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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF APEX	901 SPRING ARBOR COURT APEX, NC 27502

(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 Division of Health Service Regulation conducted an annual and follow-up survey 12/07/21 through 12/09/21, with a telephone exit on 12/09/21.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure supervision for 1 of 5 sampled residents (Resident #1) resulting in 8 falls in 3 months. The findings are: Review of Resident #1's current FL2 dated 04/22/21 revealed: -Diagnoses included hemiplegia and hemiparesis due to cerebral infarction. -She was non-ambulatory and used of a wheelchair. Review of Resident #1's Resident Register revealed an admission date of 04/26/21. Review of Resident #1's care plan dated for 06/22/21 revealed: -She was independent for toileting, transferring, ambulation, and eating. -She required minimal assistance with dressing	D 270		

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D 270	Continued From page 1 and supervision with bathing. Review of the facility's falls management and interventions policy (Rose Program) revealed: -The resident should have a fall risk assessment upon move-in and after every fall. -Fall risk assessment scores parameters including mental status, history of falls, vision, hearing, mobility, blood pressure, diagnoses, and medications to determine lower or higher risk of falls. -Resident-specific interventions should be implemented including examining physical and medical factors, physical and occupational therapy consulted for possible intervention, communicate with the physician, family and team members for any interventions. -Identify high fall risk with "rose" on room plague and resident's assistive device to alert staff to monitor visually more often for safety; and add resident specific intervention list (like fall mat or alarm) to the personal care aide/activities of daily living (PCS/ADL) log. -Review residents on "rose" program at weekly falls management meeting for effectiveness of interventions and additional falls. -Documentation of updates of Care Plan with changes in risk factors and/or interventions and update of PCS/ADL logs with changes in risk factors and/or interventions. Observation on 12/08/21 at 1:00pm revealed: -Resident #1 had a rose on the resident's name plate on the outside of her room. -Resident #1 was ambulating down the hall in her wheelchair unassisted. Review of an incident and accident report dated 10/01/21 revealed: -Resident #1 had an unwitnessed fall in her room	D 270		

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at 10:45pm.
-There were no apparent injuries noted.
-The resident was not sent to the hospital.
-Resident #1's family was notified on 10/01/21 by phone at 11:00pm.
-The primary care provider (PCP) was notified by fax on 10/01/21 at 11:00pm.

Review of the Resident #1's progress note dated 10/01/21 revealed:
-Resident #1 fell down while trying to transfer to bed herself.
-She received a scratch on the side of her arm which was dressed.
-Resident was advised not to transfer to bed by herself and ask for help.
-The Resident Care Coordinator (RCC) and family member were notified.
-There was no documentation for additional resident monitoring or increased supervision.

Review of an incident and accident report dated 10/07/21 revealed:
-Resident #1 had an unwitnessed fall in her bathroom at 11:30am.
-The resident was not sent to the hospital.
-Resident #1's family was notified on 10/07/21 by phone at 12:00pm.
-The PCP was notified at 11:30am.

Review of Resident #1's progress notes revealed:
-On 10/07/21 at 1:00pm, resident was observed in bathroom on the floor, she had an abrasion on her right elbow and complained of right hip pain; PCP was in the facility at the time and evaluated the resident who refused an X-ray.
-There was no documentation for additional resident monitoring or increased supervision.

Review of an incident and accident report dated

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10/08/21 revealed:
-Resident #1 had an unwitnessed fall in her bedroom at 9:26am.
-No apparent injury was observed.
-The resident was not sent to the hospital.
-Resident #1's family was notified on 10/08/21 by phone at 9:26am.
-The PCP was notified on 10/08/21 via fax at 9:26am.

Review of Resident #1's progress notes revealed:
-On 10/08/21 at 9:20am, the medication aide (MA) entered room and observed Resident #1 on the floor. MA checked resident's skin and vitals.
-On 10/08/21 at 10:30pm, resident requested Tylenol for headache was documented.
-There was no documentation for additional resident monitoring or increased supervision.

Review of an incident and accident report dated 10/28/21 revealed:
-Resident #1 had an unwitnessed fall in her room at 6:25pm.
-No apparent injury was observed.
-The resident was not sent to the hospital.
-Resident #1's family was notified on 10/28/21 by phone at 6:25pm.
-The PCP was notified on 10/28/21 via fax at 6:25pm.

Review of Resident #1's progress notes revealed:
-On 10/28/21 at 6:00pm, Resident #1 was observed on the floor. MA checked resident's skin and vitals. Staff helped resident stand.
-There was no documentation for additional resident monitoring or increased supervision.

Review of an incident and accident report dated 11/23/21 revealed:
-Resident #1 told the MA she had a fall at 7:30pm

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or 8:00pm but was in her wheelchair at 8:00pm.
-There were no apparent injuries noted.
-Resident #1's family was notified on 11/23/21 by phone at 8:30pm.
-The PCP was notified by fax on 11/23/21 at 8:30pm.

Review of Resident #1's progress notes revealed:
-On 11/23/21 at 10:00pm, Resident #1 requested to go to the hospital: she had a contusion on her left cheek. Family member said it was fine to send to the hospital.
-On 11/24/21 at 2:45am, Resident #1 returned from the hospital with no new orders and nurse said all scans were negative for injury.
-There was no documentation for additional resident monitoring or increased supervision.

Review of Resident #1's Personal care service Record and resident's Capacity to perform task for November 2021 revealed there was no documentation for increased supervision or changes to care provided after a fall on 11/23/21.

Review of an incident and accident report dated 12/03/21 revealed:
-Resident #1 had an unwitnessed fall in her bathroom at 4:05pm.
-The resident stated she attempted to stand up from toilet to transfer to wheelchair on her own.
-No apparent injury was observed.
-The resident was not sent to the hospital.
-Resident #1's family was notified on 10/28/21 by phone at 4:15pm.
-The PCP was notified on 12/03/21 via fax at 4:25pm.

Review of Resident #1's progress notes revealed:
-On 12/03/21 at 4:35pm, Resident #1 was observed on the floor in her bathroom.

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-She told staff she attempted to stand to transfer from toilet to wheelchair and fell to the floor but was not hurt.
-There was no documentation for additional resident monitoring or increased supervision.

Review of Resident #1's progress notes revealed:
-On 12/04/21 at 2:45pm, Resident #1 was observed on the floor in her bedroom laying on her right side.
-Emergency medical services (EMS) was called and the resident was sent to local emergency department.
-On 12/04/21 at 5:45pm, Resident #1 was back in the facility with no new orders.
-There was no documentation for additional resident monitoring or increased supervision.

Review of Resident #1's incident and accident reports revealed there was no incident or accident report available for review for the fall on 12/04/21.

Review of an incident and accident report dated 12/06/21 revealed:
-Resident #1 had an unwitnessed fall in her bathroom at 1:35pm.
-The resident was attempting to toilet herself.
-No apparent injury was observed.
-The resident was not sent to the hospital.
-Resident #1's family was notified on 10/28/21 by phone at 2:30pm.
-The PCP was notified on 12/03/21 via fax at 2:30pm.

Review of Resident #1's progress notes revealed:
-On 12/06/21 at 4:35pm, Resident #1 was observed on the floor in her bathroom.
-She was toileting herself and lost her balance.
-Her PCP was notified, and a telephone message

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left for her family.
-There was no documentation for additional resident monitoring or increased supervision.

Review of Resident #1's daily assignment personal care sheets for 7:00am to 3:00am on 11/30/21, 12/01/21, 12/02/21, 12/03/21, 12/04/21, 12/05/21, and 12/07/21 revealed there was no documentation for increased supervision or care tasks for Resident #1.

Interview with a dayshift MA on 12/08/21 at 2:30pm revealed:
-Resident #1 was a fall risk because she had a lot of falls.
-Staff were supposed to monitor resident for 3 days after a fall.
-Monitoring included observing the resident for signs of delayed bruising or complaints of pan.
-There was no sheet to document increased monitoring.
-The staff checked on resident at least every 2 hours.
-She tried to check on Resident #1 every one hour, but there was no mention of increased supervision on the facility's fall policy that she was aware of.
-There was a board in the medication room to alert the MAs when a resident had a fall and was to be monitored for any changes in medical condition.
-The MA would tell the Personal Care Aide (PCA) on duty if a resident had been added to the "hot box" and board.

Interview with a Personal Care Aide (PCA) on 12/08/21 at 3:00pm revealed:
-Staff were informed if a resident had fallen at a stand up meeting each day.
-The resident would be placed in the "hot box"

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after a fall, meaning staff were to look at the resident more often than the regular 2 hours for any signs of pain or changes in condition.
-There was no place to document increased supervision that she knew about.
-She had not been instructed to increase supervision for Resident #1.

Interview with a technician with Physical Therapy on 12/08/21 at 3:40pm revealed Resident #1's physical therapy was not started due to insurance conflicts.

Interview with a second PCA on 12/08/21 at 4:40pm revealed:
-There was no documentation that 2 hour checks were being done.
-Resident #1 had a lot of falls.
-Resident #1 stayed in the bathroom unusual lengths of time.
-She tried to monitor Resident #1 and if the resident went in the bathroom , she would encourage her to not stay more than 20 minutes.
-Residents were put on the "Rose" program to help staff to monitor for falls including positioning in wheelchairs and observing residents for signs of pain, changes in alertness or any delayed bruising after a fall for 2 or 3 days.
-She was not aware of a definite frequency for increased monitoring of residents in the "hot box" and after falls.

Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 4:10pm revealed:
-The facility did not have a policy for increased supervision for residents that included scheduled intervals other than the policy for routinely checking on all residents every 2 hours.
-Routine checks were not documented.
-Residents with more than one fall within a few

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D 270	Continued From page 8 days were placed on the" Rose" Program that involved monitoring the resident more often than every 2 hours, engaging the resident in activities to get them out of the room and more visible to staff, and watching for signs of any changes in medical conditions after a fall (for 3 days). -Staff should be checking on the "Rose" Program residents often but there was no assigned frequency or any kind of documentation for the increased supervision. Interview with a third PCA on 12/08/21 at 5:00pm revealed: -The PCAs rotated from one hall to the next daily. -She worked a most days in the facility on the afternoon shift. -She tried to check on the residents on her assigned hall at least every 2 hours but did not know of any place to document the supervision of residents. -She did not know Resident #1 was currently on increased supervision due to falls on 12/03/21, 12/04/21, and 12/06/21. -The residents who had falls had their names placed on a board in the medication room for the MA to know who fell. -Resident #1's name was on this board. -The MA would have to tell her who was to have increased supervision because she could not go in the medication room as a PCA. Based on observation, and attempted interviews it was determined Resident #1 was not interviewable.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#3) with an order for blood pressure (BP) checks with parameters.

The findings are:

Review of Resident #3's current FL-2 dated 11/23/21 revealed diagnoses included hypertension (HTN).

Review of Resident #3's previous FL-2 dated 10/07/21 revealed there was an order to check blood pressure every Monday, Wednesday and Friday and notify the provider if BP was over 180/100 or less than 90/50.

Review of Resident #3's signed Physician's Orders dated 12/07/21 revealed:
-There was an order to check BP every Monday, Wednesday and Friday and notify the provider if BP was over 180/100 or less than 90/50.

Review of Resident #3's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to check BP every Monday, Wednesday and Friday and notify provider if BP was over 180/100 or less than 90/50.
-There was documentation BPs were checked every Monday, Wednesday and Friday from 10/08/21 to 10/31/21.
-On 10/13/21, Resident #3's BP was 195/81, and on 10/15/21 her BP was 189/88.
-There was no documentation on the eMAR that the PCP had been notified of BP over 180 on

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D 273	Continued From page 10 10/13/21 or 10/15/21. Review of Resident #3's progress notes revealed there was no documentation of Resident #3's BP readings over 180 on 10/13/21 or 10/15/21 or that the primary care provider (PCP) had been notified. Review of Resident #3's November eMAR revealed: -There was an entry to check BP every Monday, Wednesday and Friday and notify provider if BP was over 180/100 or less than 90/50. -There was documentation BPs were checked every Monday, Wednesday and Friday from 11/01/21 to 11/30/21. -On 11/12/21, Resident #3's BP was 184/81. -There was no documentation on the eMAR that the PCP had been notified of BP over 180 on 11/12/21. Review of Resident #3's progress notes revealed there was no documentation of Resident #3's BP reading over 180 on 11/12/21 or that the PCP had been notified. Interview with a medication aide (MA) on 12/08/21 at 10:25am revealed: -She had been the MA who documented all three of the BPs for Resident #3 that were over 180. -After checking Resident #3's BP in the morning, if it was over 180 she would call the PCP to notify her. -She would sometimes document a note about PCP notification being completed in the eMAR, but she was unable to find that she had made any notes on 10/13/21, 10/15/21, or 11/12/21. -She had not received any new orders from the PCP when she notified her of Resident #3's BPs on 10/13/21, 10/15/21 or 11/12/21.	D 273		

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D 273	Continued From page 11 Interview with Resident #3 on 12/08/21 at 10:43am revealed: -The MA checked her BP every Monday, Wednesday and Friday and always told her what her blood pressure reading was. -She had never been told that since her blood pressure was over 180 the MA was going to notify her PCP. Interview with Resident #3's PCP on 12/08/21 at 12:25pm revealed: -The MAs did not call her directly, they were supposed to fill out a physician notification form and fax it to her so that she could review the information, write her response and fax it back to the facility. The exception to that was if MA staff were notifying her of something that occurred while she was at the facility and they notified her in person. -She had not received notification that Resident #3's BPs was over 180 on 10/13/21, 10/15/21 or 11/12/21. -If she had been notified, she would not have changed any of Resident #3's orders based on those blood pressure readings. -It was her expectation that the MA would notify her as ordered for any BPs over 180/100 or less than 90/50. Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 3:00pm revealed: -She was familiar with Resident #3's order for BP checks on Monday, Wednesday and Friday with parameters to call the PCP if BP was over 180/100 or less than 90/50. -She was unaware of the high BP readings on 10/13/21, 10/15/21 and 11/12/21. -The MAs were supposed to fax a notification to the PCP when Resident #3's BP exceeded the	D 273		

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D 273	Continued From page 12 ordered parameters. -The PCP was in the facility every Tuesday and Thursday, and the MAs often waited to notify her in person rather than sending the fax or documenting in the progress notes as they were supposed to do. Interview with the Executive Director on 12/08/21 at 4:50pm revealed: -She was unaware of Resident #3's BP readings over 180 on 10/13/21, 10/15/21 and 11/12/21 and the PCP had not been notified. -She thought the MA probably notified the PCP in person since she was there twice a week, and then forgot to document the notification. -It was her expectation that the MAs documented every communication they had with the PCP so that it could be tracked, and new orders could be written if needed.	D 273		
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 1 of 5 sampled residents (#1) with physician's orders for Thrombo-Embolic Deterrent (TED) hose.	D 276		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF APEX	901 SPRING ARBOR COURT APEX, NC 27502

(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 276	Continued From page 13 The findings are: Review of Resident #1's current FL2 dated 04/22/21 revealed diagnoses included hemiplegia and hemiparesis due to cerebral infarction. Review of Resident #1's physician's orders dated 04/22/21, 10/14/21 and 12/07/21 revealed there were orders to apply 20 to 30 mmhg (a measure of compression) knee high TED (compression) hose every morning and remove every evening. Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose scheduled to be applied daily in the morning at 8:00am and remove daily in the evening at 8:00pm. -There was documentation TED hose were applied and removed daily. Review of Resident #1's October 2021 eMAR revealed: -There was an entry for TED hose scheduled to be applied daily in the morning at 8:00am and remove daily in the evening at 8:00pm. -There was documentation TED hose were applied and removed daily. -On 10/24/21, there was documentation Resident #1 applied TED hose herself at 8:00am and staff documented removal at 8:00pm. -On 10/28/21, there was documentation Resident #1 applied TED hose herself at 8:00am and staff documented removal by the resident at 8:00pm. -On 10/29/21, there was documentation Resident #1 applied TED hose herself at 8:00am and staff documented removal at 8:00pm. Review of Resident #1's November 2021 eMAR revealed:	D 276		

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D 276	Continued From page 14 -There was an entry for TED hose scheduled to be applied daily in the morning at 8:00am and remove daily in the evening at 8:00pm. -There was documentation TED hose were applied and removed daily. - On 11/03/21, 11/05/21, 11/08/21, 11/17/21, 11/22/21, and 11/29/21, there was documentation Resident #1 applied TED hose herself at 8:00am and staff documented removal at 8:00pm. Review of Resident #1's December 2021 eMAR revealed: -There was an entry for TED hose scheduled to be applied daily in the morning at 8:00am and remove daily in the evening at 8:00pm. -There was documentation TED hose were applied and removed daily. -There was documentation TED hose were applied at 8:00am on 12/08/21. -On 12/01/21, 12/04/21, 12/05/21, and 12/06/21, there was documentation Resident #1 applied TED hose herself at 8:00am and staff documented removal at 8:00pm. Observation of Resident #1 on 12/08/21 from 7:59am to 11:00am revealed she was not wearing TED hose. Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 11:00am revealed: -Resident #1 sometimes told staff she did not want help and applied the TED hose herself occasionally, -Staff should check the resident's legs for TED hose application prior to documenting the TED hose as applied. -She did not know Resident #1's TED hose had not been applied today. -The resident would be taken to her room for application of the TED hose immediately.	D 276		

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D 276	Continued From page 15 Interview with the medication aide (MA) 12/08/21 at 11:00am revealed: -The MA on duty was responsible for ensuring residents' TED hose were applied by the MA or personal care aides (PCAs) as ordered. -The MA should document a resident's TED hose were in place after checking for application. -Resident #1 requested to apply TED hose herself. -Resident #1's TED hose were not applied earlier in the morning because the TED hose were still damp around the knee area and the resident would not let staff apply the hose. -She did not verify Resident #1 had applied her TED hose before documenting application today. Interview with Resident #1's primary care provider (PCP) on 12/08/21 at 12:30pm revealed: -She expected the facility staff to ensure Resident #1 was wearing TED hose daily as ordered. -She did not know Resident #1 was requesting to apply her own TED hose. -She would have to observe the resident applying TED hose before she would approve staff allowing the resident to apply TED hose herself. -Even then, the staff should check for TED hose application or if the resident needed assistance prior to documenting application. Interview with the Administrator on 12/08/21 at 5:25pm revealed the MA should only document a resident had TED hose on after visually checking for the TED hose were in place.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 16 (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 observation, interview and record review, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#3) with orders for a diuretic medication and a supplement. The findings are: Review of Resident #3's current FL-2 dated 11/23/21 revealed diagnoses included congestive heart failure (CHF) and hypokalemia (low potassium). Review of Resident #3's physician order dated 10/28/21 revealed there was an order to check weight daily and log at the same time every morning. Review of Resident #3's physician order dated 11/12/21 revealed: -There was an order to take an extra torsemide (a diuretic medication used to treat fluid retention caused by CHF) 40 mg per day as needed (PRN) for a weight exceeding 113 pounds (lbs). -There was an order to take an extra potassium 20 mEq tablet per day on the days Resident #3 took an extra torsemide. Review of Resident #3's hospital discharge	D 358		

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D 358	Continued From page 17	D 358		

summary dated 11/24/21 revealed:
-There was an order to discontinue torsemide 40mg PRN for weight over 113 lbs.
-There was an order for torsemide 10mg, take 2 tablets (20mg total) per day PRN for a weight gain of either 3 lbs in one day, or 5 lbs in one week.

Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to check weight daily and log at the same time every morning.
-Daily weights were documented as obtained from 11/01/21 to 11/30/21.
-Resident #3's weights were documented as obtained as follows:
-On 11/25/21, weight was 113.0 lb, on 11/26/21, weight was 112.5 lb, on 11/27/21, weight was 113.8 lb, on 11/28/21, weight was 111.0 lb, on 11/29/21, weight was 113.2 lb and on 11/30/21, weight was 113.6 lb.
-There was an entry for torsemide 10mg take 2 tablets once daily as needed for weight gain greater than 5 lbs in a week or 3 lbs in a day.
-There was documentation torsemide 20mg had been administered on 11/29/21 with reason documented as "weight gain." This was a weight gain of 2.2 lb from the previous day.
-There was an entry for potassium 20 mEq, take an extra tablet per day on the days Resident #3 took an extra torsemide.
-There was no documentation that potassium 20 mEq was administered on 11/29/21 with the torsemide 20mg.

Review of Resident #3's December 2021 eMAR revealed:
-There was an entry to check weight daily and log at the same time every morning.

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D 358	Continued From page 18 -Daily weights were documented as obtained from 12/01/21 to 12/07/21. -Resident #3's weights were documented as obtained as follows: -On 12/01/21, weight was 114.4 lb, on 12/02/21, weight was 110.4 lb, on 12/03/21, weight was 112.4 lb, and on 12/04/21, weight was 117.0 lb. -There was an entry for torsemide 10mg, take 2 tablets once daily as needed for weight gain greater than 5 lbs in a week or 3 lbs in a day. -There was documentation torsemide 20mg had been administered on 12/01/21 with documented reason being "weight gain." This was a weight gain of 0.8 lb from the previous day. -There was documentation torsemide 20mg had been administered on 12/04/21 for weight gain of 4.6 lbs. -There was an entry for potassium 20mEq, take an extra tablet per day on the days Resident #3 took an extra torsemide. -There was no documentation potassium 20mEq had been administered on 12/01/21 or 12/04/21. Interview with Resident #3 on 12/08/21 at 10:43am revealed: -She weighed herself every morning with the medication aide (MA). -She knew that if her weight was up more than 3 pounds in a day or 5 pounds in a week she was supposed to receive an extra dose of torsemide but she was unaware of any other medications she was supposed to receive due to weight gain. Interview with an MA on 12/08/21 at 10:55am revealed: -She had administered torsemide 10mg to Resident #3 on 11/29/21, 12/01/21, and 12/04/21. -She thought she had also administered potassium 20mEq on all three of those days but forgot to document that it was given.	D 358		

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-She did not remember why she had administered torsemide 10mg to Resident #3 on 11/29/21 as her weight did not increase by 3 lb in a day or 5 lb in a week; she thought she documented the weight incorrectly in the eMAR.
-She had administered the torsemide on 12/01/21 because Resident #3's weight was 114.4 which was higher than it usually was, so she gave the medication without looking back to see what Resident #3's weights had been for the last week of November 2021.

Telephone interview with a nurse from Resident #3's heart failure clinic on 12/08/21 at 2:15pm revealed:
-The physician had recently seen Resident #3 on 12/02/21 and was managing her orders for torsemide and potassium.
-They had not received notification that Resident #3 had been given torsemide 10mg without exceeding the weight parameters on 11/29/21 and 12/01/21 and that it had not been administered with potassium 20mEq; or that it had been administered on 12/04/21 as ordered for weight gain but was given without the additional potassium 20mEq.
-There was no harm done to Resident #3 as her potassium level was in the normal range when they checked it on 12/02/21, but they wanted her to receive the potassium supplement every time she took the torsemide because she had a history of hypokalemia and torsemide could deplete potassium levels in the body.
-It was their expectation that the MAs administered torsemide 10 mg and potassium 20mEq together as ordered for weight gain.

Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 3:00pm revealed:
-When a doctor wrote a new order, the MA was

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D 358	Continued From page 20 responsible for faxing the order to the pharmacy and placing that order along with the fax receipt into the resident's record. The MA also should be placing a copy of the order into their Order Tracking Binder. -It was the RCC's responsibility for performing audits on the orders in the binder with the order entered in the eMAR by the pharmacy, and checking the medication received from the pharmacy to verify they were all correct. -She was not aware of Resident #3 was receiving medications outside of the specified parameters. Interview with the Executive Director on 12/08/21 at 4:50pm revealed: -She was unaware that Resident #3 had received her PRN torsemide incorrectly two times, or without the PRN potassium three times. -It was her expectation that the MAs administered all medications as ordered, and to document every time they administer a medications.	D 358		