first resident at 11:04am and appeared to initial the medication administration record (MAR) after she observed the resident take the medications. -The MA administered one oral controlled substance (CS) medication to a second resident and documented on the CS log only, not the MAR after observing the resident take the medication. -The MA administered an oral inhaler to a third resident and appeared to document her initials on	{D 366}	Manager will monitor alternating shifts medpasses to ensure there are no precharting medications. During med refresher class will review precharting is unacceptable and not allowed. Administrator/ designee will follow med-aide weekly to ensure NO precharting.	2/20/2021

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{D 366}	Continued From page 15 the MAR after administering the inhaler. -The MA administered one CS medication to a fourth resident and documented on the CS log only, not the MAR after observing the resident take the medication. -The MA administered two CS medications to a fifth resident and documented on the CS log and then appeared to initial the MAR. Review of the December 2020 MARs for all residents on 12/08/20 at 12:40pm revealed: -All medications for the first resident observed had been initialed including 12:00pm, 3:00pm, 4:00pm, and 8:00pm medications for 12/08/20. -All medications for the second resident observed had been initialed including 12:00pm, 5:00pm, and 8:00pm medications for 12/08/20. -The MA's initials for the 12:00pm dose of the oral inhaler observed to be administered to the third resident had been written over with the same initials. -All other medications for the third resident had been initialed including 4:00pm and 8:00pm medications for 12/08/20. -All medications for the fourth resident observed had been initialed including the 12:00pm CS medication and 8:00pm medications for 12/08/20. -The MA's initials for the 12:00pm doses of CS medications for the fifth resident observed had been written over with the same initials. -All other medications for the fifth resident had been initialed including 2:00pm, 4:00pm, 5:00pm, and 8:00pm medications for 12/08/20. -All medications for the 3 residents who were observed to receive fingerstick blood sugar (FSBS) checks and/or insulin including 1:00pm, 2:00pm, 5:00pm, 5:30pm, 6:00pm, and 8:00pm medications for 12/08/20 had already been initialed as administered by the MA. -All MARs in the MAR book for all 19 residents in	{D 366}		

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{D 366}	Continued From page 16 the facility had all medications for 12/08/20 documented as administered (precharted) at 12:40pm on 12/08/20 including medications scheduled to be administered from 2:00pm through 8:00pm. -All of the precharted medications on 12/08/20 were initialed by the MA observed during the 11:30am/12:00pm medication pass on 12/08/20. Interview with the MA on 12/08/20 at 12:58pm revealed: -She had already documented the administration of all medications for all residents for 12/08/20 for all times through 8:00pm. -She was working a double shift today, 12/08/20, so she initialed all of the medications scheduled from 8:00am - 8:00pm for all residents when she was administering medications during the 8:00am medication pass. -During the 12:00 medication pass observed today, 12/08/20, she sometimes traced over her initials that were already on the MAR for 12:00pm because she knew they should not have already been documented. -She was aware that she was not supposed to prechart and she was supposed to document when she actually observed a resident take their medications. -This was how she routinely documented when she was working a double shift because she knew she would be administering all medications through the 8:00pm medication pass. Refer to interview with the facility's Manager on 12/08/20 at 2:51pm. Refer to interview with the Executive Officer on 12/08/20 at 2:51pm. Refer to interview with the Administrator on	{D 366}		

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{D 366}	Continued From page 17 12/09/20 at 12:09pm. 2. Observation of the 7:30am/8:00am medication pass on 12/09/20 from 7:42am - 8:39am revealed: -The medication aide (MA) administered medications to 4 residents during the time period observed. -The MA prepared 3 oral medications for the first resident and initialed the MAR after she punched each different tablet into the medication cup, before administering the medications to the resident. -The MA prepared 6 oral medications for a second resident and initialed the MAR after she punched each different tablet into the medication cup, before administering the medications to the resident. -The MA prepared 6 oral medications for a third resident and initialed the MAR after she punched each different tablet into the medication cup, before administering the medications to the resident. -The MA prepared 6 oral medications for a fourth resident and initialed the MAR after she punched each different tablet into the medication cup, before administering the medications to the resident. -All medications observed during this medication pass were initialed prior to the medications being administered to the resident and prior to observing the residents take their medications. Interview with the MA on 12/09/20 at 11:41am revealed: -She had been trained and knew she was supposed to document her initials on the MAR after she actually observed a resident take their medication. -She usually initialed the MAR after she punched	{D 366}		

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{D 366}	Continued From page 18 each tablet into the paper souffle medication cup because it helped her to remember which medications she had put in the cup. -She usually initialed the MAR before observing the residents take their medications because she knew which residents would take their medications and which residents would not take their medications. -If a resident did not take their medication, she could just go back and circle her initials. Refer to interview with the facility's Manager on 12/08/20 at 2:51pm. Refer to interview with the Executive Officer on 12/08/20 at 2:51pm. Refer to interview with the Administrator on 12/09/20 at 12:09pm. Interview with the facility's Manager on 12/08/20 at 2:51pm revealed: -The MAs were supposed to administer medications to the resident, observe the resident swallow the medication, and then document their initials on the MARs. -The facility did not allow precharting and the MAs were not supposed to prechart. Interview with the Executive Officer on 12/08/20 at 2:51pm revealed -The facility provided medication training for the MAs after the previous survey. -The MAs were re-trained and the MAs knew they were not supposed to prechart any medications. Interview with the Administrator on 12/09/20 at 12:09pm revealed: -The MAs should document on the MARs immediately after they observe a resident take	{D 366}		

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{D 366}	Continued From page 19 their medications , prior to going to the next resident. -No precharting was allowed at the facility.	{D 366}		