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LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 03/24/22 and 03/25/22.	{D 000}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 2 of 2 sampled residents who had orders for thromboembolic deterrent (TED) hose (#3 and #4). The findings are: 1. Review of Resident #3's current FL2 dated 10/27/21 revealed: -Diagnoses included hypertension. -There was an order for tubular support stockings (provides tissue support and light compression in the treatment of edema) apply every morning and remove at bedtime. Review of Resident #3's physician orders revealed: -There was an order signed and dated on 03/02/22 by the Primary Care Provider (PCP) to discontinue tubular support stockings. -There was an order signed and dated on 03/09/22 for knee high TED hose apply before	D 276		

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getting Resident #3 out of bed in the morning and remove after back in bed in the evening.

Observation of Resident #3 on 03/24/22 at 10:33am revealed:
-Resident #3 was sitting in a recliner chair with her eyes closed.
-There was a pair of tubular support stockings folded up and tucked inside Resident #3's shoes setting on the floor next to the recliner chair.
-Resident #3 was not wearing tubular support stockings or TED hose on her lower extremities.

Interview with a medication aide (MA) on 03/25/22 at 8:40am revealed:
-Resident #3's TED hose were too tight so she returned the TED hose to the facility's contracted pharmacy and continued to apply the tubular support stockings to Resident #3.
-The tubular support stockings were supplied by the facility's contracted physical therapist (PT).
-She did not call the PCP to get an order to discontinue Resident #3's TED hose because she just used the tubular support stockings instead.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/25/22 at 9:20am revealed:
-There was a note in the system sent from a MA at the facility that Resident #3 would no longer receive medications or medical supplies from the pharmacy because they would be dispensed by a different pharmacy dated 12/30/21.
-The last order in the pharmacy's system for Resident #3 was for tubular support stockings dated 06/20/21.

Interview with a PT on 03/25/22 at 9:37am revealed:
-He did not know Resident #3 had an order for

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TED hose.
-The facility's contracted PT company did not supply TED hose to residents.
-The facility was responsible for obtaining the TED hose.
-He measured Resident #3's legs and cut a "bunch" of the tubular support stockings when the tubular support stockings were ordered in October 2021 and gave them to the facility staff to keep on hand for when Resident #3 needed a clean pair.

Interview with a MA on 03/25/22 at 9:56am revealed:
-She faxed Resident #3's new order for TED hose on 03/09/22 to Resident #3's preferred pharmacy but did not save the confirmation the pharmacy had received the fax.
-She "normally" saved confirmations of the faxed orders and attached them to the resident's orders.
-She did not follow up why the TED hose for Resident #3 were not delivered to the facility.
-She or one of the other MA's were responsible to follow up with faxed orders to the pharmacy to make sure the orders were completed.

Telephone interview with a representative from Resident #3's preferred local pharmacy on 03/25/22 at 10:06am revealed:
-There was no documentation in the computer system of an order for TED hose for Resident #3.
-The order for Resident #3's TED hose could not have been dispensed by the pharmacy because the pharmacy did not provide medical supplies, only medications.

Telephone interview with Resident #3's PCP on 03/25/22 at 11:15am revealed:
-He ordered TED hose for Resident #3 on

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03/09/22 because Resident #3 had edema in her lower extremities.
-Resident #3 should wear the TED hose to reduce edema in her lower extremities and reducing edema was a precursor to prevent ordering a new diuretic medication (used to get rid of excess fluid in the body) for Resident #3.
-He expected the facility to follow orders and place TED hose on Resident #3.

Refer to interview with the Health and Wellness Director on 03/25/22 at 10:40am.

Refer to interview with the Administrator on 03/25/22 at 3:51pm.

2. Review of Resident #4's current FL2 dated 09/15/21 revealed diagnoses included dementia and type 2 diabetes.

Review of Resident #4's record revealed an order dated 03/02/22 for knee high TED hose to be applied before getting Resident #4 out of bed in the morning and to remove them when back in bed in the evening.

Observation of Resident #4 on 03/24/22 at 11:55am revealed Resident #4 was walking barefoot down the hall.

Observation of Resident #4 on 03/25/22 at 10:37am revealed Resident #4 was not wearing TED hose.

Interview with a Medication Aide (MA) on 03/24/22 at 2:47pm revealed:
-Resident #4 did not have a pair of TED hose.
-Another MA called the pharmacy a couple days ago to inquire about them.

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-Resident #4 refused to wear shoes and socks and she did not think staff would be able to get the TED hose on him.

Interview with another MA on 03/24/22 at 3:11pm revealed:
-She ordered a pair of extra large TED hose from the pharmacy for Resident #4 after the order was written on 03/02/22.
-The pharmacy informed them that they needed measurements of Resident #4's legs before they could send TED hose and that they would send over a form that needed to be completed.
-The form from pharmacy was received on 03/22/22.
-A physical therapist from home health was asked to obtain the measurements but needed an order.
-Resident #4's Primary Care Provider (PCP) was not available the week of 03/25/22 to write the home health order so she was going to get the order next week when he returned.
-Resident #4 did not like to wear shoes or socks and at times could be combative so she did not think he would wear the TED hose.

Telephone interview with a pharmacy technician from Resident #4's pharmacy on 03/24/22 at 3:22pm revealed:
-The form with instructions about obtaining leg measurements for TED hose was faxed to the facility on 03/07/22.
-The form was never returned so they faxed it again on 03/17/22 with no response.

Interview with the Health and Wellness Director on 03/24/22 at 4:33pm revealed:
-She did not know anything about a TED hose order for Resident #4.
-The MA's should have asked her to obtain the measurements.

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-She did not know why the MA's thought home health had to obtain the measurements.
-Resident #4's PCP was out of town but he was available by phone so even if she could not obtain the measurements the MA's could have reached him for the order.

Interview with the facility's home health physical therapist on 03/25/22 at 9:35am revealed:
-He did not know anything about an order for TED hose for Resident #4.
-He did not remember being asked to obtain measurements.

Interview with a 3rd MA on 03/25/22 at 10:02am revealed:
-She never received a fax on 03/07/22 from the pharmacy requesting information about leg measurements.
-She received the fax that was sent on 03/17/22.
-On 03/22/22 she asked the physical therapist from home health to obtain the measurements but he informed her he needed an order from Resident #4's PCP.
-She contacted the PCP but he was not able to talk and said he would get back with her but he had not.
-The last time she needed leg measurements on a resident was prior to the Health and Wellness Directors employement.
-She did not know the Health and Wellness Director was able to obtain the leg measurements.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 03/25/22 at 11:15am revealed:
-He ordered TED hose for Resident #4 on 03/02/22 because Resident #4 had transient edema in his lower extremities because he

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preferred to walk around barefoot.
-Resident #4 should wear the TED hose to reduce edema in his lower extremities.
-He expected the facility to follow orders and place TED hose on Resident #4.
-Use of TED hose for Resident #4 was for comfort but he may need a new diuretic medication (used to get rid of excess fluid in the body) if his edema was not reduced.

Interview with the Administrator on 03/25/22 at 1:55pm revealed:
-Someone mentioned the TED hose order to her but she did not remember when or who mentioned it.
-She did not know they had not been ordered and he was not wearing them.

Refer to interview with the Health and Wellness Director on 03/25/22 at 10:40am.

Refer to interview with the Administrator on 03/25/22 at 3:51pm.

_____

Interview with the Health and Wellness Director on 03/25/22 at 10:40am revealed:
-The MAs were responsible for faxing new orders to the resident's pharmacies and "most of the time" attached the fax confirmation to the order.
-Some fax confirmations were left on the fax machine and discarded later in the shredder.
-The MAs were responsible to follow-up on new orders to make sure the orders were completed.
-Herself or the Resident Care Coordinator (RCC) were responsible for chart audits to make sure orders were completed but they had not finished auditing the resident's charts.

Interview with the Administrator on 03/25/22 at 3:51pm revealed:

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D 276	Continued From page 7 -The MAs were responsible for faxing new orders to the resident's pharmacy. -The MAs were responsible for communicating new orders such as TED hose to the Health and Wellness Director during the morning staff meeting. -The MAs were not always in the morning staff meeting but they still should have communicated the order to the RCC or the Health and Wellness Director. -The MAs were responsible to notify the PCP of orders not being followed to get new orders or discontinue orders. -The RCC and the Health and Wellness Director were responsible for auditing charts to make sure orders were completed.	D 276		
{D 296}	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to have a therapeutic diet menu for 2 of 2 sampled residents with an order for a diabetic diet (Resident #5) and a low concentrated sweets diet (Resident #4). The findings are: Observation of the kitchen during the initial tour	{D 296}		

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{D 296}	Continued From page 8 on 03/24/22 at 9:39am revealed: -There was a menu book on the counter that contained a menu for a regular diet. -There was a book that documented resident diet orders. -There was no therapeutic diet menu available. 1. Review of Resident #5's current FL2 dated 06/10/21 revealed: -Diagnoses included dementia and insulin dependant diabetes. -There was an order for a diabetic diet. Review of the facility's diet order book revealed Resident #5 was documented as receiving a diabetic diet. Refer to interview with the Dietary Manager on 03/24/22 at 9:39am and 4:11pm. Refer to interview with a dietary staff on 03/24/22 at 12:25pm. Refer to interview with the Administrator on 03/25/22 at 1:55pm. 2. Review of Resident #4's current FL2 dated 09/15/21 revealed diagnoses included dementia and type 2 diabetes. Review of Resident #4's record revealed an order dated 10/02/20 for a low concentrated sweets diet. Review of the facility's diet order book revealed Resident #4 was documented in the book as receiving a low concentrated sweets diet. Refer to interview with the Dietary Manager on 03/24/22 at 9:39am and 4:11pm.	{D 296}		

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{D 296}	Continued From page 9 Refer to interview with a dietary staff on 03/24/22 at 12:25pm. Refer to interview with the Administrator on 03/25/22 at 1:55pm. _____ Interview with the Dietary Manager on 03/24/22 at 9:39am and 4:11pm revealed: -He was hired as the Dietary Manager on 01/03/22. -All residents were served from the same menu. -He did not have a menu spreadsheet to indicate what food should be served to a resident with diabetes. -He was a trained chef and knew how to prepare meals for people with diabetes. -He did not know he needed a menu spreadsheet for each therapeutic diet ordered at the facility. -He was trained on the facility's food service system when he started but he did not remember anything in the program about therapeutic menus. Interview with a cook on 03/24/22 at 12:25pm revealed she used the same menu for all residents with the exception of a smaller portion of dessert for residents with diabetes. Interview with the Administrator on 03/25/22 at 1:55pm revealed: -The Dietary Manager was a trained chef and knew how to adapt the menu to meet therapeutic diet requirements. -She thought there was a matching therapeutic menu for each ordered diet at the facility. -The new Dietary Manager completed training on the facility's food service system when he first started. -There was information on therapeutic menus in	{D 296}		

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{D 296}	Continued From page 10 the facility's food service system.	{D 296}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure therapeutic diet orders were served as ordered for 2 of 3 sampled residents (#4, #5) who had orders for a diabetic diet (#5) and a low carbohydrate diet (#4). The findings are: 1. Review of Resident #5's current FL2 dated 06/10/21 revealed: -Diagnoses included dementia and insulin dependant diabetes. -There was an order for a diabetic diet. Observation of Resident #5's lunch service on 03/24/22 at revealed: -She was served a piece of seasoned chicken, sugar-free jello, a dinner roll and a brownie topped with an apple glaze and whipped cream. -She ate 100% of her meal.	{D 310}		

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{D 310}	Continued From page 11 Attempted review of the facility's therapeutic menu revealed the facility did not have any therapeutic menus. Review of the facility's lunch meal menu dated 03/24/22 for a regular diet revealed vegetable macaroni soup, sourdough toast, a chicken club sandwich with lettuce and tomato, strawberry gelatin and a apple brownie. Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/25/22 at 11:15am revealed: -Resident #5 was ordered a diabetic diet because she had diabetes. -The facility should have informed him that she had a diabetic diet order, a diet they did not have, and he would have had it changed. -He managed Resident #5's diabetes with insulin adjustments. Refer to interview with the Dietary Manager on 03/24/22 at 9:39am and 4:11pm. Refer to interview with a dietary staff on 03/24/22 at 12:25pm. Refer to Interview with the Administrator on 03/24/22 2. Review of Resident #4's current FL2 dated 09/15/21 revealed diagnoses included dementia and type 2 diabetes. Review of Resident #4's record revealed an order dated 10/02/20 for a low concentrated sweets diet. Observation of Resident #4's lunch service on 03/24/22 at revealed:	{D 310}		

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{D 310}	Continued From page 12 -He was served a piece of seasoned chicken, sugar-free jello, a dinner roll and a brownie topped with an apple glaze and whipped cream. -He ate 100% of his meal. Attempted review of the facility's therapeutic menu revealed the facility did not have any therapeutic menus. Review of the facility's lunch meal menu dated 03/24/22 for a regular diet revealed vegetable macaroni soup, sourdough toast, a chicken club sandwich with lettuce and tomato, strawberry gelatin and a apple brownie. Telephone interview with Resident #4's Primary Care Provider (PCP) on 03/25/22 at 11:15am revealed: -Resident #4 was ordered a low concentrated sweets diet because he had diabetes. -The facility did not have therapeutic diets and he monitored Resident #4's diabetes with a finger stick blood sugar check. Refer to interview with the Dietary Manager on 03/24/22 at 9:39am and 4:11pm. Refer to interview with a dietary staff on 03/24/22 at 12:25pm. Refer to Interview with the Administrator on 03/24/22. _____ Interview with the Dietary Manager on 03/24/22 at 9:39am and 4:11pm revealed: -He was hired as the Dietary Manager on 01/03/22. -He was a trained chef and knew how to prepare meals for people with diabetes. -He did not have a menu spreadsheet to indicate	{D 310}		

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what food should be served to a resident with diabetes.
-Residents with a diabetic or low concentrated sweets diets received the regular menu with the exception of the dessert which was served at a quarter of the portion.
-The cook overlooked the dessert and served a regular portion instead of a reduced portion size.
-He did not know why the cook was in a hurry and forgot to serve vegetables but vegetables were served when they were on the menu.
-The cook was trained to served smaller portions of dessert to residents who had diabetes and had a special diet.

Interview with a cook on 03/24/22 at 12:25pm revealed:
-She was the cook for the lunch meal and plated all the meals.
-Residents who had diabetes received a smaller portion of the regular menu's dessert.
-She did not know why a regular size dessert was served.
-She was in a hurry when she plated the meals and forgot to put the vegetables on the plate.

Interview with the Administrator on 03/25/22 at 1:55pm revealed:
-The Dietary Manager was a trained chef and knew how to prepare therapeutic diets.
-He adapted the menu in order to provide appropriate meals for the residents with diabetes.
-Dietary staff usually followed the therapeutic diets but she was not sure they always did.
-She checked some of the therapeutic diets to be sure they were being served correctly but she was not able to check every meal served at the facility.

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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 review, the facility failed to ensure Medication Administration Records were accurate for 1 of 2 sampled residents (#1) who self-administered medications related to a medication used to rid the body of excess fluid and vitamin supplements (#1). The findings are: Review of Resident #1's current FL2 dated 04/29/21 revealed: -Diagnoses included chronic kidney disease.	D 367		

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-There was no order for self-administration of medications.
-There was no order for bumetanide (a diuretic medication used to rid the body of excess fluid).
-There were no orders for vitamin supplements including vitamin D, vitamin C, iron, turmeric, or glucosamine.

Review of Resident #1's Resident Register dated 04/30/21 revealed an admission date on 05/02/21.

Observation during the initial tour on 03/24/22 at 10:25am revealed:
-There were 4 clear medication pouches containing pills setting on the bedside table.
-One pouch labeled with black ink "Thursday breakfast" and contained a green tablet, 4 capsules with white powder, and one capsule with orange powder.
-A second pouch labeled with black ink "Thursday supper" contained one small white tablet, a long yellow tablet, one capsule with orange powder, and 2 capsules with white powder.
-A third pouch labeled with black ink "Thursday bedtime" contained a green tablet, a small clear capsule filled with light yellow liquid, and 4 capsules with white powder.
-A fourth pouch labeled with black ink "Sunday breakfast" contained one round yellow tablet and 13 half yellow tablets.

Interview with Resident #1 on 03/24/22 at 10:25am revealed:
-The clear medication pouches were "supplements" provided by a family member that he self-administered four times daily.
-He did not have the supplement bottles in his room because a family member put the supplements into the medication pouches and

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labeled the pouch with the day and time he took them and brought the supplements to him at the facility.
-The supplements were turmeric, vitamin D, vitamin C, glucosamine, and iron.
-The pouch labeled "Sunday breakfast" was a diuretic (a medication used to rid the body of excess fluid) prescribed by his physician and he took one tablet twice daily when needed.
-The diuretic pills were cut into half because he would take "extra" if he needed a higher dosage and took one and a half tablets twice daily if needed.

Observation of Resident #1's medication bottles stored in a cabinet in Resident #1's room revealed:
-The round, yellow tablets were bumetanide (a diuretic medication used to rid the body of excess fluid) 1mg take one tablet twice a day for 30 days with a dispense date on 10/29/21 in the quantity of 180 tablets.
-There were no supplement bottles for vitamin c, vitamin d, iron, turmeric, or glucosamine available.

Review of Resident #1's physician's orders revealed there were no orders for bumetanide, vitamin c, vitamin d, iron, turmeric, or glucosamine.

Review of Resident #1's January 2022 medication administration record (MAR) revealed there was no entry for bumetanide, vitamin c, vitamin d, iron, turmeric, or glucosamine.

Review of Resident #1's February 2022 MAR revealed there was no entry for bumetanide, vitamin c, vitamin d, iron, turmeric, or glucosamine.

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D 367	Continued From page 17 Review of Resident #1's March 2022 MAR revealed there was no entry for bumetanide, vitamin c, vitamin d, iron, turmeric, or glucosamine. Interview with a medication aide (MA) on 03/25/22 at 8:45am revealed: -She did not know what supplements or dosage of bumetanide Resident #1 took because she did not know he took bumetanide and supplements. -She did not have a physician's order for Resident #1's supplements or bumetanide and that was why the bumetanide and supplements were not documented on the MAR. -Resident #1's family member would "sometimes" take Resident #1 to physician's appointments and to the local pharmacy and she relied on Resident #1 to give her a copy of new physician's orders for medications. Telephone interview with a pharmacist from Resident #1's preferred local pharmacy revealed bumetanide 1mg take one tablet twice a day in the quantity of 180 tablets was last dispensed on 10/29/21. Interview with the Health and Wellness Director on 03/25/22 at 10:40am revealed: -She knew Resident #1 self-administered medications. -She thought all of Resident #1's medications were ordered and listed on the MAR. -She did not know the facility did not have a copy of the order or that Resident #1 was self-administering bumetanide. -She did not know Resident #1 did not have a physician's order for the supplements Resident #1 was self-administering. -The MA's were responsible for obtaining a copy	D 367		

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D 367	Continued From page 18 of new physician's orders and adding the medication orders to the MARs. -The facility's policy regarding medications was for the resident to have a physician's order for each medication and each medication entered on the MAR. Interview with the Administrator on 03/25/22 at 3:51pm revealed: -The MA's were responsible for obtaining physician's orders for all medications. -The MA's were responsible for making sure the MAR was accurate and had all medications entered on the MAR. -The Resident Care Coordinator (RCC) and Health and Wellness Director were responsible for auditing resident records to make sure physician orders were completed. -She expected staff to follow the facility's policies and procedures.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 2 sampled residents (#1) had orders to self-administer medications related to medications kept in residents' rooms including a diuretic medication and vitamins (#1).

The findings are:

Review of the facility's undated, Self-Administration of Medications Policy and Procedure revealed:
-The physician would indicate the resident was capable of self-administering medications by checking "yes" on the Physician Move-In Report and write an order for self-administration including specific medications to be self-administered.
-The facility would generate a Medication Administration Record (MAR) to show all medications and treatments ordered by the Resident's physician.

Review of Resident #1's current FL2 dated 04/29/21 revealed:
-Diagnoses included chronic kidney disease.
-There was no order for self-administration of medications.

Review of Resident #1's Resident Register dated 04/30/21 revealed an admission date on 05/02/21.

Observation during the initial tour on 03/24/22 at 10:25am revealed:
-There were 4 clear medication pouches containing pills setting on the bedside table.

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-One pouch labeled with black ink "Thursday breakfast" and contained a green tablet, 4 capsules with white powder, and one capsule with orange powder.
-A second pouch labeled with black ink "Thursday supper" contained one small white tablet, a long yellow tablet, one capsule with orange powder, and 2 capsules with white powder.
-A third pouch labeled with black ink "Thursday bedtime" contained a green tablet, a small clear capsule filled with light yellow liquid, and 4 capsules with white powder.
-A fourth pouch labeled with black ink "Sunday breakfast" contained one round yellow tablet and 13 half yellow tablets.

Review of Resident #1's record revealed there was not a physician's order to self-administer medications.

Interview with Resident #1 on 03/24/22 at 10:25am revealed:
-The clear medication pouches were "supplements" provided by a family member that he self-administered four times daily.
-He did not have the supplement bottles in his room because a family member put the supplements into the medication pouches and labeled the pouch with the day and time he took them and brought the supplements to him at the facility.
-The supplements were turmeric, vitamin D, vitamin C, glucosamine, and iron.
-The pouch labeled "Sunday breakfast" was a diuretic (a medication used to rid the body of excess fluid) prescribed by his physician and he took one tablet twice daily when needed.
-The diuretic pills were cut into half because he would take "extra" if he needed a higher dosage and took one and a half tablets twice daily if

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D 375	Continued From page 21 needed. Observation of Resident #1's medication bottles stored in a cabinet in Resident #1's room revealed: -The round, yellow tablets were bumetanide (a diuretic medication used to rid the body of excess fluid) 1mg take one tablet twice a day for 30 days with a dispense date on 10/29/21 in the quantity of 180 tablets. -There were no supplement bottles for vitamin c, vitamin d, iron, turmeric, or glucosamine available. Interview with a medication aide (MA) on 03/24/22 at 3:48pm revealed: -She knew Resident #1 had medications stored in his room. -Resident #1 had a physician's order to self-administer medications but she could not find it in his record. -Resident #1 had self-administered medications since residing at the facility. Interview with a second MA on 03/25/22 at 8:45am revealed: -She did not know what supplements or dosage of bumetanide Resident #1 took because she did not know he took bumetanide and supplements. -She did not have a physician's order for Resident #1's supplements or bumetanide and that was why the bumetanide and supplements were not documented on the MAR. -Resident #1's family member would "sometimes" take Resident #1 to physician's appointments and to the local pharmacy and she relied on Resident #1 to give her a copy of new physician's orders for medications. Telephone interview with a pharmacist from	D 375		

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Resident #1's preferred local pharmacy revealed bumetanide 1mg take one tablet twice a day in the quantity of 180 tablets was last dispensed on 10/29/21.

Interview with the Health and Wellness Director on 03/25/22 at 10:40am revealed:
-She was told by facility staff Resident #1 had a physician's order to self-administer medications, but she had not looked for the order herself.
-She knew Resident #1 self-administered medications.
-She thought all of Resident #1's medications were ordered and listed on the MAR.
-She did not know the facility did not have a copy of the order or that Resident #1 was self-administering bumetanide.
-She did not know Resident #1 did not have a physician's order for the supplements Resident #1 was self-administering.
-The MA's were responsible for obtaining a copy of new physician's orders and adding the medication orders to the MARs.
-The facility's policy regarding self-administration of medications was for the resident to have a physician's order to self-administer medications and each medication had to have an order and be documented on the MAR.

Telephone interview with Resident #1's primary care provider (PCP) on 03/25/22 at 2:40pm revealed:
-He did not have access to his medical records because he was away from the office but did not remember writing an order for Resident #1 to self-administer medications.
-He did not write an order for Resident #1 to keep medications in his room.

Telephone interview with Resident #1's

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nephrologist on 03/25/22 at 2:48pm revealed:
-He last saw Resident #1 in February 2022 for his chronic kidney disease management.
-He changed Resident #1's bumetanide to 1mg take one tablet daily as needed at the February 2022 appointment (he did not have computer access to give an exact date).
-Resident #1 should not take one and a half tablets (1.5mg) because Resident #1 did not have an order to do so.
-Resident #1 could have complications from taking too high of a dosage of bumetanide and could end up being admitted to the hospital from dehydration, increased creatinine levels (indication that the kidneys were not working well) or potassium levels that were too low.

Interview with the Administrator on 03/25/22 at 3:51pm revealed:
-She thought Resident #1 had an order to self-administer medications.
-The MA's were responsible for obtaining physician orders for residents to self-administer medications and for all the medications that were to be self-administered.
-The MA's were responsible for making sure the MAR was accurate.
-The Resident Care Coordinator (RCC) and Health and Wellness Director were responsible for auditing resident records to make sure physician orders were completed.
-She expected staff to follow the facility's policies and procedures.