

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/06/2021
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NAME OF PROVIDER OR SUPPLIER L & H AGAPE FAMILY CARE HOME BRITTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 6, 2021.	C 000		
C 147	<p>10A NCAC 13G .0406(a)(7) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff C) had a statewide criminal background check completed upon hire.</p> <p>The findings are:</p> <p>Review of Staff C's, medication aide/Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 10/28/20. -There was no documentation of a statewide criminal background check completed upon hire for Staff C or consent for a criminal background check available for review.</p> <p>Telephone interview with Staff C on 08/06/21 at 2:25 pm revealed: -She worked as a part-time staff at the facility and a sister facility operated by the Administrator. -She remembered going to the local courthouse area to obtain a criminal background check when she was hired because she went to the wrong building and was sent to a building next to the courthouse to do the criminal background</p>	C 147		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 147	<p>Continued From page 1</p> <p>request.</p> <p>-She remembered receiving the criminal background check results before she was hired.</p> <p>-The Administrator was responsible for maintaining the documentation of her criminal background check.</p> <p>Interview with the Administrator on 08/06/21 at 4:20 pm revealed:</p> <p>-Staff C worked part-time at this facility and a sister facility she operated.</p> <p>-Staff C provided a statewide criminal background check upon hire and she thought the documentation was in her personnel record.</p> <p>-She was not aware the document was missing until she looked for the document on 08/05/21.</p> <p>-It was her responsibility to ensure the criminal background check was completed for staff.</p>	C 147		
C 272	<p>10A NCAC 13G .0904(d)(2) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service</p> <p>(d) Food Requirements in Family Care Homes:</p> <p>(2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to offer or make snacks available three times a day.</p> <p>The findings are:</p>	C 272		

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C 272	<p>Continued From page 2</p> <p>Interview with the Supervisor-in-Charge (SIC) on 8/06/21 at 9:15am revealed there were 6 residents who resided in the facility.</p> <p>Observation of the kitchen area on 08/06/21 at 10:30am revealed: -There was a weekly menu for regular diets. -Snack of the day at bedtime was listed on the regular diet sheet with snacks not listed at any other time of the day. -There was a weekly "1,500 Calorie Controlled Diabetic Diet" sheet in under the regular diet sheet. -There were no snacks listed on the weekly "1,500 Calorie Controlled Diabetic Diet" sheet.</p> <p>Observations in the facility on 08/06/21 between 9:15am to 4:00pm revealed snacks were not offered or made available to residents.</p> <p>Observation of the facility's available snack supplies on 08/06/21 at 11:00am revealed there was a box of wafers, 2 bags of cookies, small bags of chips, and snack squares and round crackers in a cabinet in the kitchen area.</p> <p>Interview with a resident on 08/06/21 at 12:24pm revealed: -The staff routinely served a snack at night before bedtime. -The residents received crackers, chips, and cookies once a day at bedtime.</p> <p>Interview with 4 residents on 08/06/21 at 3:50pm to 4:05pm revealed: -The residents routinely received a snack one time a day at bedtime. -The residents would eat snacks more often if offered.</p>	C 272		

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C 272	<p>Continued From page 3</p> <p>Interview with the Supervisor-In-Charge (SIC) on 08/06/21 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -She had been working at facility for 3 weeks. -There was no guidance for snacks on the weekly menu she used for preparing meals except for snacks at bedtime. -She had orientation for the food preparation with the Administrator when she came to the facility. -She served snacks to residents routinely at bedtime. -She did not know snacks were supposed to be served 3 times a day. <p>Interview with the Administrator on 08/06/21 at 4:08pm revealed:</p> <ul style="list-style-type: none"> -The Administrator purchased all the food. -The snacks were kept in a cabinet in the kitchen area. -Staff should serve snacks 3 times a day. -She prepared the weekly menu. -She omitted entering snacks to be served 3 times a day to the menu by accident. -She had done food orientation with the SIC a couple of weeks ago and may not have made it clear to serve snacks 3 times a day. <p>Telephone interview with Resident #1's primary care Nurse Practitioner on 08/06/21 at 3:30pm was unsuccessful.</p>	C 272		
C 284	<p>10A NCAC 13G .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service</p> <p>(e) Therapeutic Diets in Family Care Homes:</p> <p>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p>	C 284		

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C 284	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 2 sampled (#1) who had an order for no concentrated sweets diets (NCS).</p> <p>The findings are:</p> <ol style="list-style-type: none"> Review of Resident #4's current FL2 dated 11/02/20 revealed: -Diagnoses included Type II diabetes, and mild retardation. -The resident had a diet order for NCS. <p>Review of Resident #4's diet order from his primary care Nurse Practitioner (NP) dated 08/05/21 revealed a diet order of NCS.</p> <p>Observation of the facility's kitchen area on 08/06/21 at 11:08am revealed: -There was a diet list posted on the refrigerator. -Resident #4 was listed to be served a diabetic diet.</p> <p>Observation of the facility's kitchen area on 08/06/21 at 11:30am revealed: -There was a weekly menu for regular diets. -There was a weekly "1,500 Calorie Controlled Diabetic Diet" sheet under the regular diet sheet. -There was no matching therapeutic diet menu for NCS available for guidance for preparation of the meal for Resident #4.</p> <p>Observation of the lunch meal on 08/06/21 at 12:15pm revealed, Resident #4 ate pepperoni and cheese pizza with water for the beverage.</p>	C 284		

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C 284	<p>Continued From page 5</p> <p>Interview with Resident #4 on 08/06/21 at 3:00pm revealed he was served the same beverages and food as other residents.</p> <p>Attempted telephone interview with Resident #4's primary care Nurse Practitioner on 08/06/21 at 3:30pm was unsuccessful.</p> <p>Refer to the interview with the Supervisor-In-Charge (SIC) on 08/06/21 at 12:22pm.</p> <p>Refer to the interview with the Administrator on 08/06/21 at 3:34pm.</p> <p>2. Review of Resident #5's current FL2 dated 11/02/20 revealed: -Diagnoses included Type II diabetes. -The resident had a diet order for NCS.</p> <p>Review of Resident #5's diet order from his primary care Nurse Practitioner (NP) dated 08/05/21 revealed a diet order of NCS.</p> <p>Observation of the facility's kitchen area on 08/06/21 at 11:08am revealed: -There was a diet list posted on the refrigerator. -Resident #5 was listed to be served a diabetic diet.</p> <p>Observation of the facility's kitchen area on 08/06/21 at 11:30am revealed: -There was a weekly menu for regular diets. -There was a weekly "1,500 Calorie Controlled Diabetic Diet" sheet under the regular diet sheet. -There was no matching therapeutic diet menu for NCS available for guidance for preparation of the meal for Resident #5.</p> <p>Observation of the lunch meal on 08/06/21 at</p>	C 284		

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C 284	<p>Continued From page 6</p> <p>12:15pm revealed, Resident #5 ate pepperoni and cheese pizza with water for the beverage.</p> <p>Interview with Resident #5 on 08/06/21 at 3:10pm revealed all the residents received the same meals.</p> <p>Attempted telephone interview with Resident #5's primary care Nurse Practitioner on 08/06/21 at 3:30pm was unsuccessful.</p> <p>Refer to the interview with the Supervisor-In-Charge (SIC) on 08/06/21 at 12:22pm.</p> <p>Refer to the interview with the Administrator on 08/06/21 at 3:34pm.</p> <p>Interview with the SIC on 08/06/21 at 12:22pm revealed:</p> <ul style="list-style-type: none"> -She had been working at facility for 3 weeks. -There was no guidance on the weekly menu she used for preparing meals for NCS diets. -She had orientation for the food preparation with the Administrator when she came to the facility. -She had not been trained on therapeutic menus and did not know how to use therapeutic menus. -She served unsweetened beverages to diabetic residents. -She did not know where to find therapeutic menu sheets for ordered therapeutic diets. -She did not have all the food listed on the weekly regular menu so she served the residents pizza. <p>Interview with the Administrator on 08/06/21 at 3:34pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for ensuring residents' diet orders were current. -She made the diet sheet for the Nurse Practitioner to sign. 	C 284		

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C 284	Continued From page 7 -She had not updated the residents' diet list posted on the refrigerator. -She did not realize there was no matching therapeutic diet spread sheet for NCS available for consultation in meal preparation.	C 284		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#2 and #4) observed during medication administration on 08/06/22 at 8:56am and 9:22am related to not administering a blood thinner medication (#2) and a resident with an order for insulin before breakfast (#4). The findings are: 1. Review of Resident #2's current FL2 dated 07/26/21 revealed: -Diagnoses included coronary artery disease (CAD), hypothyroidism, history of myocardial infarction, arterial hypotension, adrenal insufficiency, and syncope and collapse. -There was an order for aspirin 81mg daily.	C 330		

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C 330	<p>Continued From page 8</p> <p>Observation of medication administration on 08/06/21 at 8:56am revealed: -The Supervisor-in-Charge (SIC) prepared 10 oral medications for administration to Resident #2. -Aspirin 81mg was not included in the medications administered to Resident #2.</p> <p>Review of Resident #2's August 2021 electronic administration record (eMAR) on 08/06/21 at 10:15am revealed aspirin 81mg was not listed on the eMAR.</p> <p>Observation of Resident #2's medication on hand for administration on 08/06/21 at 11:20am revealed: -Resident #2's medications were dispensed from the contracted pharmacy in bubble packs. -Resident #2 had several medications dispensed from the pharmacy on 07/22/21. -Resident #2 had 2 medications dispensed from the pharmacy in bubble packs labeled with dispensing date of 07/27/21. -Resident #2 had no aspirin 81mg available for administration.</p> <p>Interview with the SIC on 08/06/21 at 11:50am revealed: -She was new to the facility since 07/16/21. -She did not enter orders into the computer, the pharmacy did that. -The Administrator was responsible for processing medication orders, faxing the orders to the pharmacy and checking the orders entered into the eMAR system. -She did not see the actual medications orders. -She administered medications as they appeared on the eMAR. -She did not know Resident #2 had an order for aspirin 81mg dated 07/26/21.</p>	C 330		

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C 330	<p>Continued From page 9</p> <p>Interview with a representative for the contracted pharmacy on 08/06/21 at 1:40pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy received the medication order for Resident #2's aspirin 81mg daily in a fax sent by the facility on 07/27/21. -The pharmacy is responsible to enter routine orders on the residents' eMARs. -Aspirin 81mg was listed on the medications to be added to Resident #2's eMAR and dispensed by the pharmacy. -The order for aspirin 81mg was overlooked by the pharmacy staff entering the medication orders on Resident #2's eMAR. -Aspirin 81mg did not get entered onto Resident #2's medication list at the pharmacy and was not sent from the pharmacy along with other new medications on 07/28/21. -The facility was responsible to check physician's order when they approved new medications added to residents' medication records. -The facility was responsible to notify the pharmacy when medication orders did not match or were omitted from entries to the residents' eMARs. -Resident #2's order for aspirin 81mg would be added to the eMAR and a supply sent out immediately. <p>Interview with the Administrator on 08/06/21 at 1:48pm revealed:</p> <ul style="list-style-type: none"> -The contracted pharmacy entered routine orders into the facility's eMAR system. -She was responsible to audit the orders sent to the pharmacy and entered on residents' eMARs for accuracy and completeness and release the order to show for medication aides to administer the medications. -She expected the pharmacy to enter orders sent the pharmacy accurately. 	C 330		

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C 330	<p>Continued From page 10</p> <ul style="list-style-type: none"> -She remembered seeing Resident #2 had aspirin 81 mg ordered when he came from the hospital, but she did not realize aspirin was left off the medications sent from the new FL2 on 07/26/21 for Resident #2. -She had not administered medications for Resident #2 since 07/28/21 or she may have caught the omission. -The medications orders were not checked by staff other than her. -She had not audited the residents' eMAR compared to physician's orders due to staff shortages. <p>Interview with Resident #2 on 08/06/21 at 3:10pm revealed "the facility took care of his medications".</p> <p>Telephone interview with Resident #1's primary care Nurse Practitioner on 08/06/21 at 3:30pm was unsuccessful.</p> <p>2. Review of Resident #4's current FL-2 dated 11/02/20 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included mild retardation, Type II diabetes, and dementia. -There was an order for fingerstick blood sugar (FSBS) before breakfast and before bedtime. -There was an order for Novolog Mix 70/30 (combination of a fast acting and long acting insulin) inject 30 units subcutaneously before breakfast; hold if FSBS less than 110. <p>Observation of medication administration on 08/06/21 at 9:22am revealed:</p> <ul style="list-style-type: none"> -The Supervisor-in-Charge (SIC) prepared FSBS supplies and obtained a FSBS reading from the resident. -Resident #4's FSBS value was 262. -The SIC consulted the resident's electronic 	C 330		

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C 330	<p>Continued From page 11</p> <p>medication administration record (eMAR) and stated the resident should receive 20 units of Novolog 70/30 Mix. -The SIC administered 20 units of Novolog Mix 70/30 via insulin pen.</p> <p>Interview with Resident #4 on 08/06/21 at 9:22am revealed: -He had breakfast around 8:00am this morning. -He usually received his insulin early in the morning but sometimes after he had eaten.</p> <p>Review of Resident #4's August 2021 electronic administration record (eMAR) on 08/06/21 at 10:30am revealed: -There was an entry for check and record blood sugar twice daily before breakfast and before bedtime listed and scheduled for 8:00am and 5:00pm. -FSBS values documented for 8:00am from 08/01/21 to 08/06/21 were 121, 262, 149, 125, 154, and 262 in chronological order. -FSBS values documented for 5:00pm from 08/02/21 to 08/05/21 were 187, 168, 97, and 237 in chronological order.</p> <p>Interview with the SIC on 08/06/21 at 11:50am revealed: -She overslept this morning and hurried to get started with breakfast. -She knew the order for insulin was to be administered before breakfast. -The resident ate breakfast before she could do his FSBS check and administer insulin. -She gave the insulin after breakfast because the FSBS reading was well over 110 and his order was to hold if less 110.</p> <p>Interview with the Administrator on 08/06/21 at 1:48pm revealed:</p>	C 330		

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C 330	<p>Continued From page 12</p> <p>-She did not know Resident #4 received insulin 1 hour after breakfast instead of before breakfast as ordered.</p> <p>-Resident #4's FSBS was pretty consistent and did not routinely got too low.</p> <p>-She would retrain the SIC for assuring medications were administered according to orders and the importance of administering insulin correctly.</p> <p>Telephone interview with Resident #1's primary care Nurse Practitioner on 08/06/21 at 3:30pm was unsuccessful.</p>	C 330		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> (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). 	C 342		

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C 342	<p>Continued From page 13</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the documentation on the electronic medication administration records (eMARs) included the initials of the medication aide (MA) who administered the medication for 3 of 3 sampled residents (Residents #1, #2. and #3).</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL2 dated 07/26/21 revealed diagnoses included coronary artery disease (CAD), hypothyroidism, history of myocardial infarction, arterial hypotension, adrenal insufficiency, and syncope and collapse.</p> <p>Review of Resident #3's previous FL2 dated 12/13/21 and current FL2 dated 07/26/21 revealed medications orders as follow:</p> <ul style="list-style-type: none"> -There was an order for amlodipine (used to treat high blood pressure and angina) 5mg once daily. -There was an order for baclofen (a muscle relaxant) 20mg 4 times day. -There was a new order for Brilinta (an blood thinner) 90mg twice a day on the current FL2 dated 07/26/21. -There was an order for Aricept (used to treat memory loss) 10mg at bedtime. -There was an order for hydrocortisone (used to treat adrenal insufficiency) 50mg in the morning. -There was an order for hydrocortisone 10mg at bedtime on the FL2 dated 12/13/21 but not on the FL2 dated 07/26/21. -There was a new order for hydrocortisone 30mg at bedtime for 3 days on the FL2 dated 07/26/21. -There was a new order for hydrocortisone 20mg at bedtime for 2 days on the FL2 dated 07/26/21. 	C 342		

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C 342	<p>Continued From page 14</p> <ul style="list-style-type: none"> -There was a new order for hydrocortisone 10mg at bedtime for 2 days on the FL2 dated 07/26/21 starting 08/04/21. -There was an order for hydroxyzine pamoate (used to treat anxiety) 50mg 4 times a day. -There was a new order for isosorbide mononitrate (used to treat angina) 30mg extended release once daily on the FL2 dated 07/26/21. -There was an order for thyroid (used to treat hypothyroidism) 120mg once daily. -There was an order for pantoprazole (used to treat acid reflux) 40mg once daily. -There was an order for Seroquel (used to treat mental disorders) 25mg twice a day. -There was an order for rosuvastatin (used to treat high cholesterol) 20mg once daily on the FL2 dated 07/26/21. -There was an order for trazadone (used to treat depression) 300mg at bedtime. -There was an order for venlafaxine (used to treat anxiety and depression) 75mg extended release once daily. <p>Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There were entries for amlodipine 5mg daily, baclofen 20mg 4 times day, Brilinta 90mg twice a day, Aricept 10mg at bedtime, hydrocortisone 50mg in the morning with 30mg at bedtime for 3 days, 20mg at bedtime, then 10mg at bedtime, hydroxyzine pamoate 50mg 4 times a day, isosorbide mononitrate 30mg extended release once daily, thyroid 120mg once daily, pantoprazole 40mg once daily, Seroquel 25mg twice a day, rosuvastatin 20mg once daily, trazadone 300mg at bedtime, and venlafaxine 75mg extended release once daily. -There was documentation Resident #3's 	C 342		

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C 342	<p>Continued From page 15</p> <p>medications were administered by the Administrator from 07/14/21 to 07/20/21 and from 07/27/21 to 07/31/21 (Resident #3 was in the hospital from 07/21/21 to 07/26/21 and documented out of facility on the eMAR). -The initials of the Administrator were the only initials on the eMAR showing documentation that medications were administered. -The initials of the medication aide (MA) that administered the medications were not on the eMAR.</p> <p>Review of Resident #3's August 2021 eMAR on 08/06/21 revealed: -There were entries for amlodipine 5mg daily, baclofen 20mg 4 times day, Brilinta 90mg twice a day, Aricept 10mg at bedtime, hydrocortisone 50mg in the morning with 30mg at bedtime for 3 days, 20mg at bedtime, then 10mg at bedtime, hydroxyzine pamoate 50mg 4 times a day, isosorbide mononitrate 30mg extended release once daily, thyroid 120mg once daily, pantoprazole 40mg once daily, Seroquel 25mg twice a day, rosuvastatin 20mg once daily, trazadone 300mg at bedtime, and venlafaxine 75mg extended release once daily. -There was documentation Resident #3's medications were administered by the Administrator from 08/01/21 to 08/05/21 at 8:00am. -The initials of the Administrator were the only initials on the eMAR showing documentation that medications were administered. -The initials of the MA that administered the medications were not on the eMAR from 08/01/21 to 08/05/21 at 8:00am.</p> <p>Refer to the interview with the Supervisor-in-Charge (SIC) in the facility on 08/06/21 at 3:03pm.</p>	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/06/2021
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C 342	<p>Continued From page 16</p> <p>Refer to the interview with the Administrator on 08/06/21 at 3:25pm.</p> <p>2. Review of Resident #1's current FL2 dated 11/02/20 revealed diagnoses that included obsessive compulsive disorder (OCD), schizoaffective disorder, hyperprolactinemia, and bipolar disorder.</p> <p>Review of Resident #1's record revealed medication orders as follows:</p> <ul style="list-style-type: none"> -There was a physician's order dated 12/21/20 for aripiprazole (used to treat bipolar disorder) 10mg once daily at 8:00pm. -There was a physician's order dated 01/16/21 for clozapine (used to treat mental disorders) 200mg daily at bedtime. -There was a physician's order dated 01/29/21 for venlafaxine (used to treat anxiety and depression) 150mg extended release once daily. -There was a physician's order dated 12/21/20 for benztropine (used to treat involuntary movements) 1mg twice daily. -There was a physician's order dated 02/08/21 for buspirone (used to treat anxiety) 5mg twice daily. -There was a physician's order dated 04/02/21 for vitamin D3 (vitamin D supplement) 50,000-unit capsule once weekly. <p>Review of Resident #1's July 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There were entries for aripiprazole 10mg daily at bedtime, clozapine 200mg daily at bedtime, venlafaxine 150mg extended release once daily, benztropine 1mg twice daily, buspirone 5mg twice daily, and vitamin D3 50,000-unit capsule once weekly. -There was documentation Resident #1's 	C 342		

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C 342	<p>Continued From page 17</p> <p>medications were administered by the Administrator from 07/14/21 to 07/31/21. -The initials of the Administrator were the only initials documented on the eMAR for administration of medications. -The initials of the medication aide (MA) who administered the medications were not documented on the eMAR.</p> <p>Review of Resident #1's August 2021 eMAR on 08/06/21 revealed: -There were entries for aripiprazole 10mg daily at bedtime, clozapine 200mg daily at bedtime, venlafaxine 150mg extended release once daily, benzotropine 1mg twice daily, buspirone 5mg twice daily, and vitamin D3 50,000-unit capsule once weekly. -There was documentation Resident #1's medications were administered by the Administrator from 08/01/21 to 08/05/21 at 8:00am. -The initials of the Administrator were the only initials documented on the eMAR for administration of medications. -The initials of the MA who administered the medications were not documented on the eMAR from 08/01/21 to 08/05/21 at 8:00am.</p> <p>Refer to the interview with the Supervisor-in-Charge (SIC) in the facility on 08/06/21 at 3:03pm.</p> <p>Refer to the interview with the Administrator on 08/06/21 at 3:25pm.</p> <p>3. Review of Resident #3's current FL2 dated 11/02/20 revealed: -Diagnoses included hypertension, autism, bipolar psychosis, and gastroesophageal reflux disorder.</p>	C 342		

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C 342	<p>Continued From page 18</p> <ul style="list-style-type: none"> -There was an order for benzotropine (used to control tremors or involuntary movements caused by other medications) 1 mg twice daily. -There was an order for hydrochlorothiazide (used to treat hypertension) 25mg daily. -There was an order for loratadine (used to treat allergies)10mg daily. -There was an order for risperidone(used to treat mental disorders) 2 mg twice daily. -There was an order for senexon-s (a combination stool softener and laxative used to treat constipation) 8.6-50mg daily. <p>Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There were entries for benzotropine 1 mg twice daily, hydrochlorothiazide 25mg daily, loratadine 10mg daily, risperidone 2 mg twice daily, and senexon-s 8.6-50mg daily. -There was documentation Resident #3's medications were administered by the Administrator from 07/14/21 to 07/31/21. -The initials of the Administrator were the only initials on the eMAR showing documentation that medications were administered. -The initials of the medication aide (MA) that administered the medications were not on the eMAR. <p>Review of Resident #3's August 2021 eMAR on 08/06/21 revealed:</p> <ul style="list-style-type: none"> -There were entries for benzotropine 1 mg twice daily, hydrochlorothiazide 25mg daily, loratadine 10mg daily, risperidone 2 mg twice daily, and senexon-s 8.6-50mg daily. -There was documentation Resident #3's medications were administered by the Administrator from 08/01/21 to 08/05/21 at 8:00am. 	C 342		

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C 342	<p>Continued From page 19</p> <ul style="list-style-type: none"> -The initials of the Administrator were the only initials on the eMAR showing documentation that medications were administered. -The initials of the MA that administered the medications were not on the eMAR for 08/01/21 to 08/05/21. <p>Refer to the interview with the Supervisor-in-Charge (SIC) in the facility on 08/06/21 at 3:03pm.</p> <p>Refer to the interview with the Administrator on 08/06/21 at 3:25pm.</p> <p>Interview with SIC in the facility on 08/06/21 at 3:03pm revealed:</p> <ul style="list-style-type: none"> -She had been employed at the facility for several weeks. -Her responsibilities included administering medications at the facility. -She had administered medications to the residents since she was checked off by the nurse (Review of the SIC's personnel record revealed a hire date of 07/09/21 and a Medication Clinical Skills Validation checklist dated 07/14/21.) -She administered medications in the facility daily from 07/14/21 to 08/05/21 at 8:00am utilizing the Administrator's initials on the eMAR because she had problems accessing the eMARs under her login. -She did not know she should not use the Administrator's initials to document on the eMARs. -Her initials were not on the eMARs from 07/14/21 to 08/05/21 at 8:00pm. -She had spoken with the Administrator on 08/05/21 and she explained how to access the eMARs. -She started using her own login to document medication administration on the eMARs on 	C 342		

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C 342	<p>Continued From page 20</p> <p>08/06/21.</p> <p>-The Administrator knew she had used the Administrator's login to access the eMARs.</p> <p>Interview with the Administrator on 08/06/21 at 3:25pm revealed:</p> <p>-The SIC had worked at the facility since July 2021.</p> <p>-She did not the SIC could not access the eMAR system utilizing the SIC's assigned login.</p> <p>-She told the MA to use her (Administrator's) log-in and password for documenting the administration of medication on the eMAR until she was able to show her how to log in.</p> <p>-She knew if the MA logged in with her information that her initials would be on the eMARs as administering medications.</p> <p>-It was her fault the SIC accessed the eMARs using the Administrator's log in.</p> <p>-She did not have a reason as to why she let the SIC utilize her log in to document medication administration on the eMARs.</p>	C 342		