STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	R 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 09/01/21 - 09/03/21.	{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 administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to an insomnia medication . The findings are: Review of Resident #1's current FL2 dated 01/01/21 revealed: -Diagnoses included vascular dementia with behaviors, chronic obstructive pulmonary disease (COPD), trigeminal neuralgia, and hypothyroidism. -There was an order for temazepam (used to treat sleep disorders) 15mg take 2 capsules every night at bedtime. Review of Resident #1's physician order dated 05/07/21 revealed an order for temazepam 30mg administer 1 capsule at bedtime as needed.	{D 358}	The Administrator/Director shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the resident's record; DHSR rules and the facility's policies. Training with Medication Aides/Supervisors on 9-17-21 including review of facility medication ordering policy and procedures. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(a). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	10/6/21

Reviewed and Acknowledged
CHarrison for JScarlett 1/31/22

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{D 358}	Continued From page 1 Review of Resident #1's medication administration record (MAR) for July 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pm. -There was documentation all doses had been administered from 07/01/21 to 07/31/21. Review of Resident #1's MAR for August 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pm. -There was documentation all doses had been administered from 08/01/21 to 08/31/21. Observation of Resident #1's medication on hand on 09/01/21 at 4:00pm revealed: -There were no temazepam 15mg capsules available. -There was one cassette of temazepam 30mg with 11 of 16 capsules remaining dispensed on 08/12/21. -The directions on the temazepam label read to administer 1 capsule at bedtime as needed. Telephone interview with a representative at the facility's contracted pharmacy on 09/01/21 at 3:34pm revealed: -Resident #1 had an order for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00am. -The scheduled temazepam order was last filled on 05/12/21 for a quantity of 12 capsules as Resident #1 was out of refills. -On 05/07/21, the pharmacy had received an order for temazepam 30mg take 1 tablet as needed at bedtime, but the scheduled order remained the same.	{D 358}	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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{D 358}	Continued From page 2 -Temazepam 30mg was dispensed on 05/07/21 for a quantity of 16 capsules. -Temazepam 30mg was dispensed on 07/15/21 for a quantity of 16 capsules. -Temazepam 30mg was dispensed on 08/12/21 for a quantity of 16 capsules. -Temazepam was prescribed for Resident #1 due to a sleep disorder. Telephone interview with Resident #1's hospice pharmacist on 09/02/21 at 12:03pm revealed: -The hospice pharmacy dispensed an 8-day supply of temazepam 15mg on 05/27/21 from their emergency backup which is all they could send because they needed a new prescription. -There would not have been any temazepam from 06/12/21 through 06/21/21. -There were clearly many gaps throughout that would prove Resident #1 was not administered her temazepam 30mg every night at bedtime as ordered. Telephone interview with a triage nurse with Resident #1's hospice provider on 09/02/21 at 11:30am revealed: -The facility's contracted pharmacy was responsible for filling Resident #1's temazepam order and billing hospice. -The hospice pharmacy provided backup temazepam so the resident would not miss any of her medication. -Hospice reimbursed the contracted facility pharmacy for all temazepam that had been dispensed. -The resident had been on temazepam for 2 years. -Temazepam was originally ordered as needed but was changed to nightly on 03/19/21. Interview with Resident #1's hospice nurse on	{D 358}	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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{D 358}	Continued From page 3 09/01/21 at 11:59am revealed: -The resident had complained that she had not been sleeping well and her sleeping pill had not been working. -She instructed the resident that she could also request her anti-anxiety medication at the same time she took her temazepam to help get some sleep. Interview with Resident #1 on 9/02/21 at 11:12am revealed: -She had not been sleeping well for several months because the sleeping pill was not working. -Not sleeping well caused her not to care about anything. -She did not do well participating with any activities because she was so tired and just wanted them to be over. -It made her irritable and short with staff and generally upset with everyone. -She had gotten to the point she just went to eat her meals and came right back to her room to lay down and rest. Telephone interview with the facility contracted provider on 09/02/21 at 11:44am revealed: -He used to be the primary care provider for Resident #1. -Resident #1 had been off and back on hospice services a few times. -He had signed the FL2 and 6-month orders for Resident #1 because he thought she had discharged from hospice services. -He wrote an order for temazepam 30mg as needed at bedtime on 05/07/21 for Resident #1 because she needed a new prescription and he thought she was on his services. -He thought that when he received requests to sign FL2s and write orders for a resident, the	{D 358}	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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{D 358}	Continued From page 4 resident had been discharged from hospice. Telephone interview with Resident #1's hospice nurse practitioner on 09/02/21 at 2:46pm revealed: -She assessed the resident every 60 days. -Originally, the resident was on a different medication for sleep, but it did not work so we changed her to temazepam. -The last couple times she saw the resident, she could tell she was not resting well because she was tired, had increased agitation, and tearfulness. -She last saw the resident on 07/14/21. -She did not know the contracted facility provider wrote a prescription for the resident on 05/07/21 because she was out of refills. -She had not been notified that the resident was out of temazepam refills and needed a new order except on 05/20/21 the hospice nurse informed her that she needed some temazepam. -A hospice nurse delivered temazepam to the facility on 05/27/21. -If the resident had not been receiving her temazepam as ordered she would show signs of irritability, crankiness, and more depressed with tearfulness and that was what she had documented on her last visit. -She should have been made aware of the resident needing refills on her temazepam. -She expected the facility to administer medications as ordered to keep the resident comfortable. Interview with the Memory Care Unit Coordinator (MCUC) on 09/02/21 at 12:30 revealed: -She regularly passed medications to the residents in memory care unit. -She had noticed the past few months that Resident #1 had been lying in bed a lot more than	{D 358}	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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{D 358}	Continued From page 5 she used to. -Resident #1 went to eat and then went straight back to her room and laid back down. -She had not been participating in activities like she used to. -Resident #1 did not have any scheduled temazepam available for administration -Resident #1 had some temazepam 30mg ordered as needed that she had used to administer as the scheduled dose on 09/01/21. -The MA who changed out cycle fill medications was supposed to ensure all medications were on the medication cart. -She did not know why Resident #1 did not have any scheduled temazepam available. Interview with a personal care aide (PCA) on 09/02/21 at 12:45 revealed: -Resident #1 had been more tired lately and had not been participating in activities for the past 3 months. -Resident #1 also talked harshly to staff but she did not mean anything by it. Interview with the Interim Director on 09/02/21 at 12:55 pm revealed: -The MA on duty checked cycle fill medications to ensure all medications were available as compared to the MAR. -The MAs checked the medication dosage and ensured the as needed medications were available. -The MAs also counted the number of medications sent with cycle fill to ensure the count was matched the dispensing log. -She expected MAs to follow up on any missing medications and call the provider for orders as needed. -Medication carts were audited on 08/27/21 for expired medications and to ensure all	{D 358}	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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{D 358}	Continued From page 6 medications were available and matched orders. -The MCUC completed her own audit on the Memory Care Unit medication cart. Interview with the Administrator on 09/02/21 at 1:05pm revealed: -The contracted facility provider could see any of the residents in the facility. -The facility had some problems with the hospice nurse practitioner refilling and signing medication orders, so the contracted facility provider signed orders for Resident #1. -The contracted pharmacy nurse audited the medication cart every 3 months. -The facility's contracted pharmacy nurse audited medication carts on 08/27/21 to ensure medications were available and did not find any problems. -She expected MAs to follow up on any missing medications and call the provider for orders as needed as it was their responsibility to ensure medications were available.	{D 358}	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK	
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name,	D 363	***** ***** ***** ***** ***** ***** ***** ***** SEE PAGE 8 FOR RESPONSE	

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D 363	Continued From page 7 until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration and protected from contamination and spillage for 3 of 3 sampled residents (Residents #8, #9, and #10). The findings are: Observations on 09/01/21 at 4:00pm of the Memory Care Unit (MCU) medication room revealed: -There were 3 medication cups of pudding with	D 363	The Administrator/Director shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with rule 10A NCAC 13F .1004(f). If medications are prepared for administration in advance, they will be prepared as indicate 1-4 in rule 13F .1004(f), DHSR rules and regulations. Training with Medication Aides/Supervisors on 9-17-21 including review of facility policy on prepouring medications was discussed. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(f). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	10/6/21

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D 363	Continued From page 8 medication in each. -Each cup had the resident's initials on the side. -No administration times were on the cups. -The cups were not sealed and did not identify the name and strength of each medication. 1. Review of Resident #8's current FL2 dated 04/25/21 revealed: -Diagnoses included dementia, atrial fibrillation, and hypertension. -There was an order for quetiapine 25mg one tablet three times a day. Observation of the Memory Care Unit (MCU) medication room counter on 09/01/21 at 4:07pm revealed: -There was a cup labeled with Resident #8's initials which contained a medication mixed with pudding sitting on the counter with 2 other residents' medications. -The Memory Care Unit Coordinator (MCUC) picked up the cup and took it to Resident #8 and administered the medication. Review of Resident #1's September 2021 medication administration record (MAR) revealed there was an entry for quetiapine 25mg one tablet three times a day scheduled for administration at 8:00 am, 12:00 pm and 4:00 pm. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Refer to interview with a MCUC on 09/01/21 4:15pm. Refer to interview with the Interim Director on 09/01/21 at 4:20pm.	D 363	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 363	Continued From page 9 Refer to the interview with the Administrator on 09/02/21 at 4:50pm. 2. Review of Resident #9's current FL2 dated 04/25/21 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, and diabetes mellitus. -There was an order for baclofen 10mg one tablet three times a day. Observation of the Memory Care Unit (MCU) medication room counter on 09/01/21 at 4:13pm revealed: -There was a cup labeled with Resident #9's initials which contained a crushed medication mixed with pudding sitting on the counter with 2 other residents' medication. -The Memory Care Unit Coordinator (MCUC) picked up the cup and took it to Resident #9 and administered the medication. Review of Resident #9's September 2021 medication administration record (MAR) revealed there was an entry for baclofen 10mg one tablet three times a day scheduled for administration at 8:00 am, 12:00 pm and 4:00 pm. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable. Refer to interview with a MCUC on 09/01/21 4:15pm. Refer to interview with the Interim Director on 09/01/21 at 4:20pm. Refer to the interview with the Administrator on 09/02/21 at 4:50pm.	D 363	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 363	Continued From page 10 3. Review of Resident #10's current FL2 dated 06/01/21 revealed: -Diagnoses included dementia, glaucoma, osteoporosis, and hypothyroidism. -There was an order for acetaminophen 500mg one tablet three times a day. Observation of the Memory Care Unit (MCU) medication room counter on 09/01/21 at 4:12pm revealed: -There was a cup labeled with Resident #10's initials which contained a crushed medication mixed with pudding sitting on the counter with 2 other residents' medication. -The Memory Care Unit Coordinator (MCUC) picked up the cup and took it to Resident #10 and administered the medication. Review of Resident #10's September 2021 medication administration record (MAR) revealed there was an entry for acetaminophen 500mg one tablet three times a day scheduled for administration at 8:00 am, 12:00 pm and 4:00 pm. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Refer to interview with a MCUC on 09/01/21 4:15pm. Refer to interview with the Interim Director on 09/01/21 at 4:20pm. Refer to the interview with the Administrator on 09/02/21 at 4:50pm. _____ Refer to interview with a Memory Care Unit Coordinator (MCUC) on 09/01/21 4:15pm.	D 363	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 363	Continued From page 11 -She pre-poured medications to help save time. -She labeled each cup with the resident's initials. -She prepared medications for the residents one at a time by reviewing the MAR for each resident, comparing the medication to the MAR, and placing the medications in the cup labeled with each residents' initials only and moving to the next resident. -The cups contained pudding and were not sealed and did not identify the name and strength of each medication. -She did not know that medications had to be covered or labeled with each medication name and strength. -She pre-poured the medications with the intention to grab and go administer by carrying all 3 cups in her hand going from resident to resident. -She had been trained not to pre-pour medications. -She knew she was not supposed to pre-pour medications as the facility did not allow it. Interview with the Interim Director on 09/01/21 at 4:20pm revealed: -She knew medications had been pre-poured as she saw them on the counter in the MCUC. -The MAs had been told not to pre-pour medications. -She expected medications to be given when they were due and not pre-poured. Interview with the Administrator on 09/02/21 at 4:50pm revealed: -She knew medications had been pre-poured because when the Interim Director saw them she reported it to her immediately. -The MAs had previously been told they were not allowed to pre-pour medications. -She expected all medications to be given when	D 363	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 363	Continued From page 12 due and not pre-poured in advance.	D 363		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (Resident #1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated	D 367	The Administrator/Director shall ensure The resident's medication administration record (MAR) shall be accurate and include the following: resident's name; name of the medication or treatment order; strength and dosage or quantity of medication administered; instructions for administering the medication or treatment; reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; date and time of administration; documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, name or initials of the person administering the medication or treatment. All MARs for every resident were reviewed for accuracy by facility Director on 10-01-21. Training with Medication Aides/ Supervisors on 9-17-21 including review of facility medication policy and procedures. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(j). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	10/6/21

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	HAL029010	A. BUILDING: _____ B. WING _____	R 09/03/2021

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D 367	Continued From page 13 01/01/21 revealed: -Diagnoses included vascular dementia with behaviors, chronic obstructive pulmonary disease (COPD), trigeminal neuralgia, and hypothyroidism. -There was an order for temazepam (used to treat sleep disorders) 15mg take 2 tablets every night at bedtime. Review of Resident #1's physician order dated 05/07/21 revealed an order for temazepam 30mg administer 1 tablet at bedtime as needed. Review of Resident #1's medication administration record (MAR) for July 2021 revealed: -There was an entry for temazepam 15mg take 2 tablets every night at bedtime scheduled for 8:00am. -There was documentation all doses had been administered from 07/01/21 to 07/31/21. Review of Resident #1's MAR for August 2021 revealed: -There was an entry for temazepam 15mg take 2 tablets every night at bedtime scheduled for 8:00am. -There was documentation all doses had been administered from 08/01/21 to 08/31/21. Observation of Resident #1's medication on hand on 09/01/21 at 4:00pm revealed: -There were no temazepam 15mg capsules available. -There was one cassette of temazepam 30mg with 11 of 16 tablets remaining. -The directions on the temazepam label read to administer 1 capsule at bedtime as needed. Telephone interview with a representative at the	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 14 facility's contracted pharmacy on 09/01/21 at 3:34pm revealed: -Resident #1 had an order for temazepam 15mg take 2 tablets every night at bedtime scheduled for 8:00am. -The scheduled temazepam order was last filled on 05/12/21 for a quantity of 12 tablets as Resident #1 was out of refills. -On 05/07/21, the pharmacy had received an order for temazepam 30mg take 1 tablet as needed at bedtime, but the scheduled order remained the same. -Temazepam 30mg was dispensed on 05/07/21 for a quantity of 16 capsules. -Temazepam 30mg was dispensed on 07/15/21 for a quantity of 16 capsules. -Temazepam 30mg was dispensed on 08/12/21 for a quantity of 16 capsules. -Temazepam was prescribed for Resident #1 due to a sleep disorder. Telephone interview with Resident #1's hospice pharmacist on 09/02/21 at 12:03pm revealed: -The primary pharmacy dispensed a 20-day supply of temazepam 15mg on 04/22/21 and billed the hospice pharmacy which should have lasted through 05/12/21. -The primary pharmacy dispensed a 16-day supply of temazepam 30mg on 05/07/21 and billed the hospice pharmacy and it should have lasted from 5/13/21 through 05/28/21. -The primary pharmacy dispensed a 6-day supply of temazepam 15mg on 05/12/21 and billed the hospice pharmacy and it should have lasted from 5/29/21 through 06/03/21. -The hospice pharmacy dispensed an 8-day supply of temazepam 15mg on 05/27/21 from their emergency backup which is all they could send because they needed a new prescription. It should have lasted from 06/04/21 through	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 15 06/11/21. -There would not have been any temazepam from 06/12/21 through 06/21/21. -The primary pharmacy dispensed a 15-day supply of temazepam 15mg on 06/22/21 and billed the hospice pharmacy and it should have lasted from 06/22/21 through 07/06/21. -There would not have been any temazepam from 07/07/21 through 07/14/21. -The primary pharmacy dispensed a 16-day supply of temazepam 30mg on 07/15/21 and billed the hospice pharmacy and it should have lasted from 07/15/21 through 07/30/21. -There would not have been any temazepam from 07/31/21 through 08/11/21. -The primary pharmacy dispensed a 16-day supply of temazepam 30mg on 08/12/21 and billed the hospice pharmacy and it should have lasted from 08/12/21 through 08/27/21 if they had been administered as ordered. -There were clearly many gaps throughout that would prove Resident #1 was not administered temazepam 30mg every night at bedtime as ordered. Telephone interview with a triage nurse with Resident #1's hospice provider on 09/02/21 at 11:30am revealed: -The facility's contracted pharmacy was responsible for filling Resident #1's temazepam order and billing hospice. -The hospice pharmacy provided backup temazepam so the resident would not miss any of her medication. -Hospice reimbursed the contracted facility pharmacy for all temazepam that had been dispensed. -The resident had been on temazepam for 2 years. -Temazepam was originally ordered as needed	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 16 but was changed to nightly on 03/19/21. Interview with Resident #1's hospice nurse on 09/01/21 at 11:59am revealed: -The resident had complained that she had not been sleeping well and her sleeping pill had not been working. -She instructed the resident that she could also request her Xanax at the same time she took her temazepam to help get some sleep. Interview with Resident #1 on 9/02/21 at 11:12am revealed: -She had not been sleeping well for several months because the sleeping pill quit working. -Not sleeping well caused her not to care about anything. She did not do well participating with any activities because she was so tired and just wanted it to be over. -It made her irritable and short with staff and generally upset with everyone. -She has gotten to the point she just went to eat her meals and came right back to her room to lay down and rest. Telephone interview with the facility contracted provider on 09/02/21 at 11:44am revealed: -He had signed the FL2 and 6-month orders for Resident #1 because he thought she had come off hospice services. -He wrote an order for temazepam 30mg as needed at bedtime on 05/07/21 for Resident #1 because she needed a new prescription and he thought she was on his services. -He thought that when he received requests to sign FL2's and write orders for a resident, the resident had come off hospice. Telephone interview with Resident #1's hospice	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 17 nurse practitioner on 09/02/21 at 2:46pm revealed: -The last couple times she saw the resident, she could tell she was not resting well because she was tired, had increased agitation, and tearfulness. -She last saw the resident on 07/14/21. -She did not know the contracted facility provider wrote a prescription for the resident on 05/07/21 because she was out of refills. -She had not been notified that the resident was out of temazepam refills and needed a new order except on 05/20/21 the hospice nurse informed her that she needed some temazepam. Interview with the Memory Care Unit Coordinator (MCUC) on 09/02/21 at 12:30 revealed: -She had noticed the past few months that Resident #1 had been lying in bed a lot more than she used to. -Resident #1 did not have any scheduled temazepam available for administration -Resident #1 had some temazepam 30mg ordered as needed that she had used to administer as the scheduled dose on 09/01/21. -The MA who changed out cycle fill was supposed to ensure all medications were on the medication cart. -She did not know why Resident #1 did not have any scheduled temazepam available. -She believed the MARs were accurate as she only administered medication if the medication was available. Interview with the Interim Director on 09/02/21 at 12:55 pm revealed: -The MA on duty checked cycle fill to ensure all medications were available as compared to the MAR. -They checked the medication dosage, ensured	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 18 the as needed medications were available, and counted the controlled substances that came with cycle fill to ensure the count was correct to ensure nothing happened during transit. -Medication carts were audited on 08/27/21 for expired medications and to ensure all medications were available and matched orders. -The SCUC completed her own audit on her medication cart. -When a MA did not administer a medication, they were supposed to circle their initials on the MAR and document why it was not administered on the back of the MAR. -She expected all MARs to be accurate. Interview with the Administrator on 09/02/21 at 1:05pm revealed: -The facility's contracted pharmacy nurse audited medication carts on 08/27/21 to ensure medications were available and did not find any problems. -The contracted pharmacy nurse audited the medication cart every 3 months. -She expected MARs to be accurate and for the MAs to document when and why a medication was not administered. 2. Review of Resident #2's current FL2 dated 04/01/21 revealed diagnoses that included dementia, foraminal stenosis, chronic pain disorder, emphysema, chronic obstructive pulmonary disease (COPD), and degenerative disc disease. Review of Resident #2's record revealed there was a verbal physician's order dated 08/10/21 for Septra-DS/trimethoprim (used to treat infection) take one tablet twice daily for seven days. Review of Resident #2's August 2021 medication	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 19 administration record (MAR) revealed: -There was no typed or written entry for Septra-DS/trimethoprim take one tablet twice daily for seven days. -There was no documentation that Septra-DS/trimethoprim was administered in August 2021. Telephone interview with a representative from the facility's contracted pharmacy on 09/01/21 at 4:33pm revealed there was a quantity of 14 Septra-DS/trimethoprim tablets dispensed on 08/10/21. Interview with the Resident Care Coordinator (RCC) on 09/01/21 at 5:20pm revealed: -The facility had a cassette of the Septra-DS/trimethoprim on hand during the week of 08/10/21. -Septra-DS/trimethoprim was administered as ordered during the week of 08/10/21. Interview with the Interim Director (ID) on 09/01/21 at 5:30pm revealed: -She administered the Septra-DS/trimethoprim to Resident #2 during the week of 08/10/21. -She did not know why the medication was not documented on the MAR. -The ID or Administrator-in-Charge verified orders and added or changed them on the MAR. -She expected all MARs to be accurate. Interview with the Administrator on 09/02/21 at 1:05pm revealed: -She did not know Septra-DS/trimethoprim was not on Resident #2's MAR. -She expected MARs to be accurate and for the medication aides to document when and why a medication was not administered.	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 20 3. Review of Resident #3's FL2 dated 01/01/21 revealed: -Diagnoses including dementia with behaviors, cognitive communication deficit and atrial fibrillation. -There was an order for citalopram 20mg 1 tablet once a day used to treat behaviors. Review of Resident #3's 01/01/2021 revealed an order for citalopram 20mg 1 tablet once a day. Review of Resident #3's medication administration record (MAR) for August 2021 and September 2021 revealed an entry for citalopram 20mg 1 tablet once a day documented as given from 08/27/21 through 09/02/21. Observation of Resident #3's medications on hand on 09/02/21 revealed a cartridge containing 8 tablets labeled citalopram 10mg 1 tablet every day dispensed on 08/27/21. Based on observation, record review and interview, it was determined Resident #3 was not interviewable. Telephone interview with a representative from the facility's contracted pharmacy on 09/02/21 at 10:38am revealed: -A verbal order from Resident #3's hospice provider was received from the facility on 08/26/21 to change citalopram 20mg 1 tablet once a day to citalopram 10mg 1 tablet every day. -The pharmacy printed MARs for the facility at the end of the previous month. -Orders received in between printing the facility MARs were added by the facility staff, therefore the pharmacy would not have changed the order on the MAR until the new MAR in September 2021.	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 21 -The order change for Resident #3's citalopram was missed somehow and was not changed on the September 2021 MAR. Interview with a medication aide (MA) on 09/02/21 at 11:45am revealed: -The MAs checked medication cartridges delivered by pharmacy before adding them to the medication cart. -The Interim Director or Administrator were responsible to add new orders or changes to the MAR. -If something was incorrect and the Interim Director and Administrator were unavailable, MAs could call the provider to verify orders. -When MAs received the needed medication order, they then transcribed the order or change onto the MAR. Telephone interview with the hospice provider on 09/02/21 at 12:05pm revealed: -Resident #3 needed to be weaned from the citalopram dose of 20mg once a day. -She spoke to the medication aide (MA) on 08/26/21 to request a verbal order to pharmacy to decrease Resident #3's citalopram from 20mg once a day to 10mg once a day. -The facility's MAs took verbal/telephone orders and faxed them to the pharmacy. Interview with a second medication aide (MA) on 09/02/21 at 12:15pm revealed: -She did not remember taking a verbal order from hospice for Resident #3's citalopram 20mg to change to 10mg. -When MAs received verbal orders, they wrote the orders on the facility's order sheets and gave them to the Interim Director of Administrator to check. -When orders were verified, the Interim Director,	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 22 Administrator or MAs added or changed orders on the MAR. Telephone interview with a third medication aide (MA) on 09/02/21 at 3:42pm revealed: -She performed the checks on medication cartridges during the pharmacy medication exchange on 08/27/21 around 9:30pm. -She noticed Resident #3's citalopram was 10mg instead of 20mg. -She thought she would not have been able to contact the hospice provider that late at night, so she did not attempt to verify the order change. -It was common practice for the MA who took the order would add it to the MAR. -She did not change the MAR because she thought the MA who took the verbal order would change the MAR the next morning. -She was then on leave from work and was not able to follow-up with the MA who took the order. Interview with Interim Director on 09/02/21 at 10:40am revealed: -She did not know that Resident #3's citalopram order changed on 08/26/21. -When hospice staff had a new order or order change, they gave the orders to the Interim Director or the Administrator. -MAs would go through medication refills from pharmacy. -If a medication or a dose did not match the resident, the MAs notified the Interim Director or the Administrator. -The Interim Director or Administrator verified orders and added/changed them on the MAR. Interview with the Administrator on 09/02/21 at 10:50am revealed: -She did not know Resident #3's citalopram order changed on 08/26/21.	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 367	Continued From page 23 -The MA on duty checked medication delivered on medication exchange day on 08/27/21 from the pharmacy. -If MAs saw a dose or frequency was incorrect, they notified the Interim Director or Administrator. -The Interim Director or Administrator verified the order in question and added or changed the MAR to match. -The pharmacy printed MARs for each month, but new orders or changes between printing were added by herself or the Interim Director.	D 367	***** ***** ***** ***** ***** ***** ***** ***** THIS	
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 1 of 5 residents sampled (#1) with orders for a narcotic sleep aid, and anti-anxiety medication. The findings are: Review of Resident #1's current FL2 dated 01/01/21 revealed diagnoses included vascular dementia with behaviors, chronic obstructive	D 392	PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** ***** SEE PAGE 25 FOR RESPONSE	

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D 392	Continued From page 24 pulmonary disease (COPD), trigeminal neuralgia, and hypothyroidism. 1. Review of Resident #1's current FL2 dated 01/01/21 revealed there was an order for temazepam (used to treat sleep disorders) 15mg take 2 capsules every night at bedtime. Observation of Resident #1's medication on hand on 09/01/21 at 4:00pm revealed: -There were no temazepam 15mg capsules available. -There was one cassette of temazepam 30mg with 11 of 16 capsules remaining. -The directions on the temazepam label read to administer 1 capsule at bedtime as needed. Review of the facility's Controlled Substances Count Sheet (CSCS) revealed Resident #1 had 9 capsules of temazepam 30mg left for administration labeled as dispensed on 08/12/21 for a quantity of 16 capsules. Telephone interview with a representative at the facility's contracted pharmacy on 09/01/21 at 3:34pm revealed: -Resident #1 had an order for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pm. -The scheduled temazepam order was last filled on 05/12/21 for a quantity of 12 capsules as Resident #1 was out of refills. -On 05/07/21, the pharmacy had received an order for temazepam 30mg take 1 tablet as needed at bedtime, but the scheduled order remained the same. -Temazepam 30mg take 1 capsule at bedtime as needed was dispensed on 07/15/21 for a quantity of 16 capsules. -Temazepam 30mg take 1 capsule at bedtime as	D 392	The Administrator/Director shall ensure readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. All MARs and control count sheet for every resident were reviewed for accuracy by facility Director on 10-01-21. Training with Medication Aides/Supervisors on 9-17-21 including review of facility medication and controlled substances count policy and procedures. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor control count records periodically to ensure accurate documentation of controlled substance in accordance to rule 10A NCAC 13F .1008(a). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter. Documentation will be kept at the facility for review.	10/6/21

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	HAL029010	A. BUILDING: _____ B. WING _____	R 09/03/2021

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D 392	Continued From page 25 needed was dispensed on 08/12/21 for a quantity of 16 capsules. -The pharmacy sent a CSCS to the facility with each dispensed date for the temazepam. Telephone interview with Resident #1's hospice pharmacist on 09/02/21 at 12:03pm revealed: -The primary pharmacy dispensed a 16-day supply of temazepam 30mg on 07/15/21 and billed the hospice pharmacy and it should have lasted from 07/15/21 through 07/30/21. -There would not have been any temazepam from 07/31/21 through 08/11/21. -The contracted pharmacy dispensed a 16-day supply of temazepam 30mg on 08/12/21 and billed the hospice pharmacy and it should have lasted from 08/12/21 through 08/27/21 if they had been administered nightly. -Resident #1 was not administered her temazepam 30mg every night at bedtime as ordered based on the supply of temazepam dispensed to the resident. Review of Resident #1's medication administration record (MAR) for July 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pm. -There was documentation all doses had been administered from 07/01/21 to 07/31/21. -There was an entry for temazepam 30mg capsule as needed at bedtime and there were no doses documented as administered from 07/01/21 to 07/31/21. Review of the facility's CSCS for Resident #1's temazepam 30mg dispensed on 05/07/21 labeled for one capsule at bedtime as needed compared to the July 2021 MAR revealed:	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 26 -On 07/01/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS. -On 07/02/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS, but there were no initials of the staff signing out the medication (blank). -There was no CSCS sheet available for review for temazepam 30mg at bedtime documented administered on the residents MAR from 07/03/21 to 07/15/21. Review of the facility's CSCS for Resident #1's temazepam 30mg dispensed on 07/15/21 compared to the July 2021 MAR revealed: -Temazepam 30mg was documented as signed out on the CSCS and the MAR daily from 07/16/21 to 07/31/21. -On 07/19/21 at 8:00pm, the medication aide's (MA) signature was not the same as the MA who had documented administration on the MAR. Review of Resident #1's MAR for August 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pm. -There was documentation temazepam was administered at bedtime from 08/01/21 to 08/31/21. -There was an entry for temazepam 30mg capsule as needed at bedtime and there were no doses documented as administered from 08/01/21 to 08/31/21. Review of the facility's CSCS for Resident #1's temazepam compared to the August 2021 MAR revealed: -There was no CSCS available for review for documentation as signed out for temazepam 15mg take 2 capsules at bedtime or temazepam	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 27 30mg at bedtime as needed from 08/01/21 to 08/17/21. -The CSCS for temazepam 30mg labeled for one capsule at bedtime as needed dispensed on 08/12/21 for 16 capsules had documentation for signed out at 8:00pm each night starting on 08/28/21 to 08/31/21. -On 08/29/21 at 8:00pm, temazepam 30mg was documented as signed out on the CSCS, but the documentation for the staff who signed out on the CSCS did not match the staff documenting administration on the MAR. Review of Resident #1's MAR for September 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pm. -There was documentation all doses had been administered from 09/01/21 to 09/02/21. -There was an entry for temazepam 30mg capsule as needed at bedtime and there were no doses documented as administered from 09/01/21 to 09/02/21. Review of the facility's CSCS for Resident #1's temazepam compared to the September 2021 MAR revealed the CSCS for temazepam 30mg labeled for one capsule at bedtime as needed dispensed on 08/12/21 for 16 capsules had documentation as signed out at 8:00pm on 09/01/21 to 09/02/21. Interview with the Memory Care Unit Coordinator (MCUC) on 09/02/21 at 12:30 revealed: -Resident #1 had some temazepam 30mg ordered as needed that she had used to administer as the scheduled dose on 09/01/21 because she was out of the scheduled dose of temazepam 15mg 2 capsules at bedtime.	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 28 -She did not know why Resident #1 did not have any scheduled temazepam available. -She did not know how long she had been out of her scheduled dose of temazepam. Interview with the Administrator on 09/02/21 at 1:05pm revealed the facility had some problems with the hospice nurse practitioner refilling and signing medication orders, so the contracted facility provider wrote an order for Resident #1's temazepam refill. Refer to interview with the Memory Care Unit Coordinator (MCUC) on 09/03/21 at 3:45pm. Refer to interview with the Interim Director on 09/02/21 at 12:55 pm. Refer to interview with the Administrator on 09/02/21 at 1:05pm. Refer to the interview with the Administrator on 09/03/21 at 5:05pm. 2. Review of Resident #1's current FL2 dated 01/01/21 revealed: -There was an order for alprazolam 0.25mg (used to treat anxiety) twice a day. -There was an order for alprazolam 0.25mg every 4 hours as needed. Telephone interview with Resident #1's contract pharmacy's medication technician on 09/03/21 at 11:12pm revealed alprazolam 0.25mg dispensing dates as follows: -Alprazolam 0.25mg was dispensed on 06/04/21 for 28 tablets. -Alprazolam 0.25mg was dispensed on 06/18/21 for 28 tablets. -Alprazolam 0.25mg was dispensed on 07/02/21	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 29 for 28 tablets. -Alprazolam 0.25mg was dispensed on 07/16/21 for 28 tablets. -Alprazolam 0.25mg was dispensed on 07/29/21 for 28 tablets. Telephone interview with Resident #1's hospice pharmacist on 09/03/21 at 3:05pm revealed: -Alprazolam 0.25mg was dispensed on 08/16/21 for 15 tablets. -Alprazolam 0.25mg was dispensed on 08/27/21 for 12 tablets. Review of Resident #1's medication administration record (MAR) for June 2021 revealed: -There was an entry for alprazolam 0.25mg twice daily for anxiety/agitation scheduled for administration at 8:00am and 8:00pm. -There was documentation all doses had been administered from 06/01/21 to 06/30/21. -There was an entry for alprazolam 0.25mg every 4 hours as needed with no documentation for as needed administration. Review of the facility's Controlled Substances Count Sheet (CSCS) for Resident #1's alprazolam 0.25mg compared to the June 2021 MAR and July MAR revealed: -Alprazolam 0.25mg dispensed on 06/04/21 labeled for one tablet twice a day was administered from 06/05/21 to 06/18/21 matching documentation as signed out on the CSCS. -Alprazolam 0.25mg dispensed on 06/18/21 labeled for one tablet twice a day was administered from 06/19/21 to 06/30/21 matching documentation as signed out on the CSCS. except on 07/01/21 at 8:00am when the staff documenting administration on the MAR did not match the staff signing out alprazolam 0.25mg on	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 30 the CSCS; and one 076/01/21 at 8:00pm the CSCS was not documented for the staff signing out the medication. Review of Resident #1's MAR for July 2021 revealed: -There was an entry for alprazolam 0.25mg twice daily for anxiety/agitation scheduled for administration at 8:00am and 8:00pm. -There was documentation all doses had been administered from 07/01/21 to 07/31/21. -There was an entry for alprazolam 0.25mg every 4 hours as needed with no documentation for as needed administration. Review of the facility's CSCS for Resident #1's alprazolam 0.25mg compared to the July 2021 MAR revealed: -For alprazolam 0.25mg dispensed on 06/18/21; On 07/01/21 at 8:00am the staff who signed out alprazolam 0.25mg on the CSCS did not match the staff documenting administration on the MAR; and on 07/01/21 at 8:00pm the CSCS was incomplete for documenting the staff who administered the medication according to the MAR. -Alprazolam 0.25mg dispensed on 07/02/21 labeled for one tablet twice a day was administered from 07/04/21 to 07/15/21 matching documentation as signed out on the CSCS except on 07/11/21 at 8:00am, the CSCS was incomplete for documenting the staff who administered alprazolam compared to the MAR; on 07/12/21 at 8:00am and 8:00pm, the CSCS was incomplete for the staff who administered alprazolam compared to the MAR. -Alprazolam 0.25mg dispensed on 07/16/21 labeled for one tablet twice a day was administered from 07/16/21 to 07/30/21 matching documentation as signed out on the CSCS	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 31 except on 8 opportunities when the staff documented administration on the MAR did not match staff who documented as signed out alprazolam 0.25mg on the CSCS. -On 07/24/21 at 8:00am and 8:00pm, staff who signed out alprazolam 0.25mg on the CSCS did not match staff who documented administration on the MAR. -On 07/26/21 at 8:00am and 8:00pm, staff who signed out alprazolam 0.25mg on the CSCS did not match staff who documented administration on the MAR. -On 07/27/21 at 8:00am and 8:00pm, staff who signed out alprazolam 0.25mg on the CSCS did not match staff who documented administration on the MAR. -On 07/28/21 at 8:00am and 8:00pm, staff who signed out alprazolam 0.25mg on the CSCS did not match staff who documented administration on the MAR. Review of Resident #1's MAR for August 2021 revealed: -There was an entry for alprazolam 0.25mg twice daily for anxiety/agitation scheduled for administration at 8:00am and 8:00pm. -There was documentation all doses had been administered from 08/01/21 to 08/30/21. -There was an entry for alprazolam 0.25mg every 4 hours as needed with no documentation for as needed administration. Review of the facility's CSCS for Resident #1's alprazolam 0.25mg compared to the August 2021 MAR revealed: -For alprazolam 0.25mg dispensed on 07/30/21 for 28 tablets there was one tablet 08/02/21 at 8:00am the staff who signed out alprazolam 0.25mg on the CSCS did not match the staff documenting administration on the MAR.	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 32 -There was a CSCS sheet for alprazolam 0.25mg one tablet twice a day with a start date of 08/13/21 for 14 tablets with 8 of 14 tablets signed out on the CSCS by a staff that did not match the staff who documented administration on the MAR (At 8:00am and 8:00pm on 08/13/21, 08/14/21, 08/15/21 and at 8:00pm on 08/16/21 and 08/17/21. -There was a CSCS sheet for alprazolam 0.25mg one tablet twice a day with a start date of 08/20/21 for 15 tablets with 5 of 15 tablets signed out on the CSCS by a staff that did not match the staff who documented administration on the MAR (at 8:00am and 8:00pm on 08/21/21, 08/22/21, and at 8:00am on 08/24/21. -There was no documentation on a CSCS for alprazolam 0.25mg documented on the MAR for 8:00pm on 08/27/21 and 8:00am on 08/28/21. -There was a CSCS sheet for alprazolam 0.25mg one tablet twice a day with a start date of 08/28/21 for 14 tablets with 4 of 14 tablets signed out on the CSCS by a staff that did not match the staff who documented administration on the MAR (At 8:00pm on 08/29/21, 8:00am and and 8:00pm on 08/29/21, and 8:00pm on 08/31/21). Review of Resident #1's alprazolam 0.25mg available for administration revealed there were 2 tablets available for administration on 09/03/21 at 3:00pm matching the quantity indicated on the current CSCS. Interview with the Memory Care Unit Coordinator (MCUC) on 09/03/21 at 3:45pm revealed: -She could not find a CSCS for alprazolam for the dates of 08/13/21-08/27/21 so she created one on 09/02/21. -She knew the Resident #1's alprazolam had been administered but she wanted to be able to account for them.	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 33 Refer to interview with the Memory Care Unit Coordinator (MCUC) on 09/03/21 at 3:45pm. Refer to interview with the Interim Director on 09/02/21 at 12:55 pm. Refer to interview with the Administrator on 09/02/21 at 1:05pm. Refer to the interview with the Administrator on 09/03/21 at 5:05pm. _____ Interview with the MCUC on 09/03/21 at 3:45pm revealed: -The MA who changed out cycle fill medications was supposed to ensure all medications were on the medication cart. -She tried to complete medication cart audits 2 times per week to ensure medications were available and CSCSs were accurate and signed. -She had not been able to count controlled medications at the end of her shift and there was no one to count with. -She knew she was supposed to count controlled medications each shift to ensure the count was correct and the CSCSs had been properly signed off. -Due to staffing issues she had been administering medications on the assisted living and the MCU. Interview with the Interim Director on 09/02/21 at 12:55 pm revealed: -The MA on duty checked cycle fill medications to ensure all medications were available as compared to the MAR. -They checked the medication dosage, ensured the as needed medications were available, and counted the controlled substances that came with	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 34 cycle fill medications to ensure the count was correct to ensure nothing happened during transit. -She expected MAs to follow up on any missing medications and call the provider for orders as needed. -Medication carts were audited on 08/27/21 for expired medications and to ensure all medications were available and matched orders. -The MCUC completed her own audit on her medication cart. -She did not know documentation on the CSCS had blanks where the MA was supposed to sign the medication out. -She did not know the CSCS did not match the MAR. -She did not know staff were not signing off on the CSCS each time a controlled medication was administered. -She expected the CSCS to be accurate and correspond with the MARs. -She had not audited any CSCSs as she was new in that position. Interview with the Administrator on 09/02/21 at 1:05pm revealed: -The facility's contracted pharmacy nurse audited medication carts on 08/27/21 to ensure medications were available and did not find any problems. -She did not know documentation on the CSCS had blanks where the MA was supposed to sign the medication out. -She did not know the CSCS did not match the MAR. -She did not know staff were not signing off on the CSCS each time a controlled medication was administered. -She expected the CSCS to be accurate and correspond with the MARs.	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	

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D 392	Continued From page 35 Interview with the Administrator on 09/03/21 at 5:05pm revealed: -The staff were trained to sign out controlled medications on the CSCS and document administration on the MAR when administering medications. -She did not know Resident #1's CSCS were not accurate compared to the resident's MAR for administration of controlled medications (temazepam and alprazolam). -The MCUC was responsible to ensure tracking of controlled medications was accurate. -The Administrator occasionally did random audits for the MARS being complete but expected the MCUC or the Interim Director to do more thorough auditing. -The facility had experienced a lot of staff shortages and the MCUC and Interim Director had been filling in the staffing shortages which took away from their time for auditing the CSCS and MARs.	D 392	***** ***** ***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***** *****	