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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 08/02/22 to 08/04/22.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to ensure an immediate response and intervention for 1 of 5 sampled residents (#1) in accordance with the facility's policies and procedures who had an unwitnessed fall. The findings are: Review of the undated facility's Incident/Accident Reporting Policy revealed: -The Incident/Accident must be documented as soon as possible after the situation was stabilized. -When the incident/accident occurred, the staff would evaluate the situation and immediately	D 271		

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intervene to promote the safety of the resident(s) involved in the situation.
-The resident was to be assessed and call for assistance.
-The resident was to be assured and not left alone.
-First aid was to be administered and/or emergency transfer to a hospital if necessary.
-Resident #1's physician and responsible party was to be notified.
-The Health and Wellness Director (HWD) and Administrator were to be notified.
-The incident was to be documented in the Incident/Accident report.

Review of the undated facility Fall Management policy revealed all falls were to be reported and documented in the Incident /Accident Report.

Review of the undated facility Documentation Expectation training revealed:
-Documentation was to be completed by exception, such as with falls.
-The Incident/Accident reports were to be completed as soon as possible after the fall.

Review of the undated facility Abuse Prevention Program training revealed neglect was defined as a passive act of omission.

Review of Resident #1's current FL2 dated 09/20/21 revealed:
-Diagnoses included pneumonia and acute kidney injury.
-She was constantly disorientated.
-She was semi-ambulatory.

Review of Resident #1's Care Plan dated 03/14/22 revealed:
-She required limited assistance with toileting,

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ambulation, bathing, dressing and grooming.
-She was independent with eating and transfers.

Review of Resident #1's Incident and Accident Report dated 06/26/22 at 6:55pm revealed:
-A personal care aide (PCA) reported to the medication aide (MA), Resident #1 was on the floor.
-Resident #1 complained of her head hurting.
-Resident #1 did not "seem right" and "her speech was off".
-The MA notified the HWD, 911 and Resident #1's Power of Attorney (POA).

Review of Resident #1's Care Notes dated 06/26/22 at 10:33pm revealed:
-Resident #1 fell, hit her head and was transported to the emergency room (ER).
-The fall happened on first shift and Resident #1 was assisted off of the floor and placed in bed.
-There was no documentation vital signs were obtained.
-It was documented as, "just passed info that she was fine and they just put her in bed".
-Resident #1 was not acting or speaking right, and eyes were "not looking good".
-There was no documentation of a fall prior to shift change.

Review of the facility's 24-Hour Shift Report dated 06/26/22 revealed:
-The documentation was for night shift, (7:00pm to 7:00am) and completed by the MA and PCA.
-Resident #1 sustained a fall.
-There was no documentation from the day shift, (7:00am to 7:00pm) staff related to Resident #1 falling on day shift.

Review of the 911 Run Report from the local sheriff's department dated 06/26/22 revealed:

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-There was a 911 call received from the facility on 06/26/22 at 7:40pm.
-Emergency Medical Services (EMS) arrived at the facility at 7:47pm to find Resident #1 no longer on the floor, conscious, breathing, not responding normally, not completely alert, and an injury to the head.
-The chief complaint was documented as a fall and hit her head.
-Resident #1 was transported to the hospital at 7:56pm.

Review of Resident #1's emergency room (ER) Physician's report dated 06/26/22 revealed:
-The documented chief complaint was a fall.
-The facility staff reported to EMS that Resident #1 fell "earlier" that day (06/26/22) but 911 was not immediately called.
-When EMS arrived at the facility, Resident #1 was found in her bed and denied being in pain.
-She declined to go to the ER but the facility's staff insisted that she go to the ER.
-EMS noticed that Resident #1's pupils were dilated and she had a left conjugate gaze (is the ability of the eyes to work together in unison).
-The facility staff told EMS that Resident #1 acted normal this morning (06/26/22) and was talkative.
-Resident #1 fell a little after 6:00pm and they found her on the floor in the hallway with a dilated pupil and nonsensical speech.
-EMS had to physically assist Resident #1 out of bed, which was not normal for her.
-Due to the information obtained by EMS, of Resident #1's pupils were a left conjugated gaze, not talking normal, required assistance, and the way Resident #1 presented to the ER with a left conjugated gaze, a fall and not moving lower extremities, a code stroke was called.
-Resident #1's head and chest computed tomography (CT) scan revealed acute left sided

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rib fractures and no new stroke.
-Due to Resident #1's history of a cerebrovascular accident and the unclear circumstances around her fall, she was admitted to the hospital for a fall with injuries and Transient Ischemic Attack (TIA).

Review of Resident #1's Hospital Discharge Summary dated 06/30/22 revealed:
-Resident #1 was monitored for three days.
-Resident #1 required a level of care greater than an assisted living.
-Discharge diagnoses included, altered mental status, blindness, dementia, physical debility, urinary tract infection and rib fractures.

Telephone interview with Resident #1's Guardian on 08/02/22 at 10:52am revealed:
-On 06/26/22, late in the evening, she received a call from the night shift MA reporting that Resident #1 fell on day shift.
-The night shift (7:00pm-7:00am) MA notified her Resident #1 was sent to the ER after Resident #1 was found in her bed complaining of pain to her head.
-She did not receive a notification from the day shift (7:00am-7:00pm) staff related to Resident #1's fall.
-She was informed, by the night shift MA, Resident #1 was just placed in bed, not assessed, no vital signs obtained or a call to 911 after a head injury for about 45 minutes before being sent to the ER.
-Her biggest concern was the increased risk for Resident #1 developing a bleed in the brain after a head injury without immediate emergency medical care.
-After the hospitalization, Resident #1 was not able to return to the facility and was admitted to a skilled nursing facility with hospice and palliative

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care services due to her change in mental status, rib fractures and decline in mobility.
-It was her expectation the day shift staff call 911 immediately after the fall, notify her of the fall and notify her of the transport to the hospital.

Telephone interview with a night shift MA on 08/03/22 at 9:11am revealed:
-She worked from 7:00pm to 7:00am which was considered night shift.
-On 06/26/22, between 6:30pm and 6:45pm, she was waiting to clock in when the night shift PCA notified her Resident #1 was on the floor in the hallway.
-The PCA stated there was a MA and two PCA's with Resident #1 assisting Resident #1 up off of the floor.
-She began work around 6:55pm and the day shift MA did not report off about Resident #1's fall on day shift only that Resident #1 was "fine".
-She took the "fine" as no injuries.
-The 24 hour shift report was blank for day shift.
-After she began her shift about 7:00pm, after getting her medication cart ready she went to check on Resident #1 somewhere between 7:00pm and 7:30pm.
-She found Resident #1 in bed and complaining of pain to her head.
-Resident #1 had a knot to the back of her head, slurred speech, glassy eyes and was not "acting right" because Resident #1's baseline was talkative and able to ambulate with the use of a walker.
-She obtained a blood pressure on Resident #1 which was around 190/80.
-She notified the HWD before calling 911 around 7:30pm and Resident #1's guardian was notified after Resident #1 was sent to the hospital.
-Resident #1 was transported to the hospital and an incident/accident report was filled out.

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-Resident #1 was in her room for about 45 minutes before 911 was called after falling and hitting her head.
-It was the day shift MA's responsibility after finding Resident #1 on the floor to obtain vital signs and check for injuries, notify 911, the HWD, and the resident's guardian.
-It was also the day shift MA's responsibility to fill out the incident/accident report, give a verbal report to night shift and document on the 24-hour shift report and Resident #1's care notes.

Telephone interview with a night shift PCA on 08/03/22 at 9:13am revealed:
-She worked from 7:00pm to 7:00am which was considered night shift.
-She arrived at the facility around 6:30pm and saw Resident #1 on the floor outside of her bedroom.
-There were two day shift PCAs and one day shift MA with Resident #1.
-The day shift MA and PCA assisted Resident #1 up off of the floor and assisted her to bed.
-She continued to the staff break room and waited to clock in.
-The night shift MA came in to the staff break room and she informed the night shift MA, Resident #1 was in the floor when she came in.
-She and the night shift MA, after clocking in for work, did not receive report about Resident #1 being on the floor.
-One of the day shift PCAs who was assisted Resident #1 was not working, just at the facility visiting.
-The visiting PCA informed her after shift change, she found Resident #1 on the floor and notified the day shift MA.
-The visiting PCA informed her, Resident #1 complained of pain to her head and hip and the MA just got her off the floor, placed Resident #1

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in her bed, did not take vital signs and did not report the fall.
-She told the night shift MA she had received information from another PCA who was visiting the facility when she arrived to work that Resident #1 was found on the floor, complained of pain to her head and hip, and was assisted to bed, vital signs were not obtained and the fall was not reported to the night shift MA.
-She and the MA went to Resident #1's room and found Resident #1 complaining of pain to her head and hip, unable to speak correctly and acting unusual.
-The night shift MA called 911, and Resident #1 was sent to the hospital.
-The night shift MA notified the HWD and Resident #1's guardian.

Interview with the HWD on 08/03/22 at 10:00am revealed:
-They have two shifts at the facility, a day shift that begins at 7:00am until 7:00pm and a night shift from 7:00pm until 7:00am.
-On 06/26/22, between 7:00pm and 7:30pm the night shift MA informed her Resident #1 fell, hit her head, complained of pain to the head and was acting unusual when sent out.
-Resident #1 was sent out to the ER for evaluation.
-The MA did not specify what time the fall occurred and she did not ask.
-The facility policy for an unwitnessed fall, and complaint of pain to head or suggestion of a head injury, the resident was to be sent out to the hospital for evaluation.
-It was the responsibility of the day shift MA to send Resident #1 to the hospital as soon as Resident #1 complained of pain to head and was not acting right.
-The day shift MA did not notify her that Resident

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#1 fell on 06/26/22 before the change of shift.
-It was the day shift MA's responsibility to document the fall in Resident #1's record or care notes, on the 24-report sheet, give report to the night shift MA and fill out an incident/accident form prior to leaving the facility.
-It was the responsibility of the day shift MA to respond to Resident #1's fall, obtain information about injuries including complaints and physical injuries such as bumps to her head, obtain vital signs and call 911.
-It was the night shift MAs responsibility to document the fall in the chart notes and on the incident/accident form.
-She did not review Resident #1's record after the fall.

Interview with the day shift MA on 08/03/22 at 12:10pm revealed:
-She worked from 7:00am to 7:00pm which was considered day shift.
-She was working on 06/26/22 when Resident #1 fell.
-A PCA informed her that Resident #1 was found on the floor between 6:30pm and 6:45pm.
-She checked Resident #1 for injuries and did not find any.
-Resident #1 did not complain of pain and stated she was ok.
-She helped Resident #1 to her bed.
-At the end of her shift she did not report the fall to the next shift because there were no injuries or complaints from Resident #1.
-She did not document in the chart notes, the 24-hour sheet or fill out an incident report.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 08/03/22 at 3:02pm revealed:
-He was notified of her fall on 06/26/22 through

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the office answering service after Resident #1 was transported to the hospital.
-Due to Resident #1's history of dementia and dilated pupils, she should have been sent to the hospital immediately after her fall to have her head evaluated with computed tomography (CT, a procedure to evaluate for intracranial bleeding).
-He did not know there was a delay in emergency care for Resident #1 after her fall that caused a head injury.
-The delay in Resident #1 receiving emergent care, including a CT scan, could have lead to a delayed diagnosis of an intracranial bleed which could have lead to death.

Interview with an Administrator on 08/03/22 at 12:30pm revealed:
-The day shift MA was responsible for contacting the HWD immediately after Resident #1's unwitnessed fall.
-The day shift MA should have reported Resident #1's vitals, location of the fall and any unusual behaviors to the HWD, then the HWD would have given directions on the next steps to take.
-It was not acceptable that the day shift MA put Resident #1 in bed without taking vitals and reporting the fall to the HWD.
-Failure to report to the HWD, the night shift MA and not calling 911 was considered abandonment and neglect.
-She was aware that Resident #1 fell on 06/26/22 but she was not aware that the fall occurred on day shift.
-She assumed the fall happened on night shift since the night shift MA reported the fall and called 911.
-The fall policy stated any unwitnessed fall or a fall with a head injury required an immediate call to 911.
-She expected the day shift MA to follow all of the

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D 271	Continued From page 10 facility's policies and procedures. _____ The facility failed to immediately respond and provide care for Resident #1 when she fell, hit her head and complained of pain in her head and hip and by assisting her back to bed, resulting in 911 being contacted an hour and ten minutes after Resident #1 demonstrated signs and symptoms of a stroke. This delay in responding emergently to Resident #1's fall resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/03/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 3, 2022.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up 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 timely follow up for 1 of 5 sampled residents related to missing a medication used to treat dementia related behaviors (Resident # 3). The findings are: Review of Resident #3's current FL2 dated 07/06/22 revealed: -Diagnoses included dementia.	D 273		

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-An order for divalproex sprinkles 125mg (a medication used to stabilize moods) twice a day.
-The recommended level of care was the special care unit (SCU).

Review of Resident #3's physician's orders dated 04/25/22 revealed an order for divalproex sprinkles 125mg twice daily.

Review of Resident #3's June 2022 electronic medication administration records (eMAR) revealed:
-An entry for divalproex sprinkles 125mg scheduled twice a day at 8:00am and 8:00pm.
-Divalproex sprinkles were documented as not administered forty two times.
-The reason for not administering the medication was documented in the notes as "waiting on medication" or "waiting on arrival".

Review of Resident #3's July 2022 eMAR revealed:
-An entry for divalproex sprinkles 125mg scheduled twice a day at 8:00am and 8:00pm.
-Divalproex sprinkles was documented as not administered twenty four times.
-The reason for not administering the medication was documented in the notes as "waiting on refill from pharmacy".

Review of Resident #3's charting notes revealed:
-On 04/23/22 Resident #3 became very agitated, punched and kicked staff then fell to the floor.
-He was sent to the emergency department due to pain in his left leg and the physician was notified.
-On 05/27/22 Resident #3 was out of divalproex sprinkles due to the medication not arriving in the mail.
-The Health and Wellness Director (HWD) asked

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the MA to call the pharmacy in the morning (05/28/22) and contact the physician.
-On 07/17/22 Resident #3 refused care from all of the staff and was very combative.

Interview with a MA on 08/03/22 at 10:35am revealed:
-She normally contacted the Primary Care Provider (PCP) when a resident missed medication due to the medication not being in the facility.
-She did not contact Resident #3's PCP to inform him that Resident #3 had missed divalproex sprinkles because the HWD and Administrator told her that they were handling the situation.
-She had never been instructed to contact a mental health provider to inform them of residents' missing medications.

Interview with a second MA on 08/04/22 at 2:00pm revealed:
-She was aware that Resident #3 had run out of divalproex sprinkles in June 2022 and was told that the medication was ordered but it took a while to arrive.
-Resident #3's medications came from his preferred outside pharmacy and not the facility's pharmacy, so she faxed them the order for divalproex sprinkles to reorder the medication.
-She did not inform the mental health provider about Resident #3 missing several doses of the medication since she had contacted the Resident #3's pharmacy to reorder it.

Telephone interview with Resident #3's family member on 08/04/22 at 9:43am revealed:
-She was aware Resident #3's preferred pharmacy refused to dispense the divalproex sprinkles.
-She paid the facility's contracted pharmacy to

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dispense the medication and was not aware if Resident #3 had missed doses.

Interview with the Resident Care Coordinator (RCC) on 08/04/22 at 2:05pm revealed:
-She had been working at the facility for about one month.
-She knew to contact the pharmacy if a resident missed medication due to the medication not being in the facility.
-She had not been trained on when to contact the provider if a resident missed medication.

Interview with the HWD on 08/03/22 at 2:30pm, on 08/04/22 at 10:15am and 1:00pm revealed:
-She was aware that Resident #3 was out of divalproex sprinkles at the end of May 2022 and contacted the facility's contracted pharmacy to supply the medication.
-She knew the facility's contracted pharmacy sent a thirty-day supply of the divalproex sprinkles in July 2022 and thought the pharmacy sent medication in June 2022 as well.
-She was not aware that the facility did not receive divalproex sprinkles for Resident #3 in June 2022.
-The MA should have contacted the mental health provider to inform her that Resident #3 had missed doses of divalproex sprinkles.

Telephone interview with Resident #3's Mental Health Provider on 08/03/22 at 3:47pm revealed:
-She started prescribing divalproex sprinkles for Resident #3 in April 2022 to treat his dementia and dementia related behaviors.
-The facility typically contacted her to request different medications for residents but did not alert of her if residents missed or refused medications.
-The last time the facility contacted her about

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D 273	Continued From page 14 Resident #3 was in April 2022. -She visited Resident #3 on a monthly basis and staff had never informed her that he had missed multiple doses of divalproex sprinkles. -Resident #3 could have experienced more dementia related behaviors, like the ones that caused him to fall and be sent to the emergency department on 04/23/22, due to missing several doses of divalproex sprinkles. -She expected the facility to contact her when they could not get the medication in the building. Interview with an Administrator on 08/04/22 at 12:45pm and 3:20pm revealed: -She was the Administrator for another facility that came in to help while the facility's Administrator was on vacation. -If a resident ran out of a medication then the backup pharmacy should be contacted. -If the backup pharmacy cannot deliver the medication that day then the MA was expected to contact the ordering provider to inform them of the situation. -The provider should have been contacted on the first day that Resident #3 did not have any divalproex sprinkles to take. Based on interviews and observations it was determined that Resident #3 was uninterviewable.	D 273		
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	D 358		

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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 interviews, observations and record reviews, the facility failed to ensure medication used to stabilize mood was administered as ordered for 1 of 5 sampled residents (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 07/06/22 revealed:
-Diagnoses included dementia.
-An order for divalproex sprinkles 125mg (a medication used to stabilize moods) twice daily.

Review of Resident #3's physician's orders dated 04/25/22 revealed an order for divalproex sprinkles 125mg twice daily.

Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed:
-An entry for divalproex sprinkles 125mg, scheduled twice a day at 8:00am and 8:00pm.
-There was documentation divalproex sprinkles 125mg were administered at 8:00am from 06/01/22 to 06/04/22 and on 06/13/22, 06/19/22, 06/22/22, 06/29/22 and 06/30/22.
-There was documentation divalproex sprinkles 125mg were administered at 8:00pm from 06/01/22 to 06/05/22 and on 06/25/22, 06/27/22, 06/29/22 and 06/30/22.
-There was documentation divalproex sprinkles 125mg were not documented as administered at 8:00am from 06/05/22 to 06/12/22, 06/14/22 to 06/18/22, 06/20/22 to 06/21/22 and 06/23/22 to

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06/28/22.
-There was documentation divalproex sprinkles 125mg were not documented as administered at 8:00pm from 06/06/22 to 06/24/22, 06/26/22 and 06/28/22.

Review of Resident #3's July 2022 eMAR revealed:
-An entry for divalproex sprinkles 125mg scheduled twice a day at 8:00am and 8:00pm.
-There was documentation divalproex sprinkles 125mg were administered at 8:00am from 07/05/22 to 07/07/22, 07/09/22, 07/13/22, 07/19/22 to 07/20/22, 07/26/22 to 07/27/22 and 07/29/22 to 07/31/22.
-There was documentation divalproex sprinkles 125mg were administered at 8:00pm from 07/04/22 to 07/15/22, 07/18/22 to 07/19/22, 07/21/22 to 07/22/22, 07/24/22 to 07/31/22.
-There was documentation divalproex sprinkles 125mg were not documented as administered at 8:00am from 07/01/22 to 07/04/22, 07/08/22, 07/10/22 to 07/12/22, 07/14/22 to 07/18/22, 07/21/22 to 07/25/22 and 07/28/22.
-There was documentation divalproex sprinkles 125mg were not documented as administered at 8:00pm from 07/02/22 to 07/03/22, 07/16/22 to 07/17/22, 07/20/22 and 07/23/22.

Interview with a medication aide (MA) on 08/03/22 at 10:35am revealed:
-Resident #3 received most of his medications from his preferred outside pharmacy and not the facility's pharmacy, she had to call them when it was time to reorder the medications.
-He also received a couple of medications from the facility's contracted pharmacy and those were on a monthly cycle fill so she did not have to contact the pharmacy each month to reorder.
-She remembered Resident #3's divalproex

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sprinkles took "a while" to get to the facility but could not remember which pharmacy supplied the medication.
-If a resident was out of medication then she was supposed to inform the Health and Wellness Director (HWD) or the Administrator or call the pharmacy.
-She did not call the pharmacy when Resident #3 was out of divalproex sprinkles because the HWD and Administrator told her they would take care of it.

Interview with a second MA on 08/04/22 at 2:00pm revealed:
-She was told Resident #3's divalproex sprinkles were ordered but it was taking the medication a while to arrive.
-She faxed the order for the divalproex sprinkles to Resident #3's preferred outside pharmacy multiple times and did not hear back from them.
-The medication did not arrive so she told the HWD and the Administrator at the facility and made a note on the eMAR that the facility was waiting on the medication to arrive.

Interview with Resident Care Coordinator (RCC) on 08/04/22 at 2:05pm revealed:
-She had been working at the facility for a month and had not been asked to contact the pharmacy about Resident #3's divalproex sprinkles.
-If a resident ran out of medication, the MAs were supposed to notify the pharmacy and the pharmacy could enter a hold order on the eMAR until the medication arrived.
-The HWD or Administrator could contact the pharmacy if the MAs needed help.

Telephone interview with Resident #3's family member on 08/04/22 at 9:43am revealed:
-The resident's preferred pharmacy refused to

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dispense the divalproex sprinkles until Resident #3 could be seen by the preferred pharmacy's provider.
-She was not able to take Resident #3 to the preferred pharmacy's provider so she agreed to pay for the medication from the facility's contracted pharmacy.
-She did not keep the receipts from the contracted pharmacy and was not sure when the medication was delivered to the facility or how long Resident #3 had been using the contracted pharmacy.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/03/22 at 3:13pm revealed:
-The pharmacy had an order for divalproex sprinkles 125mg twice a day that was signed on 04/25/22.
-On 04/27/22, divalproex sprinkles 125mg, 28 pills were dispensed to the facility.
-On 05/16/22, divalproex sprinkles 125mg, 14 pills were dispensed to the facility.
-On 05/28/22, divalproex sprinkles 125mg, 14 pills were dispensed to the facility.
-On 07/27/22, divalproex sprinkles 125mg, 60 pills were dispensed to the facility.
-The pharmacy did not dispense divalproex sprinkles to the facility in June 2022.
-On 05/15/22, the facility sent the pharmacy a message and requested one week of divalproex sprinkles 125mg since they were waiting on the divalproex sprinkles to arrive from the VA.
-On 05/25/22, the facility sent the pharmacy a message and requested more divalproex sprinkles 125mg since the medication had not arrived from Resident #3's preferred pharmacy.

Observation of Resident #3's medication on hand on 08/03/22 at 10:39am revealed divalproex

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sprinkles 125mg were dispensed on 07/27/22 from the facility's contracted pharmacy.

Interview with the HWD on 08/03/22 at 2:30pm and on 08/04/22 at 1:00pm revealed:
-Resident #3's preferred pharmacy did not supply the divalproex sprinkles so the facility had to get the medication from their contracted pharmacy.
-She was aware that he missed doses of divalproex sprinkles at the end of May 2022 and contacted the preferred pharmacy as well as the facility's contracted pharmacy.
-The preferred pharmacy told her the medication was reordered would come in the mail.
-The divalproex sprinkles did not arrive in the mail, so she ordered the medication from the facility's contracted pharmacy.
-Typically, a MA would tell her when a residents' medication did not arrive.
-She was not aware that the contracted pharmacy did not dispense the divalproex sprinkles in June 2022.
-A MA should have requested the medication from the backup pharmacy on the day Resident #3's divalproex sprinkles ran out.
-She and the Administrator typically did medication cart audits and eMAR audits every month, but she was not aware that Resident #3 missed doses of divalproex sprinkles in June 2022 and July 2022.

Telephone interview with Resident #3's mental health provider on 08/03/22 at 3:47pm revealed:
-She started prescribing divalproex sprinkles for Resident #3 in April 2022 to treat his dementia and dementia related behaviors.
-If he missed several doses of divalproex sprinkles then he could experience behaviors related to his dementia.

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D 358	Continued From page 20 Interview with an Administrator on 08/04/22 at 12:45pm revealed: -She was the Administrator for another facility that came in to help while the facility's Administrator was on vacation. -She expected the MA to call Resident #3's preferred pharmacy to ask why Resident #3's divalproex sprinkles were not delivered and then inform the HWD or Administrator. -When the facility's contracted pharmacy was not able to provide the divalproex sprinkles, the MA should have called the backup pharmacy to fill the medication. -The MA should have also placed a hold on the eMAR until the medication was in the building. Based on interviews and observations it was determined that Resident #3 was uninterviewable.	D 358		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to personal care and supervision. The findings are: Based on record reviews and interviews, the facility failed to ensure an immediate response	D914		

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D914	Continued From page 21 and intervention for 1 of 5 sampled residents (#1) in accordance with the facility's policies and procedures who had an unwitnessed fall.	D914		