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D 000	Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services completed an annual survey on 01/27/22 and 01/28/22.	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 3 of 4 residents (#4, #5, #6) observed during the medication pass including errors with a medication for seasonal allergies (#4), a diuretic for swelling, a potassium supplement, a medication for urinary retention (#5), and a rapid-acting insulin (#6); and for 1 of 3 residents sampled (#3) for record review including an error with a medication used to lower blood pressure and heart rate. The findings are: 1. The medication error rate was 20% as evidenced by the observation of 5 errors out of 25 opportunities during the 8:00am and 11:00am medication passes on 01/28/22. a. Review of Resident #5's current FL-2 dated 05/05/21 revealed:	D 358		

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D 358	Continued From page 1 -Diagnoses included heart disease, essential hypertension, diabetes mellitus type 2, hyperlipidemia, anemia, muscle weakness, chronic obstructive pulmonary disease, osteoarthritis of the knee, anxiety, difficulty walking, history of repeated falls, and history of fracture of metatarsal bone. -There was an order for Potassium Chloride ER 20mEq 1 tablet every day. (Potassium Chloride ER is an extended released potassium supplement and should not be crushed. Too much of the medication can be released at one time if it is crushed and it can irritate the mouth and throat.) Review of Resident #5's standing house orders dated 12/01/21 revealed an order for all medication may be given by mouth and/or crushed (check do not crush list) and placed in applesauce or pudding unless otherwise noted. Review of Resident #5's January 2022 medication administration record (MAR) revealed: -There was an entry for Potassium Chloride ER 20mEq 1 tablet every day scheduled for 8:00am. Observation of the 8:00am medication pass on 01/28/22 revealed: -The medication aide (MA) crushed Resident #5's oral tablets, including the Potassium Chloride ER 20mEq tablet and administered the crushed medications in pudding at 8:15am. -The Potassium Chloride was extended released and should not be crushed. Review of Resident #5's medications on hand on 01/28/22 at 1:09pm revealed there was a supply of Potassium Chloride ER 20mEq with instructions on the label that read, "Do NOT CHEW or CRUSH before swallowing".	D 358		

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D 358	Continued From page 2 Interview with the MA on 01/28/22 at 1:04pm revealed: -She usually crushed Resident #5's oral tablets, including the Potassium Chloride tablet. -The facility had a Do Not Crush (DNC) medication list in a notebook but she was unsure where the notebook was located. -The MAs were supposed to check the DNC list for medications that should not be crushed. -She had asked Resident #5's hospice nurse about crushing Resident #5's medications (could not recall when). -The hospice nurse told her the resident's medications could be crushed if needed but they did not discuss specific medications. -She did not notice the instructions on the Potassium Chloride label indicating it should not be crushed. Review of the facility's DNC medication list located on the cork board in the medication room revealed Potassium Chloride was included on the list as medication that should not be crushed because it was a time released formulation. Interview with the Resident Care Coordinator (RCC) on 01/28/22 at 2:20pm revealed: -Only certain medications could be crushed. -There was a DNC medication list in a notebook in the medication room. -She expected the MAs to check the DNC list prior to crushing a medication to determine if a medication could be crushed. -If instructions on the medication label indicated a medication should not be crushed, then it should not be crushed. -She was not aware Resident #5's Potassium Chloride ER tablet was being crushed. -The Potassium Chloride ER tablet should not be	D 358		

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crushed.
-The MAs should have notified her so she could contact the primary care provider (PCP) to have the medication changed to a liquid.

Telephone interview with Resident #5's hospice nurse on 01/28/22 at 3:57pm revealed:
-She was not aware Resident #5's medications were being crushed for administration to the resident.
-She did not recall anyone at the facility discussing with her about crushing Resident #5's medications.
-If she had been aware, she would have contacted Resident #5's PCP to change the Potassium Chloride to a liquid formulation.

Telephone interview with Resident #5's PCP on 01/28/22 at 2:47pm revealed:
-Resident #5's Potassium Chloride ER tablet should not be crushed because if crushed it would get into the bloodstream all at once instead of releasing slowly throughout the day.
-The Potassium Chloride could have been changed to a liquid formulation if she had been notified.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

b. Review of Resident #5's current FL-2 dated 05/05/21 revealed an order for Flomax 0.4mg 1 capsule every day. (Flomax may be used to treat urinary retention. According to the manufacturer, Flomax capsules should not be crushed, chewed, or opened and should be swallowed whole. Flomax can cause low blood pressure.)

Review of Resident #5's standing house orders

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dated 12/01/21 revealed an order for all medication may be given by mouth and / or crushed (check do not crush list) and placed in applesauce or pudding unless otherwise noted.

Review of Resident #5's January 2022 medication administration record (MAR) revealed:
-There was an entry for Flomax 0.4mg 1 capsule every day scheduled for 8:00am.
-The resident's blood pressure ranged from 119/73 - 189/92 from 01/01/22 - 01/28/22.

Observation of the 8:00am medication pass on 01/28/22 revealed:
-The medication aide (MA) crushed Resident #5's oral tablets, mixed them in pudding, then opened one Flomax 0.4mg capsule and mixed the contents in the pudding with the other crushed medications.
-The MA administered the crushed medications in pudding, including the Flomax to the resident at 8:15am.

Review of Resident #5's medications on hand on 01/28/22 at 1:10pm revealed there was a supply of Flomax 0.4mg capsules with instructions on the label that read, "Do NOT CHEW or CRUSH. Swallow whole".

Interview with the MA on 01/28/22 at 1:04pm revealed:
-She usually crushed Resident #5's oral tablets and opened the Flomax capsule and mixed the contents in pudding.
-The facility had a Do Not Crush (DNC) medication list in a notebook but she was unsure where the notebook was located.
-The MAs were supposed to check the DNC list for medications that should not be crushed.
-She had asked Resident #5's hospice nurse

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about crushing Resident #5's medications (could not recall when).
-The hospice nurse told her the resident's medications could be crushed if needed but they did not discuss specific medications.
-She did not notice the instructions on the Flomax label indicating it should be swallowed whole.

Review of the facility's DNC medication list located on the cork board in the medication room revealed Flomax was included on the list because it was a modified-release granule.

Interview with the Resident Care Coordinator (RCC) on 01/28/22 at 2:20pm revealed:
-Only certain medications could be crushed.
-There was a DNC medication list in a notebook in the medication room.
-She expected the MAs to check the DNC list prior to crushing a medication or opening a capsule to determine if that could be done.
-If instructions on the medication label indicated a medication should be swallowed whole, then it should be swallowed whole.
-She was not aware Resident #5's Flomax capsule was not being administered whole.
-The MAs should have notified her so she could contact the primary care provider (PCP) for an alternative.

Telephone interview with Resident #5's hospice nurse on 01/28/22 at 3:57pm revealed:
-She was not aware Resident #5's medications were being crushed and/or opened for administration to the resident.
-She did not recall anyone at the facility discussing with her about crushing or opening Resident #5's medications.
-If she had been aware, she would have contacted Resident #5's PCP for an alternative.

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D 358	Continued From page 6 Telephone interview with Resident #5's PCP on 01/28/22 at 2:47pm revealed Resident #5's Flomax capsule should be swallowed whole because when opened all of the medication would get into the bloodstream all at once and could cause the resident to have low blood pressure. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. c. Review of Resident #5's current FL-2 dated 05/05/21 revealed an order for Furosemide 20mg 1 tablet once a day. (Furosemide is a diuretic used to treat swelling and fluid retention.) Observation of the 8:00am medication pass on 01/28/22 revealed: -The medication aide (MA) prepared and administered 7 medications to Resident #5 at 8:15am. -Furosemide was not administered or offered to Resident #5 when she received her other morning medications at 8:15am. Interview with the MA on 01/28/22 at 8:15am revealed Resident #5's Furosemide was not administered because there was none available to administer. Review of Resident #5's January 2022 medication administration record (MAR) revealed: -There was an entry for Furosemide 20mg 1 tablet every day scheduled for 8:00am. -Furosemide was documented as not administered due to being unavailable on 01/28/22 at 8:00am.	D 358		

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A second interview with the MA on 01/28/22 at 1:04pm revealed:
-After the morning medication pass (could not recall specific time), she found Resident #5's Furosemide in the wrong location in the overstock supply in the bottom drawer of the medication cart.
-She notified the Resident Care Coordinator (RCC) the Furosemide was more than one hour overdue to be administered.
-The RCC told her not to administer the Furosemide on 01/28/22 since it was late.
-The RCC was responsible for notifying the primary care provider (PCP).

Observation of Resident #5's medications on hand on 01/28/22 at 1:04pm revealed there was a supply of Furosemide 20mg tablets dispensed on 01/26/22 with 30 of 30 tablets remaining.

Interview with the RCC on 01/28/22 at 2:20pm revealed:
-She expected the MAs to check the overstock medication drawer when they could not locate a medication in the usual supply drawer.
-She was not aware Resident #5's Furosemide was not administered that morning on 01/28/22.
-She was not notified by the MA and she did not instruct the MA not to administer the resident's Furosemide.
-The facility's policy was to contact the resident's provider to determine if a late medication could be administered.
-If aware, she would have contacted Resident #5's hospice provider to see if the Furosemide could have been administered late.

Telephone interview with Resident #5's hospice nurse on 01/28/22 at 3:57pm revealed:
-Prior to the resident receiving Furosemide (could

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not recall date started), the resident had pitting edema (swelling) in her feet and right hand.
-Since the resident started receiving Furosemide, the swelling in her feet and hand had improved.
-The Furosemide should be administered as ordered.
-She was not concerned if the resident missed only 1 dose of the Furosemide.

Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.

d. Review of Resident #6's current FL-2 dated 02/17/21 revealed diagnoses included diabetes mellitus type 2 with hyperglycemia and chronic kidney disease stage 3.

Review of Resident #6's primary care provider (PCP) visit note dated 12/15/21 revealed:
-The PCP noted the resident currently took Novolog insulin 6 units with meals. (Novolog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection.)
-The resident's blood sugar ranges were 88 - 219.
-The list of current medication orders on the visit notes included Novolog insulin 6 units 3 times daily and Novolog insulin as directed 3 times daily immediately before meals.

Review of Resident #6's physician's orders and resident care notes for December 2021 and January 2022 revealed no documentation the PCP was contacted to clarify the Novolog insulin order.

Review of Resident #6's January 2022 medication administration record (MAR) revealed:

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-There was a current entry for Novolog insulin inject 6 units 3 times daily before meals.
-Novolog insulin was scheduled for 7:30am, 11:00am, and 5:00pm.

Interview with the medication aide (MA) on 01/28/22 at 11:05am revealed the lunch meal was usually served around 12:00pm.

Observation of the 11:00am medication pass on 01/28/22 revealed the MA administered 6 units of Novolog insulin into Resident #6's left abdomen at 11:12am.

Interview with Resident #6 on 01/28/22 at 12:09pm revealed:
-She was waiting to receive her lunch meal.
-She had already received her lunchtime insulin.
-She was currently feeling "fine" and had no symptoms of low blood sugar.
-When her blood sugar was low, she usually started sweating and started getting hot.

Observation of Resident #6 on 01/28/22 revealed the resident was served lunch at 12:12pm, 1 hour after being administered Novolog insulin.

Interview with the MA on 01/28/22 at 1:17pm revealed:
-She administered based on the scheduled time on the eMAR.
-Resident #6's Novolog insulin was scheduled for 11:00am and that was when it appeared on the eMAR for administration.
-She tried to administer insulin about 30 minutes prior to the meal and she thought long-acting insulin could be administered 1 hour prior to the meal.
-She did not know when rapid-acting insulin should be administered in accordance with a

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meal.
-Resident #6 had never complained of having low blood sugar to her.

Interview with the Resident Care Coordinator (RCC) on 01/28/22 at 2:20pm revealed:
-Insulin ordered before meals should be administered within 15 minutes of a meal or with a snack.
-Rapid-acting insulin should be administered within 15 minutes of eating food.
-She or the MAs were responsible for clarifying medication orders.
-Resident #6's Novolog insulin order should have been clarified.
-Novolog was rapid-acting insulin and should not have been administered 1 hour before the meal because it could cause the resident's blood sugar to drop too low without receiving food for an hour.

Telephone interview with Resident #6's primary care provider (PCP) on 01/28/22 at 2:47pm revealed:
-She usually ordered Novolog insulin to be administered immediately after a meal to prevent low blood sugar.
-Resident #6's Novolog order may have been listed multiple times due to some hospitalizations.
-She should have been contacted by the facility to clarify the Novolog order.

e. Review of Resident #4's current FL-2 dated 01/12/22 revealed:
-Diagnoses included benign essential hypertension, cerebral infarction, heart disease, malaise, and dementia.
-There was an order for Flonase Nasal Spray 50mcg instill 1 spray into each nostril every day. (Flonase is used to treat allergy symptoms such as runny nose and sneezing.)

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D 358	Continued From page 11 Observation of the 8:00 a.m. medication pass on 01/28/22 revealed Flonase Nasal Spray was not administered or offered to Resident #4 when he received his other morning medications at 8:01am. Review of Resident #4's January 2022 medication administration record (MAR) revealed: -There was an entry for Flonase Nasal Spray 50mcg instill 1 spray into each nostril every day scheduled for 8:00am. -Flonase Nasal Spray was documented as administered from 01/01/22 - 01/28/22 at 8:00am. Interview with Resident #4 on 01/28/22 at 11:54am revealed: -He did not think he been administered any Flonase Nasal Spray that morning on 01/28/22. -He denied any current allergy symptoms. Interview with the medication aide (MA) on 01/28/22 at 1:00pm revealed: -She usually administered the Flonase Nasal Spray to Resident #4 when he received his other morning medications scheduled for 8:00am.. -She forgot to administer the Flonase Nasal Spray that morning on 01/28/22. -The resident had been sneezing a lot lately and he sometimes had a runny nose. Observation of Resident #4's medications on hand on 01/28/22 at 1:01pm revealed: -There was 1 bottle of Flonase Nasal Spray dispensed on 12/28/21 for Resident #4. -The open date documented on the label was 01/18/22. Interview with the Resident Care Coordinator (RCC) on 01/28/22 at 2:20pm revealed:	D 358		

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D 358	Continued From page 12 -MAs were supposed to administer medications as ordered. -Resident #4 should have received the Flonase Nasal Spray that morning on 01/28/22 in his room at the same time he received his other medications scheduled for 8:00am. Telephone interview with Resident #4's primary care provider (PCP) on 01/28/22 at 2:47pm revealed: -Resident #4 was receiving Flonase Nasal Spray for his runny nose. -She expected the Flonase to be administered as ordered. 2. Review of Resident #3's current FL-2 dated 05/05/21 revealed: -Diagnoses included chronic systolic congestive heart failure, essential hypertension, chronic obstructive pulmonary disease, history of dizziness, pleural effusion other condition classified elsewhere, presence of a cardiac pacemaker, nonrheumatic aortic stenosis, ventricular tachycardia, personal history of transient ischemic attack and cerebral infarction without residual effects. -There was a notation in the medication section of the FL-2 to refer to the physician orders dated 05/05/21. -There was an order for Metoprolol ER 25mg daily related to acute systolic congestive heart failure. Hold if the heart rate (HR) was less than 70. (Metoprolol is a medication used to treat congestive heart failure and lowers the blood pressure and heart rate.). -There was an order to check the resident's pulse on Mondays and notify the resident's primary care provider (PCP) if the pulse was 140 or greater or less than 50.	D 358		

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Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol ER 25mg daily, hold if HR less than 70 with a scheduled administration time at 8:00am.
-There was an entry for blood pressures (BPs) daily with the scheduled administration time of Metoprolol ER 25mg at 8:00am.
-There was documentation Metoprolol ER 25mg was administered at 8:00am from 11/01/21 - 11/30/21.
-There was documentation the resident's BP was obtained at 8:00am from 11/01/21 - 11/30/21 when Metoprolol ER 25mg was administered instead of the resident's HR as ordered.
-There was an entry to check the resident's pulse weekly on Mondays and call for a pulse of 140 or greater or less than 50 with a scheduled time at 8:00am.
-The residents pulse was documented as 72 on 11/01/21, 70 on 11/08/21, 72 on 11/15/21, 71 on 11/22/21 and 74 on 11/29/21.
-There was no documentation the resident's HR was checked except weekly on Mondays at 8:00am.

Review of Resident #3's December 2021 eMAR revealed:
-There was an entry for Metoprolol ER 25mg daily, hold if HR less than 70 with a scheduled administration time at 8:00am.
-There was an entry for BPs daily with the scheduled administration time of Metoprolol ER 25mg at 8:00am.
-There was documentation Metoprolol ER 25mg was administered at 8:00am from 12/01/21 - 12/31/21.
-There was documentation the resident's BP was obtained at 8:00am from 12/01/21 - 12/31/21

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when Metoprolol ER 25mg was administered instead of the resident's HR as ordered.
-There was an entry to check the resident's pulse weekly on Mondays and call for a pulse of 140 or greater or less than 50 with a scheduled time at 8:00am.
-The residents pulse was documented as 71 on 12/06/21, 74 on 12/13/21, 71 on 12/20/21 and 74 on 12/27/21.
-There was no documentation the resident's HR was checked except every week on Mondays at 8:00am.

Review of Resident #3's January 2022 eMAR revealed:
-There was an entry for Metoprolol ER 25mg daily, hold if HR less than 70 with a scheduled administration time at 8:00am.
-There was an entry for BPs daily with the scheduled administration time of Metoprolol ER 25mg at 8:00am.
-There was documentation Metoprolol ER 25mg was administered at 8:00am from 01/01/22 - 01/27/22.
-There was documentation the resident's BP was obtained at 8:00am from 01/01/22 - 01/27/22 when Metoprolol ER 25mg was administered instead of the resident's HR as ordered.
-There was an entry to check the resident's pulse weekly on Mondays and call for a pulse of 140 or greater or less than 50 with a scheduled time at 8:00am.
-The residents pulse was documented as 71 on 01/03/22, 76 on 01/10/22, 73 on 01/17/22 and 76 on 01/24/22.
-There was no documentation the resident's HR was checked except every week on Mondays at 8:00am.

Interview with Resident #3 on 01/28/22 at

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12:26pm revealed:
-He had experienced occasional dizziness off and on for years.
-He had not had any chest pain or fainting episodes.
-He had not been told by staff his heart rate had been below 70 that he was aware of.

Telephone interview with a pharmacy technician with the facility's contracted pharmacy provider on 01/28/22 at 11:22am revealed:
-Metoprolol ER was a beta blocker that slowed the heart rate.
-Resident #3 had an order for Metoprolol ER 25mg daily, hold for a HR less than 70 dated 05/05/21.
-The pharmacy entered all received medication orders into the eMAR system for the facility to approve for administration.
-The facility had access to add or change medication orders within the eMAR system.
-She could not confirm who originally added Resident #2's Metoprolol ER 25mg order dated 05/05/21 in the eMAR system.

Interview with a medication aide (MA) on 01/28/22 at 1:03pm revealed:
-Medication parameters were written by the residents' ordering provider.
-It was the responsibility of the facility's contracted pharmacy provider to enter medication orders and parameters associated with the medication orders.
-Once entered, the eMAR would populate any new orders which needed verification under the resident's name in the eMAR.
-It was the responsibility of the Resident Care Coordinator (RCC) to review orders once entered by the facility's contracted pharmacy provider.
-The RCC would check the eMAR throughout the

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day for new orders pending verification.
-The RCC would compare the hard copy order to the order in the eMAR.
-Resident medications were filled in multidose pill packs by the facility's contracted pharmacy.
-On the left inside cover of the multidose pill pack were the medication names, administration orders, and picture of the medications.
-He would compare the resident's medication order listed in the eMAR to the resident's medication administration order on the inside of the multidose pill pack for the correct medication, dosage, and administration time prior to popping the mediation in the pill cup.
-The mediation administration orders did not contain parameter orders.
-The eMAR would include any parameters orders.
-There were no residents who resided in the facility who had HR parameters for a medication.
-A resident's HR would be documented on the eMAR if assessed.
-Resident #3's HR should be documented on the eMAR.
-He had just looked at Resident #3's January 2022 eMAR and the resident's HR was not documented because there was only a place to document the resident's BP.
-He had not thought to tell management there was no where to document Resident #3's HR on the eMAR because the HR displayed on the electronic cuff when assessing the resident's BP.
-He verified his initials were documented as administering Resident #3's Metoprolol ER 25mg on 01/27/22 at 8:00am.
-He could not recall what Resident #3's HR was on 01/27/22 prior to administering Metoprolol ER 25 mg on 01/27/22.
-On 01/27/22 he only documented Resident #3's blood pressure because there was no where to document the HR.

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D 358	Continued From page 17 -He had never noticed the order to hold Resident #3's Metoprolol for a HR less than 70 in the administration orders of the multidose pill pack. -He did not remember what Resident #3's HR was normally. -He was not aware of Resident #3 having a HR obtained below 70. -All MAs should have obtained Resident #3's HR prior to administering Metoprolol ER, however he was not certain because the resident's HR was not documented. Interview with the RCC on 01/28/22 at 1:40pm revealed: -She expected the MA to compare the eMAR to the medication administration instructions before preparing the medications, when popping the medications in the pill cup, and after administering the medications. -She scanned new orders in the electronic system when received and after faxing the orders to the pharmacy. -It was the responsibility of the facility's contracted pharmacy to enter orders on the eMAR to include any ordered parameters, such as holding a medication for a HR less than 70. -She reviewed the eMARs throughout the day for any new orders, even when working from home. -If she clicked on "new orders", anything in red indicated the need to be reviewed. -She compared the scanned orders to the what was entered into the eMAR by the facility's contracted pharmacy. -When parameters were ordered, she clicked "parameter notes" in the eMAR which would assign in the eMAR the vital sign that had ordered parameters or instructions associated with the medication. -The MAs could not document the vital signs for ordered parameters without the "parameter	D 358		

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notes" being added to the eMAR.
-From a drop-down box she chose the appropriate vital sign, such as BP, HR, respiration, or temperature.
-She expected the MAs to tell her if the wrong vital sign box populated on the eMAR as soon as they realized the error to ensure the correct documentation.
-She was not aware Resident #3's BPs were documented with the administration of Metoprolol ER 25mg daily at 8:00am instead of the resident's HR.
-She could not determine if Resident #3's Metoprolol ER 25mg had been administered as ordered from November 2021 - current because the resident's HR was not documented.
-The MAs should have informed her when they were administering Resident #3's Metoprolol and were documenting the resident's BP instead of his HR as ordered.
-Resident #3's HR should have been documented on the eMAR instead of BPs when administering Metoprolol ER 25mg daily.
-She had "overlooked" the entry to document Resident #3's BP readings instead of HR readings when administering Metoprolol ER 25mg daily.
-Resident #3 had a history of vertigo but had not reported dizziness that she was aware of.
-She expected the MAs to administer medications as ordered for the safety of the residents.
-She performed record audits to ensure residents' medications were administered as ordered by comparing the residents' current FL-2, orders and eMARS.
-She was not sure when she last performed a record audit to review medication orders for Resident #3.

Telephone interview with Resident #3's

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D 358	Continued From page 19 cardiologist on 01/28/22 at 4;00pm revealed: -She expected the facility to remain compliant with the resident's medication orders. -The resident's order was not followed when BP readings were documented instead of HR readings when administering Metoprolol ER 25mg daily to the resident. -The resident had a pacemaker that was set to pace the heart at 60 beats per minute however, the goal was for the resident's heart to maintain the pulse rate, not the pacemaker device. -She expected the facility to ensure the resident received Metoprolol 25mg ER daily and hold the medication if the HR was less than 70.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication	D 367		

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D 367	Continued From page 20 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration records (MARs) were accurate for 1 of 3 sampled residents (#2) related to a medication administered to treat high blood pressure not being included and documented on the MAR. The findings are: Review of Resident #2's current FL-2 dated 02/17/21 revealed: -Diagnoses included cerebral vascular accident (CVA), diabetes mellitus (DM) with ketoacidosis with coma, hypertension (HTN), unspecified schizophrenia. -There was an order for Lisinopril 10mg take one tablet every day. (Lisinopril is a medication used to treat high blood pressure). Review of Resident #2's primary care provider (PCP) visit note dated 09/23/21 revealed there was an order to continue Lisinopril 10mg 1 tablet daily. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was not an entry for Lisinopril 10mg 1 tablet daily. -There was no documentation of Lisinopril 10mg 1 tablet daily being administered. Review of Resident #2's December 2021 eMAR for Resident #2 revealed: -There was not an entry for Lisinopril 10mg 1 tablet daily.	D 367		

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D 367	Continued From page 21 -There was no documentation of Lisinopril 10mg 1 tablet daily being administered. Review of Resident #2's January 2022 eMAR for Resident #2 revealed: -There was not an entry for Lisinopril 10mg 1 tablet daily. -There was no documentation of Lisinopril 10mg 1 tablet daily being administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/28/22 at 11:48am revealed the pharmacy's most recent dispensing of Lisinopril 10mg tablets was on 01/12/22 with instructions to administer 1 tablet daily. Observation on 01/27/22 at 9:50am of Resident #2's medications on hand revealed: -Medications were supplied in multi-dose packaging. -Medications to be administered at 8:00am daily were supplied together in an 8:00am dosing package. -Lisinopril 10mg was included in the 8:00am dosing package. Interview with a medication aide (MA) on 01/28/22 at 9:50am revealed: -She was not aware the Lisinopril was not on the eMAR for the months of November 2021, December 2021, and January 2022. -She had administered Resident #2's medications on 01/28/22. -She did not remember if the Lisinopril 10mg was administered or discarded at 8:00am on 01/28/22. -She did not recall if she had ever discarded the Lisinopril 10mg from Resident #2's 8:00am dosing package.	D 367		

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D 367	Continued From page 22 -If a medication had to be discarded, it would be put into the sharp's container. -There was no documentation of any discarded medications for Resident #2. Interview with the Resident Care Coordinator (RCC) on 01/28/22 at 1:40pm revealed she expected the MAs to compare the eMAR to the medication administration instructions before preparing the medications, when popping the medications in the pill cup, and after administering the medications. Telephone interview with Resident #2's PCP on 01/28/22 at 2:47pm revealed: -She last saw Resident #2 on 01/19/22. -She expected medications on physician order list be followed as per the current medications on the sheet.	D 367		