STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ADDISON OF FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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 03/02/22 - 03/03/22.	{D 000}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) including orders for scheduled and sliding scale insulin. The findings are: Review of Resident #3's current FL-2 dated 09/09/21 revealed: -Diagnoses included diabetes mellitus type 2 and dementia without behavioral disturbance. -There was an order for Novolog Mix 70/30 insulin inject 4 units subcutaneously (SQ) before meals. (Novolog Mix 70/30 is a mixture of rapid-acting insulin and intermediate-acting insulin used to control blood sugar.)	D 344		

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D 344	Continued From page 1 Review of Resident #3's physician's order dated 12/02/21 revealed an order for Novolog insulin inject 3 units SQ before meals. (Novolog is rapid-acting insulin used to control blood sugar. Novolog Mix and Novolog are not the same.) Review of Resident #3's physician's order dated 12/09/21 revealed an order for Humalog insulin per sliding scale 3 times a day: 61 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units and recheck if blood sugar is greater than 400. (Humalog is rapid-acting insulin used to control blood sugar. Humalog and Novolog are similar but not the same insulin.) Review of Resident #3's physician's orders dated 01/09/22 revealed: -There was an order to discontinue Humalog. -There was an order to discontinue Novolog. -The order did not specify Novolog sliding scale or scheduled insulin. -There was an order for Novolog Mix 70/30 inject 4 units SQ before meals. Review of Resident #3's primary care provider (PCP) visit note dated 01/27/22 revealed: -Novolog Mix 70/30 insulin inject 4 units SQ before meals was listed as a current medication. -Novolog sliding scale insulin was not listed as a current medication order. Review of Resident #3's physician's order sheet signed and dated 02/10/22 revealed: -There was an order for Novolog Mix 70/30 inject 4 units SQ before meals. -There was an order for Novolog insulin 3 times a day per sliding scale: 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5	D 344		

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units; 351 - 400 = 6 units; call physician if greater than 400.

Review of Resident #3's PCP visit note dated 02/24/22 revealed:
-Novolog Mix 70/30 insulin inject 4 units SQ before meals was listed as a current medication.
-Novolog insulin as directed SQ 3 times per day was listed in the current order section.
-Novolog sliding scale insulin was not listed as a current medication order.

Review of Resident #3's physician's orders revealed no documentation the orders for Novolog insulin had been clarified.

Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog insulin inject 3 units 3 times a day before meals scheduled for 7:30am, 11:30am, and 4:30pm.
-Novolog insulin 3 units before meals was documented as administered from 01/01/22 - 01/10/22 at 4:30pm then it was documented as discontinued on 01/10/22.
-There was an entry for Novolog Mix 70/30 insulin inject 4 units SQ before meals scheduled for 7:30am, 11:30am, and 4:30pm.
-Novolog Mix 70/30 insulin was documented as administered 3 times a day before meals from 01/11/22 - 01/31/22.
-There was an entry for Novolog insulin per sliding scale 3 times per day: 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; and call physician if over 400.
-Novolog sliding scale insulin was scheduled for 8:00am, 12:00pm, and 5:00pm from 01/01/22 - 01/10/22.

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-There was another entry for Novolog insulin per sliding scale 3 times per day: 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; and call physician if over 400.
-Novolog sliding scale insulin was scheduled for 6:00am, 11:00am, and 4:00pm from 01/10/22 - 01/31/22.
-The resident's blood sugar ranged from 63 - 284 from 01/01/22 - 01/31/22.

Review of Resident #3's February 2022 eMAR revealed:
-There was an entry for Novolog Mix 70/30 insulin inject 4 units SQ before meals scheduled for 7:30am, 11:30am, and 4:30pm.
-Novolog Mix 70/30 insulin was documented as administered 3 times a day before meals from 02/01/22 - 02/28/22.
-There was an entry for Novolog insulin per sliding scale 3 times per day: 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; and call physician if over 400.
-Novolog sliding scale insulin was scheduled for 6:00am, 11:00am, and 4:00pm from 02/01/22 - 02/28/22.
-The resident's blood sugar ranged from 44 - 351 from 02/01/22 - 02/28/22.

Review of Resident #3's March 2022 eMAR revealed:
-There was an entry for Novolog Mix 70/30 insulin inject 4 units SQ before meals scheduled for 7:30am, 11:30am, and 4:30pm.
-Novolog Mix 70/30 insulin was documented as administered from 03/01/22 - 03/02/22.
-There was an entry for Novolog insulin per sliding scale 3 times per day: 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350

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= 5 units; 351 - 400 = 6 units; and call physician if over 400.
-Novolog sliding scale insulin was scheduled for 8:00am, 12:00pm, and 5:00pm was documented as administered on 2 occasions from 03/01/22 - 03/02/22.
-The resident's blood sugar ranged from 49- 247 from 03/01/22 - 03/02/22.

Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed:
-The pharmacy got a verbal order on 12/10/21 to change Humalog sliding scale insulin to Novolog sliding scale insulin because the resident's insurance would not pay for Humalog.
-The order dated 01/09/22 to discontinue Novolog should have been clarified because it did not specify Novolog sliding scale insulin or Novolog scheduled insulin.

Interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm revealed:
-He or the Resident Care Coordinator (RCC) were responsible for clarifying medication orders.
-He was not aware the pharmacy had received a verbal order for Resident #3's Humalog insulin to be changed to Novolog insulin.
-He had not noticed the order dated 01/09/22 to discontinue Novolog insulin did not specify if it was the scheduled or sliding scale Novolog or if both should have discontinued.
-He was not sure if the resident should still be receiving Novolog sliding scale insulin.
-He would contact the provider for clarification.

Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable.

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D 344	Continued From page 5 Attempted telephone interview with Resident #3's PCP on 03/03/22 at 4:45pm was unsuccessful.	D 344		
{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 and in accordance with the facility's policies for 3 of 5 residents (#6, #7, #8) observed during the medication passes including errors with medications used to treat low thyroid hormone production (#6), to prevent unwanted blood clots (#1), and to lower blood sugar (#7); and for 1 of 5 residents sampled (#3) for record review including errors with medications for diabetes, seasonal allergies, sleep, high blood pressure, and vitamin supplements. The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am and 12:00pm medication passes on 03/03/22. a. Review of Resident #6's current FL-2 dated	{D 358}		

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{D 358}	Continued From page 6 05/13/21 revealed diagnoses included dementia, hypertension, muscle weakness, and hyperlipidemia. Review of Resident #6's primary care provider (PCP) order dated 05/14/21 revealed an order for Levothyroxine 25mcg, 1 tablet in the morning on an empty stomach, once a day at 6:00am for hypothyroidism. (Levothyroxine is used to treat hypothyroidism and is taken on an empty stomach for optimal absorption in the small intestines.) Observation of the 8:00am medication pass on 03/03/22 revealed: -The medication aide (MA) located Resident #6 in the dining room as breakfast concluded. -Resident #6 was administered her morning medications, including Levothyroxine, at 8:21am. -The resident had finished eating her breakfast. -Levothyroxine was not administered at 6:00am on an empty stomach as ordered. Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 25mcg, 1 tablet by mouth every morning on an empty stomach at 6:00am. -Levothyroxine was scheduled for administration at 8:00am. Observation of Resident #6's medications on hand on 03/03/22 at 1:47pm revealed there was a supply of Levothyroxine filled on 02/18/22 with instructions on the label to take 1 tablet by mouth every morning on an empty stomach at 6:00am. Interview with the MA on 03/03/22 at 1:47pm revealed:	{D 358}		

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{D 358}	Continued From page 7 -She did not notice the medication label or eMAR had instructions to administer the resident's Levothyroxine on an empty stomach and at 6:00am until now. -The resident's Levothyroxine was scheduled for 8:00am, 1 hour after breakfast which was served at 7:00am. -Levothyroxine was usually administered on an empty stomach because it had to have time to absorb. -The MAs faxed orders for medications to the pharmacy. -The Health and Wellness Director (HWD) or the Resident Care Coordinator (RCC) reviewed and compared the medication label, eMARs, and orders for discrepancies. -The MAs were expected to notify the HWD or RCC when the eMAR or medication label instructions were not correct or did not match orders. -She had not notified the HWD or RCC of the error with the schedule administration time on the eMAR. Interview with the HWD on 03/03/22 at 2:15pm revealed: -Medications ordered to be given on an empty stomach should be given before breakfast. -The pharmacy entered the instructions and scheduled times for the Resident #6's Levothyroxine into the eMAR system. -The HWD and RCC verified orders and instructions on the eMAR were the same. -The MAs were expected to notify the HWD or RCC when errors were found on the eMAR or medication label. Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:57pm revealed:	{D 358}		

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-The pharmacy entered orders faxed from the facility or the residents' provider's office into the eMAR system.
-The facility reviewed and approved the orders and instructions in the eMAR system prior to the orders becoming active on the eMAR.
-The facility also had access to the eMAR system and could enter and modify orders in the eMAR system.

Attempted telephone interview with Resident #6's PCP on 03/03/22 at 4:45pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable.

b. Review of Resident #1's current FL-2 dated 02/28/22 revealed:
-Diagnoses included chronic kidney disease, hypertension, diabetes, seizures, muscle weakness, cerebellar ataxia, and myasthenia gravis.
-There was an order for Clopidogrel 75mg 1 tablet every day. (Clopidogrel is an antiplatelet that prevents blood clots which cause heart attacks and strokes.)

Review of Resident #1's March 2022 electronic medications administration record (eMAR) revealed:
-There was an entry for Clopidogrel 75mg 1 tablet every day.
-Clopidogrel was scheduled to be administered at 8:00am.

Observation of the 8:00am medication pass on 03/03/22 revealed:
-The medication aide (MA) prepared Resident #1's morning medications for administration by

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separating the medication bubble cards into 3 stacks, small tablets, large tablets and extra-large tablets.
-There were 8 medication cards in the stack for small tablets.
-There were 5 medications cards in the stack for large tablets.
-There was 1 medication card in the stack for extra-large tablets.
-The MA punched medications from each of the 3 stacks into 3 different paper souffle medication cups.
-The cup with small tablets contained 7 tablets instead of 8 tablets.
-The cup with large tablets contained 5 tablets.
-The cup with the extra-large tablet had 1 tablet the MA split in half.
-The MA administered 13 tablets to Resident #1 at 8:38am.

A second review of Resident #1's March 2022 eMAR revealed 14 different oral medications were documented as administered to the resident on 03/03/22 at 8:00am.

Observation of Resident#1's 8:00am medication bubble cards on 03/03/22 at 11:54am revealed a Clopidogrel 75mg tablet was stuck to the back of the medication card.

Interview with the MA on 03/03/22 at 11:54am revealed:
-She separated Resident #1's oral medications into small, large and an extra-large tablet split in half at the request of the resident.
-She did not notice the Clopidogrel tablet on the back of the medication card before she administered the morning medications to the resident.
-Tablets getting stuck to the back of the mediation

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card had happened before and she forgot to check the back of the card that morning.
-The MAs were supposed to notify the Health and Wellness Director (HWD) of missed doses of medications.
-The HWD was supposed to notify the resident's primary care provider (PCP).

Interview with the HWD on 03/03/22 at 2:15pm revealed:
-The MAs should make sure pills were not stuck on the back of mediation cards when administering medications.
-The MAs were expected to notify the HWD or Resident Care Coordinator (RCC) of missed doses of scheduled medications.
-He instructed the MA to document a medication administration error in Resident #1's eMAR for Clopidogrel scheduled at 8:00am on 03/03/22.
-He had not notified the resident's PCP of the missed dose of Clopidogrel.

Telephone interview with Resident#1's PCP on 03/03/22 at 4:37pm revealed:
-Resident #1 was prescribed Clopidogrel to prevent blood clots.
-Multiple missed doses of Clopidogrel increased the resident's risk of developing blood clots, but one dose was not a concern.
-The facility was expected to notify her when residents missed doses of ordered medications.
-She was not aware of Resident #1's missed dose of Clopidogrel on 03/03/22.

c. Review of Resident #7's current FL-2 dated 10/28/21 revealed:
-Diagnoses included diabetes mellitus type 2, cerebral infarction, and hypertension.
-There was an order for Glimepiride 2mg 1 tablet twice a day. (Glimepiride is used to treat high

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blood sugar levels caused by type 2 diabetes. The manufacturer recommends Glimepiride be taken with the first big meal of the day because taking on an empty stomach can result in hypoglycemia.)

Review of Resident #7's primary care provider (PCP) orders dated 11/21/21 revealed an order for Glimepiride 2mg 1 tablet one time each day with lunch.

Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Glimepiride 2mg 1 tablet daily with lunch.
-Glimepiride was scheduled to be administered at 12:00pm.
-Blood sugar checks were scheduled daily at 8:00am, 12:00pm, 5:00pm and 8:00pm.

Interview with the medication aide (MA) on 03/03/22 at 11:00am revealed:
-She checked Resident #7's blood sugar for lunch time at 11:00am on most days.
-Lunch was typically served around 12:00pm daily.

Observation of the 12:00pm medication pass on 03/03/22 revealed:
-Resident #7's blood sugar was 146 and she did not require insulin.
-The MA administered Glimepiride 2mg to Resident #7 at 11:06am.
-Glimepiride was not administered with lunch as ordered.

Observation of Resident #7's medication on hand on 03/03/22 at 1:39pm revealed there was a supply of tablets with instructions to take 1 tablet

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{D 358}	Continued From page 12 daily with lunch. Interview with Resident #7 on 03/03/22 at 11:06am revealed she did not eat breakfast that day because it was served too early and she was not awake. Observation on 03/03/22 revealed Resident #7 was served lunch at 12:16pm, 1 hour and 10 minutes after Glimepiride was administered. A second interview with Resident #7 on 03/03/22 at 1:00pm revealed: -She had her blood sugar checked between 11:00am to 12:00pm on most days. -The MAs administered her Glimepiride when they checked her blood sugar, prior to eating. A second interview with the MA on 03/03/22 at 1:39pm revealed: -She started checking ordered mealtime blood sugars at 11:00am daily. -Medications ordered to administer with a meal could be given 30 minutes before or 30 minutes after the resident began their meal. -She administered Resident #7's Glimepiride and blood sugar check scheduled for 12:00pm at 11:06am because they popped up on the eMAR at 11:00am. Interview with the Health and Wellness Director (HWD) on 03/03/22 at 2:15pm revealed the facility's policy was for medications ordered to be given with a meal to be administered right before the resident ate and no more than 30 minutes after the meal. Telephone interview with Resident #7's PCP on 03/03/22 at 4:37pm revealed: -Glimepiride was ordered for Resident #7 to help	{D 358}		

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	HAL026068	A. BUILDING: _____ B. WING _____	R 03/03/2022

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{D 358}	Continued From page 13 control her high blood associated with type 2 diabetes. -The resident's Glimepiride was ordered to be administered with her lunch to prevent hypoglycemia. -The facility was expected to follow the instructions provided in the order or pharmacy recommendation. 2. Review of Resident #3's current FL-2 dated 09/09/21 revealed diagnoses included diabetes mellitus type 2, primary essential hypertension, hyperlipidemia, allergic rhinitis, generalized muscle weakness, adjustment insomnia, dementia without behavioral disturbance, cognitive communication deficit, restlessness, and agitation. a. Review of Resident #3's current FL-2 dated 09/09/21 revealed an order for Metformin 1,000mg 1 tablet twice daily. (Metformin is used to control blood sugar.) Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 1,000mg 1 tablet twice daily scheduled at 8:00am and 5:00pm. -Metformin was documented as not administered on 01/31/22 at 5:00pm due to being on order. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Metformin 1,000mg 1 tablet twice daily scheduled at 8:00am and 5:00pm. -Metformin was documented as not administered from 02/01/22 - 02/03/22 due to being on reorder and not on the cart.	{D 358}		

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{D 358}	Continued From page 14 Review of a refill request fax form dated 02/02/22 revealed there was a request to reorder Resident #3's Metformin. Review of a refill request fax form dated 02/10/22 revealed there was a request to reorder Resident #3's Metformin. Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed: -The facility just started transitioning to monthly cycle fills for routine scheduled medications. -The pharmacy dispensed a 30-day supply of Metformin on 12/13/21 and that left no refills. -The pharmacy usually notified the facility and the provider when a medication was out of refills. -The facility was also supposed to notify the provider when a medication was out of refills. -Metformin was not dispensed again until a 14-day supply was dispensed on 02/02/22 and then a 30-day supply. Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm. Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm. b. Review of Resident #3's current FL-2 dated 09/09/21 revealed an order for Vitamin D3 50mcg 1 capsule twice daily. (Vitamin D3 is used to treat low Vitamin D levels.) Review of Resident #3's physician order dated 01/17/22 revealed an order for Vitamin D3 50mcg 1 capsule once a day. Review of Resident #3's January 2022 electronic	{D 358}		

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{D 358}	Continued From page 15	{D 358}		

medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 50mcg 1 capsule twice daily scheduled at 8:00am and 8:00pm from 01/01/22 - 01/18/22.
-Vitamin D3 was documented as not administered at 8:00am on 01/15/22 - 01/18/22 due to being on order and not on the cart.

Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed:
-The facility just started transitioning to monthly cycle fills for routine scheduled medications.
-The pharmacy dispensed a 30-day supply of Vitamin D3 on 12/13/21, 01/17/22, and 02/11/22.

Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm.

Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm.

c. Review of Resident #3's current FL-2 dated 09/09/21 revealed an order for Loratadine 10mg 1 tablet once daily. (Loratadine is used to treat and prevent symptoms of seasonal allergies.)

Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Loratadine 10mg 1 tablet once daily scheduled at 8:00am.
-Loratadine was documented as not administered at 8:00am from 01/23/22 - 01/26/22 due to being unavailable.

Review of a refill request fax form dated 01/24/22 revealed there was a request to reorder Resident #3's Loratadine.

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{D 358}	Continued From page 16 Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed: -The facility just started transitioning to monthly cycle fills for routine scheduled medications. -The pharmacy dispensed a 30-day supply of Loratadine on 12/20/21; a 23-day supply on 01/25/22; and a 30 day supply on 02/14/22. Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm. Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm. d. Review of Resident #3's current FL-2 dated 09/09/21 revealed an order for Adult Multivitamin 1 tablet once daily. (Adult Multivitamin is a vitamin supplement.) Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Adult Multivitamin 1 tablet once daily scheduled for 8:00am. -Adult Multivitamin was documented as not administered at 8:00am from 01/03/22 - 01/06/22 due to being on order and not on the cart. Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm. Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm. e. Review of Resident #3's current FL-2 dated 09/09/21 revealed an order for Carvedilol 12.5mg 1 tablet twice daily. (Carvedilol is used to lower blood pressure.)	{D 358}		

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{D 358}	Continued From page 17 Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Carvedilol 12.5mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -Carvedilol was documented as not administered on 01/04/22 at 8:00am due to being on order. Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed: -The facility just started transitioning to monthly cycle fills for routine scheduled medications. -The pharmacy dispensed a 30-day supply of Carvedilol on 12/07/21, 01/05/22, 02/02/22, and 02/12/22. Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm. Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm. f. Review of Resident #3's current FL-2 dated 09/09/21 revealed an for Melatonin 3mg 1 tablet at bedtime. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Melatonin 3mg 1 tablet at bedtime scheduled at 8:00pm. -Melatonin was documented as not administered from 02/26/22 - 02/28/22 due to being on order. Review of a refill request fax form dated 02/02/22 revealed there was a request to reorder Resident #3's Melatonin.	{D 358}		

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{D 358}	Continued From page 18 Review of a refill request fax form dated 02/28/22 revealed there was a request to reorder Resident #3's Melatonin. Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed: -The facility just started transitioning to monthly cycle fills for routine scheduled medications. -The pharmacy dispensed a 30-day supply of Melatonin on 01/10/22; a 14-day supply on 02/02/22; a 30-day supply on 02/11/22, and a 20-day supply on 02/28/22. Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm. Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm. g. Review of Resident #3's current FL-2 dated 09/09/21 revealed an order for Amlodipine 2.5mg 1 tablet once daily. (Amlodipine lowers blood pressure.) Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Amlodipine 2.5mg 1 tablet once daily scheduled at 8:00am -Amlodipine was documented as not administered on 02/20/22 at 8:00am due to not being on the cart. Review of a refill request fax form dated 02/10/22 revealed there was a request to reorder Resident #3's Amlodipine. Review of a refill request fax form dated 02/15/22	{D 358}		

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{D 358}	Continued From page 19 revealed there was a request to reorder Resident #3's Amlodipine. Review of a refill request fax form dated 02/20/22 revealed there was a request to reorder Resident #3's Amlodipine. Telephone interview with the Operations Manager at the facility's contracted pharmacy on 03/03/22 at 3:54pm revealed: -The facility just started transitioning to monthly cycle fills for routine scheduled medications. -The pharmacy dispensed a 30-day supply of Amlodipine on 12/07/21 and 01/04/22; a 7-day supply on 02/10/22; a 2-day supply on 02/15/22; and a 30 day supply on 02/16/22. Refer to interview with a medication aide (MA) on 03/03/22 at 1:54pm. Refer to interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm. _____ Interview with a medication aide (MA) on 03/03/22 at 1:54pm revealed: -She did not recall Resident #3 running out of any medications. -The MAs usually reordered medications when they reached the supply in the colored strip on the medication cards Interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:35pm revealed: -The MAs were responsible for ordering medications when there was a 5-day supply remaining. -The MAs were supposed to pull the stickers from the medication labels, put the stickers on a reorder sheet, and fax it to the pharmacy. -The facility just started a new system with	{D 358}		

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{D 358}	Continued From page 20 monthly cycle fills on 02/18/22 to try to help prevent medications from running out and being unavailable. -Some of the issue with medications not being on the cart were due to the MAs putting the medication cards in the wrong designated area on the medication cart. -The MAs were supposed to check the entire medication cart if a medication card was not in the designated area to make sure it had not been misplaced. -The MAs were responsible for checking medications to see if anything needed to be reordered daily.	{D 358}		