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D 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on September 14, 2022 to September 15, 2022. The complaint investigation was initiated by the Bertie County Department of Social Services on July 1, 2022.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled resident's (#1, #2) orders were implemented related to lab work (#1, #2) and vital signs (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 04/26/22 revealed: -Diagnoses included dementia with behaviors. -Resident #1 was incontinent of bladder. a. Review of Resident #1's hospital discharge summary dated 05/10/22 revealed he was admitted to the hospital 05/03/22 with a diagnosis	D 276		

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of urinary tract infection (UTI).

Review of Resident #1's physician order sheet dated 05/11/22 revealed there was an order to obtain a urinalysis (U/A) on 05/14/22 with results to primary care provider (PCP).

Review of Resident #1's record on 09/15/22 revealed there were no U/A results.

Review of Resident #1's emergency department (ED) to hospital admission revealed:
-Resident #1 was sent to the ED on 06/22/22 by the facility because he was having bleeding from his mouth.
-Resident #1 was admitted to the hospital on 06/22/22 with a diagnosis of UTI.
-Resident #1 passed away in the hospital on 06/25/22 due to septic shock (a widespread infection that causes organ failure).

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-The facility did not obtain a U/A on Resident #1 because he was incontinent of urine.
-She spoke to a home health nurse about obtaining a U/A for Resident #1 and the nurse said she would try to get one.
-She spoke to Resident #1's primary care provider (PCP) and made him aware that the facility was unable to obtain a U/A because the resident was incontinent of urine.
-The PCP did not give any new orders for Resident #1 and did not discontinue the U/A.
-She did not document her conversation with the home health nurse or the PCP.

Review of Resident #1's client coordination note report dated 05/11/22, 05/20/22, 05/25/22, and 06/01/22 revealed a home health nurse visited

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the resident on these days and there was no documentation that they had been notified by facility staff that Resident #1 needed a U/A.

Review of Resident #1's PCP progress note dated 05/24/22 revealed that he visited the resident and there was no documentation that he had been notified that the facility was unable to obtain a U/A on Resident #1.

Interview with the Administrator on 09/15/22 at 3:37pm revealed he expected resident's lab work to be done when it was ordered by the PCP.

Interview with the facility's contacted PCP on 09/14/22 at 10:11am revealed Resident #1's former PCP no longer worked for the facility's contracted physician group.

Telephone interview with the facility's contracted PCP on 09/15/22 at 2:39pm revealed:
-She expected residents to receive U/As as ordered because elderly people could quickly go into sepsis (a life threatening condition when a person's body responds to an infection).
-She would expect to be notified if the facility could not obtain a U/A on a resident.
-If she were notified by the facility that they could not obtain a U/A on a resident she would see if someone could obtain an in and out urinary catheterization on the resident.
-If they were unable to obtain a urinary catheterization, she would instruct facility staff to watch the resident closely for confusion or fever and report symptoms to her and if these symptoms were reported to her she would send the resident to the ED so they could be evaluated for UTI.

b. Review of Resident #1's psychiatry initial

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consult note dated 04/27/22 revealed:
-There were orders for complete blood count (CBC), comprehensive metabolic panel (CMP), and a valproic acid level to be done in 1 week, fax results to mental health provider (A CBC measures components in the blood such a red blood cells, white blood cells, and platelets. A CMP measures blood sugar levels, electrolyte and fluid balance, kidney function, and liver function. Valproic acid is a medication used to treat seizures and bipolar disorder).
-There was an order for Depakote 125mg three times a day (Depakote is valproic acid).

Review of Resident #1's psychiatry progress note dated 05/11/22 revealed:
-Resident #1 recently started Depakote.
-She requested a Depakote level on Resident #1, but it was not done.
-There was an order for CBC, CMP, and valproic acid level, fax results to mental health provider.

Review of Resident #1's record revealed there was a CBC, CMP, and valproic acid level obtained for Resident #1 on 05/16/22.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-The facility's mental health provider emailed resident's progress notes with orders to her after each resident visit.
-The phlebotomist came out to the facility weekly to draw lab work.
-It was her responsibility to make sure ordered labs were obtained on residents.
-She must have missed seeing the lab work ordered for Resident #1 on 04/27/22.

Interview with the Administrator on 09/15/22 at 3:37pm revealed:

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-He expected the facility to ensure that all labs were done as ordered and reported to the PCP.
-Lab work for residents should be done as soon as possible after it was ordered by the PCP.

Telephone interview with Resident #1's mental health provider on 09/14/22 at 2:05pm revealed:
-She started Resident #1 on a medication that required a valproic acid level to be tested to ensure the resident's level was within therapeutic range and not at a toxic level.
-It was important to ensure that Resident #1's valproic acid level was drawn as ordered because if the resident's level was too high it might cause the resident to have hepatic (liver) toxicity or thrombocytosis (a disorder where the blood produces too many platelets).

2. Review of Resident #2's current FL-2 dated 07/18/22 revealed diagnoses included dementia, hypertension, diabetes, and coronary artery disease.

a. Review of Resident #2's mental health provider orders dated 06/22/22 revealed there was an order to check a Valproic Acid level and fax the results to the provider.

Review of Resident #2's mental health provider visit note dated 06/22/22 revealed:
-The resident was on medications to manage her behavioral changes related to a cognitive decline, including a medication that required monitoring of Valproic Acid level.
-She ordered a Valproic Acid level to ensure that the resident was on the correct dose of Depakote.

Review of Resident #2's mental health provider orders dated 07/20/22 revealed there was an

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order to check a Valproic Acid level and fax the results to the provider.

Review of Resident #2's mental health provider visit note dated 07/20/22 revealed:
-She requested a Valproic Acid level on the last visit which was 06/22/22 and it was not completed.
-Resident #2 was on medication to manage her mood and behavioral changes related to cognitive decline which required monitoring of Valproic Acid levels.

Review of Resident #2's mental health provider visit note dated 08/03/22 revealed:
-She requested Valproic Acid levels related to Resident #2's use of medication to manage her mood and behavioral changes.
-The lab work requested had not been completed on 06/22/22 and 07/20/22.

Review of Resident #2's mental health provider orders dated 08/17/22 revealed there was an order to fax provider the lab work that was requested on 06/22/22.

Review of Resident #2's mental health provider visit note dated 08/17/22 revealed:
-Valproic Acid level studies had been requested June 2022 and she has yet to get the results.
-She ordered the lab work to be completed again today and to be faxed to her.

Review of Resident #2's facility record revealed there was no Valproic Acid level completed on 06/22/22, 07/20/22, and 08/03/22 as ordered.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-She received the mental health provider's

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progress notes and orders via email after the visit.
-The phlebotomist came out weekly to draw lab work.
-She filled out paperwork for Resident #2 to receive a Valproic Acid level on 08/01/22.
-She was not aware why the lab work was not completed.
-It was her responsibility to ensure that labs were drawn as ordered and results sent to the providers as ordered.

Interview with the Administrator on 09/15/22 at 3:37pm revealed:
-He expected Resident #2's Valproic Acid level to be drawn and reported as ordered by the provider.
-It was the SCC responsibility to ensure that Resident #2's Valproic Acid was completed as ordered.

Telephone interview with Resident #2's mental health provider on 09/15/22 at 2:06pm revealed:
-Resident #2 was on chronic medication that required a Valproic Acid level to be tested to ensure the resident's level was within therapeutic range and not at a toxic level.
-She asked the SCC during her tele-health visits on 07/20/22, 08/03/22, and 08/17/22 where the Valproic Acid level was for Resident #2 and was told that the laboratory that draws the facility's lab work had not come out to the facility yet.
-It was important to ensure that Resident #2's Valproic Acid level was drawn as ordered because if the resident's level was too high it might cause the resident hepatic (liver) toxicity or thrombocytosis (a disorder where your blood produces too many platelets).

b. Review of Resident #2's current FL-2 dated

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07/18/22 revealed there was an order for monthly vital signs.

Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to check vital signs monthly, scheduled for the 5th of the month from 7:00am-3:00pm.
-Vital signs were documented as not done with comment "resident bed ridden" on 08/05/22.

Review of Resident #2's September 2022 eMAR revealed:
-There was an entry to check vital signs monthly, scheduled for the 5th of the month from 7:00am-3:00pm.
-Vital signs were documented as not done with comment "resident bed ridden" on 09/05/22.

Telephone interview with a medication aide (MA) on 09/14/22 at 10:25am revealed:
-She documented not done on the residents eMAR for vital signs in August 2022 and September 2022.
-She should have completed the vital signs on the resident.
-The vital sign tasks popped up on the computer as a task to complete for their shift.
-It was her responsibility to complete Resident #2's vital signs as ordered.

Interview with the lead MA on 09/14/22 at 10:55am revealed:
-The MAs were responsible for taking resident's monthly vital signs.
-It was not appropriate to not take a resident's vital signs because they were bed bound.
-Resident #2's vital signs had not been discontinued by the primary care provider (PCP).

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-She was not aware that Resident #2 did not receive monthly vital signs as ordered by the PCP.

Interview with the Special Care Coordinator (SCC) on 09/14/22 at 3:00pm revealed:
-She was not aware that Resident #2 did not have monthly vital signs completed as ordered in August and September of 2022.
-It was not acceptable to not perform vital sign checks on a resident because they were bed bound.
-It was the MAs responsibility to check resident's vital signs as ordered by the PCP.
-Resident #5 has a history of high blood pressure and was on medications for high blood pressure so it was important to monitor her vital signs as ordered.
-There was no eMAR audit process in place.

Interview with the Administrator on 09/15/22 at 3:37pm revealed he expected all orders to be completed as ordered by the PCP including Resident #2's monthly vital signs.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful.

_____

The facility failed to ensure that an ordered urinalysis was obtained on a resident (#1) after the resident was discharged from the hospital with a urinary tract infection that put the resident at risk for developing sepsis (a complication caused by an infection) and that ordered lab work was obtained on residents (#1, #2) including lab work to check medication levels that could become toxic and cause hepatic (liver) toxicity or thrombocytosis (a disorder where the blood

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D 276	Continued From page 9 produces too many platelets). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 15, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 30, 2022.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#2, #5) observed during the medication pass used for heart health, Vitamin D deficiency and iron replacement (#2), a pain medication that was discontinued (#2), and eye drops (#5) and for 2 of 3 sampled residents (#1, #2) medications that were administered after being discontinued by the mental health provider (#1,#2), and a medication	D 358		

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that was discontinued after hospitalization (#2).

The findings are:

1. The medication error rate was 24% as evidenced by the observation of 5 errors out of 31 opportunities during the 8:00am medication pass on 09/14/22.

a. Review of Resident #2's current FL-2 dated 07/18/22 revealed:
-Diagnosis included dementia, hypertension, diabetes, and coronary artery disease.
-There was an order for Lyrica 50mg three times a day (Lyrica is a medication used to treat nerve and muscle pain).

Review of Resident #2's subsequent physician's orders dated 08/15/22 revealed there was an order to discontinue Lyrica 50mg.

Observation of the morning medication pass on 09/14/22 revealed:
-The medication aide (MA) prepared morning medications for Resident #2, including one Lyrica 50mg.
-The MA administered Resident #2 oral medications including Lyrica 50mg at 8:31am.

Review of Resident #2's September 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lyrica 50mg to be given three times a day, scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Lyrica 50mg was documented as administered on 09/14/22 at 8:00am.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/15/22 at

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9:02am revealed they did not receive an order on 08/15/22 to discontinue Lyrica 50mg so the medication was still active on Resident #2's profile and being dispensed.

Interview with the MA on 09/14/22 at 10:56am revealed:
-The Special Care Coordinator (SCC) was responsible for processing orders and discontinuing them on the eMAR.
-MAs did not have the ability to discontinue or process a medication.
-She administered Resident #2's Lyrica based on the eMAR and what the pharmacy sent.
-She was not aware that Lyrica was discontinued on 08/15/22.

Interview with the SCC on 09/14/22 at 3:00pm revealed:
-She thought that pharmacy had discontinued the Lyrica order on 08/15/22.
-She was responsible for ensuring that medication orders were faxed to the pharmacy, discontinued on the eMAR and pulled from the medication cart.

Interview with the Administrator on 09/14/22 at 3:37pm revealed the lead MA and SCC were responsible for faxing pharmacy orders, processing orders on the eMAR and removing the medications from the medication cart when there was a change in orders.

Review of electronic communication by Resident #2's primary care provider (PCP) dated 09/14/22 at 7:17pm revealed:
-She received a call on 09/14/22 from the facility that Resident #2 was still receiving Lyrica 50mg.
-She was trying gradual dose reduction since the resident was on a number of different

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medications.
-Resident #2 "did not suffer any ill effects from continuing medication".
-She advised staff to discontinue Lyrica today (09/14/22) as ordered previously.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

b. Review of Resident #2's physician's order dated 08/15/22 revealed:
-There was an order for Ferrous Sulfate delayed release/enteric coated (DR/EC) 325mg twice a day (a medication used to treat iron deficiency.) An Enteric Coated Ferrous Sulfate has a special coating to prevent stomach irritation and upset and reduce the risk of stomach bleeding and should not be crushed or chewed to maintain the protective coating of the tablet.)
-There was an order that all medications may be given by mouth and/or crushed (check do not crush list) and placed in applesauce or pudding unless otherwise noted.

Observation of the 8:00am medication pass on 09/14/22 revealed:
-The medication aide (MA) prepared morning medications for Resident #2, including one Ferrous Sulfate DR/EC 325mg tablet.
-The MA crushed Resident #2's oral medications, including the DR/EC, mixed them in yogurt and administered them to the resident at 8:31am.

Observation of Resident #2's medications on

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hand on 09/14/22 revealed Ferrous Sulfate DR/EC was in her morning multiple medications pack and evening multiple medications pack.

Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Ferrous Sulfate (DR/EC) 325mg twice a day, scheduled for administration at 8:00am and 8:00pm.
-Ferrous Sulfate (DR/ER) 325mg was documented as administered on 09/14/22 at 8:00am.
-There was no information noted on the eMAR to indicate the medication should not be crushed.

Review of the facility's Do Not Crush (DNC) medication list, last updated 04/09/10 revealed: Ferrous Sulfate was included on the list as a medication that should not be crushed due to the enteric coating.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/22 at 9:02am revealed:
-Ferrous Sulfate was enteric coated and therefore should not be crushed.
-He was not familiar with the DNC list that the facility utilized.
-Resident #2 received some of her medications in a multiple medication packet and Ferrous Sulfate was one of them.
-The pharmacy profiled the resident's medications but was not responsible for activating them on the eMAR or filling out special instructions as in DNC because they were not aware when residents needed their medications crushed.

Interview with the MA on 09/14/22 at 10:55am

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revealed:
-She was not aware that Ferrous Sulfate was on the DNC list.
-The DNC list was on the medication cart.
-When residents had medications that could not be crushed, there was a warning that populated on the eMAR.
-Resident #2's Ferrous Sulfate did not populate any instructions to DNC when it popped on the eMAR.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-She was not aware that Resident #2 had a medication that was not to be crushed according to the facility's DNC list.
-She expected MAs to check the DNC and not crush medications that were enteric coated or delayed release.

Interview with the Administrator on 09/15/22 at 3:37pm revealed he expected MAs to follow the DNC list and not administer medications that were on the DNC list, including Resident #2's Ferrous Sulfate.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

c. Review of Resident #2's physician's orders dated 08/15/22 revealed there was an order for Aspirin 81mg to be given once daily (Aspirin is a preventative anti-inflammatory medication used for heart health).

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D 358	Continued From page 15 Review of Resident #2's subsequent physician orders dated 07/18/22 revealed there was an order for Aspirin 81mg daily. Observation of the 8:00am medication pass on 09/14/22: -The medication aide (MA) prepared and administered ten medications to Resident #2 at 8:31am. -Aspirin 81mg was not offered or prepared and administered to the resident when she received her other medications. Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg daily, scheduled for administration at 8:00am. -Aspirin 81mg was documented as administered on 09/14/22 at 8:00am. Observation of Resident #2's medications on hand on 09/14/22 at 10:55am revealed Resident #2 did not have any Aspirin 81mg on the medication cart. Interview with the MA) on 09/14/22 at 10:56am revealed: -Resident #2 did not have any Aspirin on the medication cart. -She was going to call the pharmacy to send Resident #2's Aspirin. -She should have charted on the eMAR as not administered under the 09/14/22 Aspirin dose since the resident did not receive it. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/22 at 9:02am revealed:	D 358		

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-They did not have an active order for Resident #2's Aspirin 81mg dose.
-The pharmacy had a discontinue order for Aspirin 81mg on 07/05/22 for Resident #2.
-Prior to 07/05/22, Resident #2 received her Aspirin 81mg in her multiple medication packet.
-The pharmacy did not receive the signed physician's orders dated 07/18/22.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-She was not sure why there was no Aspirin available for administration for Resident #2.
-The MA should not have documented administered on the eMAR if the resident did not receive the medication, including Resident #2's Aspirin 81mg dose.
-She expected Resident #2 to have medications available for administration including her Aspirin.

Interview with the Administrator on 09/15/22 at 3:37pm revealed he expected Resident #2 to receive her medications as ordered, including her Aspirin.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

d. Review of Resident #2's physician orders dated 08/15/22 revealed there was an order for Vitamin D3 25mcg daily (Vitamin D3 is a vitamin used to replace Vitamin D3 deficiency).

Observation of the 8:00am medication pass on

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09/14/22:
-The medication aide (MA) prepared and administered ten medications to Resident #2 at 8:31am.
-Vitamin D3 25mcg was not offered or prepared and administered to the resident when she received her other medications.

Observation of Resident #2's medications on hand on 09/14/22 at 10:55am revealed Resident #2 had Vitamin D3 25mcg on the medication cart available for administration in a bubble packet card.

Interview with the MA on 09/14/22 at 10:56am revealed:
-She documented Vitamin D3 on the eMAR for Resident #2 but only pulled out two bubble packets and forgot the third which was her Vitamin D3.
-She should not have charted administered on the eMAR for Resident #2's Vitamin D3 but was nervous and thought that she had given it with her other medications.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed she expected Resident #2 to receive all of her medications as ordered including her Vitamin D3.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

e. Review of Resident #5's current FL-2 dated

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02/07/22 revealed diagnoses included dementia, diabetes, and a history of falls.

Review of Resident #5's physician's orders dated 08/15/22 revealed there was an order for Restasis 0.05% eye drops, 1 drop in each eye twice a day (used to increased tear production which helps prevent inflammation).

Observation of the morning medication pass on 09/14/22 revealed:
-The medication aide (MA) administered Resident #5's oral medications at 8:40am at the nurses' station.
-The MA did not offer or administer Resident #5 Restasis eye drops during the morning medication pass.
-At 8:48am the MA sanitized her hands and the resident left the nurses station to use the bathroom in her room.

Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Restasis 0.05%, with instructions to instill 1 drop into both eyes twice a day, scheduled for administration at 8:00am and 8:00pm.
-Restasis 0.05% was documented as administered on 09/14/22 at 8:00am.

Observation of Resident #5's medications on hand on 09/14/22 at 10:45am revealed Resident #5 had a container of Restasis 0.05% single dose vials available for administration on the medication cart.

Interview with Resident #5 on 09/14/22 at 9:30am revealed:
-She did not receive her eye drops this morning.

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-She had eye drops ordered because her eyes get dry and itchy.
-The MA did not come find her after she left the nurses station to give her the eye drops.
-She was not having dry eyes now, but if she did not get the eye drops today, her eyes would be dry.

Interview with the MA on 09/14/22 at 10:45am revealed:
-She forgot to administer Resident #5's eye drops.
-She usually administers Resident #5's eye drops after her pills and before her insulin, but there were no facial tissues on the cart this morning.
-She was going to go get tissues and then administer Resident #5's eye drops but had forgotten.
-She should not have charted as administered on the eMAR until she administered the eye drops.

Interview with the Special Care Coordinator (SCC) on 09/14/22 at 11:30am revealed:
-She expected the MA to administer Resident #5's Restasis 0.05% eye drops as ordered.
-Resident #5 was ordered Restasis 0.05% for dry eyes.

Interview with the Administrator on 09/14/22 at 2:15pm revealed he expected medications to be administered as ordered including Resident #5's eye drops.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful.

2. Review of Resident #2's Mental Health Provider (MHP) note dated 06/20/22 revealed:

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-There was an order to start Namenda 7mg once a day for 30 days then discontinue (Namenda is a medication used to slow the progression of Alzheimer's disease).
-Resident #2 was on Namenda for treatment of a cognitive disorder.
-Due to Resident #2's chronic kidney disease and progressive decline in renal function, Namenda was tapered to a lower dose of 7mg to try for gradual dose reduction.

a. Review of Resident #2's MHP note dated 07/20/22 revealed:
-There was an order to discontinue Namenda 7mg.
-Resident #2 was on Namenda to support cognitive health.
-Gradual reduction of Namenda was started, but despite clear orders to discontinue the medication, the resident continued to receive it.

Review of Resident #2's MHP note dated 08/03/22 revealed:
-There was an order to discontinue Namenda 7mg.
-There was an order from Resident #2's previous visit in July of 2022 to discontinue Namenda but it was never completed.

Review of Resident #2's MHP note dated 08/17/22 revealed an order to discontinue Namenda 7mg.

Review of Resident #2's July 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Namenda 7mg once a day with instructions to take for 30 days and then discontinue, scheduled for administration at 8:00am.

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-Namenda 7mg was documented as administered from 07/01/22 through 07/02/22 and 07/06/22 through 07/31/22 at 8:00am.
-Resident #2 was in the hospital on 07/04/22 and 07/05/22.

Review of Resident #2's August 2022 eMAR revealed:
-There was an entry for Namenda 7mg once a day with instructions to take for 30 days and then discontinue, scheduled for administration at 8:00am.
-Namenda 7mg was documented as administered from 08/01/22 through 08/11/22 and 08/16/22 at 8:00am.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-She received the MHP notes for Resident #2 via email after the visit.
-She was responsible for faxing the orders to the pharmacy.
-Sometimes the pharmacy entered a stop date on the orders.
-She did not recall if she entered the order or if pharmacy did for Resident #2's Namenda.
-It was her responsibility that medications that were discontinued were removed from the eMAR and taken off of the medication cart.

Telephone interview with Resident #2's MHP on 09/15/22 at 2:06pm revealed:
-She tried multiple times to discontinue Resident #2's dose of Namenda to gradually reduce the resident to come off of the medication.
-The resident has compromised kidney function because of her chronic kidney disease.
-Continuing the Namenda when it was supposed to be discontinued may have caused 2-5% kidney injury.

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D 358	Continued From page 22 b. Review of Resident #2's hospitalization discharge orders dated 07/05/22 revealed: -There was an order to discontinue Aspirin 81mg daily (a preventative anti-inflammatory medication used for heart health). -She was hospitalized for general weakness and high levels of calcium in her blood. Review of Resident #2's subsequent physician orders dated 07/18/22 revealed there was an order for Aspirin 81mg daily. Review of Resident #2's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg daily, scheduled for administration at 8:00am. -Aspirin 81mg was documented as administered from 07/01/22 through 07/03/22 at 8:00am. -Resident #2 was hospitalized from 07/04/22 through 07/05/22 and Aspirin 81mg was documented as not administered. -Aspirin 81mg was documented as administered from 07/06/22 through 07/11/22, 07/13/22 though 07/16/22, 07/18/22 through 07/22/22, and 07/30/22 to 07/31/22 at 8:00am. -Aspirin 81mg was documented as not administered with reason being 'on hold' on 07/11/22, 07/12/22, 07/17/22, 07/23/22 through 07/29/22 at 8:00am. Observation of Resident #2's medications on hand on 09/14/22 at 10:55am revealed Resident #2 did not have any Aspirin 81mg on the medication cart. Interview with the medication aide (MA) on 09/14/22 at 10:56am revealed: -Resident #2 did not have any Aspirin on the	D 358		

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medication cart.
-She was going to call the pharmacy to send Resident #2's Aspirin today (09/14/22)
-She should have charted on the eMAR as not administered under the 09/14/22 Aspirin dose since the resident did not receive it.
-She could not remember if Resident #2 had a bottle of Aspirin on the medication cart of if pharmacy sent it in a separate packet.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/22 at 9:02am revealed:
-They did not have an active order for Resident #2's Aspirin 81mg dose.
-The pharmacy had a discontinue order for Aspirin 81mg on 07/05/22 for Resident #2.
-Prior to 07/05/22, Resident #2 received her Aspirin 81mg in her multiple medication packet.
-The pharmacy did not receive the signed physician's orders dated 07/18/22 to restart the Aspirin.

Interview with the lead MA on 09/15/22 at 10:55am revealed:
-She was just recently (within the last two weeks) given access to discontinue medications on the eMAR.
-The SCC and her were responsible for ensuring that orders were faxed to the pharmacy and that the eMAR was adjusted accordingly.
-She was not aware of an audit process in place for ensuring medications that were discontinued were taken off the eMAR, including Resident #2's Aspirin.
-There was a bottle of Aspirin 81mg of house stock on the medication cart.
-Staff was pulling the Aspirin 81mg from the house stock on the medication cart to administer to Resident #2.

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D 358	Continued From page 24 Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed: -She was responsible for faxing hospital discharge orders to the pharmacy. -She was responsible for ensuring that the eMAR matched the orders. -She did not remember checking to ensure that the Aspirin was restarted by the pharmacy on 07/18/22. -There was not a process for who discontinued and restarted orders; sometimes the pharmacy did it and sometimes the facility was responsible for it. -She was not aware that staff was using the house Aspirin to administer Resident #2 her ordered medications. Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/14/22 at 3:50pm and 09/15/22 at 2:40pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. 3. Review of Resident #1's current FL-2 dated 04/27/22 revealed diagnoses included dementia with behaviors. Review of Resident #1's Resident Registered revealed he was admitted to the facility 04/15/22. Review of Resident #1's emergency department (ED) to admission note revealed Resident #1 passed away at the hospital 06/25/22. a. Review of Resident #1's hospital discharge summary dated 05/10/22 revealed he was	D 358		

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admitted to the hospital 05/03/22 with a diagnosis of urinary tract infection (UTI).

Review of Resident #1's physician order sheet dated 05/11/22 revealed there was an order for Augmentin 500mg twice a day for 7 days (Augmentin is an antibiotic).

Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Augmentin 500mg twice daily with meals for 7 days scheduled for administration at 8:00am and 5:00pm with a start date of 05/13/22 and an end date of 05/17/22.
-Augmentin 500mg was documented as administered from 05/13/22 to 05/17/22 at at 8:00am and 5:00pm.

Interview with the lead medication aide (MA) on 09/15/22 at 11:05am revealed:
-Resident #1 should have received all 7 days of Augmentin as ordered.
-The Augmentin orders appeared to have been put into the eMAR system wrong.
-The Special Care Coordinator (SCC) put medication orders on the eMAR.
-She was unsure what would have been done with any Augmentin that was left over for Resident #1.

Interview with the SCC on 09/15/22 at 3:00pm revealed:
-The facility's contracted pharmacy put medications on the eMAR and then she approved the medications.
-She was not sure why Resident #1's Augmentin was only scheduled on the eMAR for 5 days instead of 7 days.
-Resident #1 should have received all 7 days of

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Augmentin as ordered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/22 at 9:35am revealed:
-Fourteen tablets of Augmentin 500mg were dispensed for Resident #1 at 9:00pm on 05/11/22.
-Resident #1's Augmentin left the pharmacy at the noon medication run on 05/12/22.

Telephone interview with the facility's contracted primary care provider (PCP) on 09/15/22 at 2:39pm revealed:
-She expected residents to receive a full course of antibiotics as ordered.
-If a resident did not receive a full course of an antibiotic for a UTI it could lead to the resident developing another UTI.
-If a resident did not receive a full course of an antibiotic it could cause the resident to become resistant to the antibiotic in the future.

b. Review of a prescription for Resident #1 dated 04/27/22 revealed there was an order for tramadol 50mg every 6 hours as needed for pain for up to 5 days.

Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for tramadol 50mg every 6 hours as needed for pain for up to 5 days with a start date of 04/27/22 and no end date.
-Tramadol 50mg was documented as administered on 04/28/22 at 8:55am and 11:14pm and on 04/30/22 at 9:55am.

Review of Resident #1's May 2022 eMAR revealed:

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-There was an entry for tramadol 50mg every 6 hours as needed for pain for up to 5 days with a start date of 04/27/22.
-Tramadol 50mg was documented as administered on 05/19/22 at 6:17am and 05/24/22 at 10:00am.

Review of Resident #1's June 2022 eMAR revealed:
-There was an entry for tramadol 50mg every 6 hours as needed for pain for up to 5 days with a start date of 04/27/22.
-Tramadol 50mg was documented as administered on 06/01/22 at 10:43am.

Interview with the lead medication aide (MA) on 09/15/22 at 11:05am revealed it was the Special Care Coordinator's (SCC) responsibility to make sure a resident's medications were entered correctly on the eMAR.

Interview with the SCC on 09/15/22 at 3:00pm revealed:
-She knew when a medication should be discontinued because she read medication orders when they were received.
-When medications arrived from the pharmacy, she approved the medications on the eMAR.
-She put medication end dates on the eMAR or sometimes the pharmacy may enter end dates.
-Resident #1's tramadol should have been ended on the eMAR after 5 days as ordered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/15/22 at 9:35am revealed:
-Twenty tablets of tramadol 50mg were dispensed for Resident #1 on 04/27/22 with no refills on the order.
-Resident #1's tramadol should have been

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discontinued on the eMAR after 5 days as ordered.

c. Review of Resident #1's current FL-2 dated 04/27/22 revealed:
-There was an order for rivastigmine tartrate 3mg twice daily for dementia related behaviors.
-There was an order for clonazepam 0.5mg every day as needed for acute anxiety/agitation behaviors.
-There was an order for hydroxyzine 50mg every 6 hours as needed for nausea/restlessness/anxiety.
-There was an order for quetiapine 50mg every day as needed for agitation.

Review of Resident #1's psychiatry initial consult note dated 04/27/22 revealed:
-Resident #1 was prescribed low-dose rivastigmine for management of cognitive defects.
-It was not clear if Resident #1's rivastigmine was helpful and it was possible that it was contributing to worsening of his symptoms.
-It was concerning that Resident #1 was on 3 different medications as needed for behaviors, clonazepam, hydroxyzine, and quetiapine.
-There was an order to discontinue rivastigmine 3mg twice a day.
-There was an order to discontinue clonazepam 0.5mg daily as needed.
-There was an order to discontinue quetiapine 50mg daily as needed.

Review of Resident #1's hospital discharge instructions dated 05/10/22 revealed there was an order to discontinue rivastigmine 3mg.

Review of Resident #1's psychiatry progress note dated 05/11/22 revealed:
-Resident #1's rivastigmine was ordered to be

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discontinued on 04/27/22 because she was concerned it could be contributing to his behaviors.
-Rivastigmine was not discontinued by the facility for Resident #1 and was most likely contributing to his periodic behavioral concerns.
-She would make another attempt to discontinue Resident #1's rivastigmine.
-As needed clonazepam and quetiapine were still on Resident #1's electronic medication administration record (eMAR).
-Facility staff had requested a refill of Resident #1's clonazepam which she provided.
-There was an order to discontinue rivastigmine 3mg twice a day.
-There was an order to discontinue quetiapine 50mg daily as needed.

Review of Resident #1's psychiatry progress note date 06/22/22 revealed:
-Resident #1's quetiapine 50mg as needed had not been discontinued on the eMAR.
-There was an order to discontinue quetiapine as needed orders.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for rivastigmine 3mg twice daily for dementia related behaviors scheduled for 9:00am and 9:00pm.
-Rivastigmine 3mg was documented as administered every day from 04/15/22 to 04/24/22.
-Rivastigmine 3mg was documented as on hold from 04/25/22 to 04/30/22.
-There was an entry for clonazepam 0.5mg every day as needed for acute anxiety/agitation behaviors.
-Clonazepam 0.5mg as needed was documented as administered 04/19/22, 04/21/22, 04/22/22,

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and 04/24/22.
-There was an entry for quetiapine 50mg every day as needed for agitation.
-Quetiapine 50mg as needed was not documented as administered 04/15/22-04/30/22.

Review of Resident #1's May 2022 eMAR revealed:
-There was an entry for rivastigmine 3mg twice daily for dementia related behaviors scheduled at 9:00am and 9:00pm.
-Rivastigmine was documented as on hold 05/01/22.
-Rivastigmine was documented as administered 05/02/22 and 05/03/22 at 9:00am and 9:00pm.
-Rivastigmine was documented as administered 05/10/22 at 9:00pm.
-Rivastigmine was documented as not administered 05/04/22 to 05/09/22 due to Resident #1 being in the hospital.
-Rivastigmine 3mg was discontinued on the eMAR on 05/11/22.
-There was an entry for clonazepam 0.5mg every day as needed for acute anxiety/agitation/behaviors.
-Clonazepam 0.5mg as needed was documented as administered 05/02/22 at 3:29pm.
-Clonazepam 0.5mg as needed was discontinued on 05/12/22.
-There was an entry for quetiapine 50mg every day as needed for agitation.
-Quetiapine 50mg as needed was not documented as administered from 05/01/22 to 05/31/22.

Review of Resident #1's June 2022 eMAR revealed:
-There was an entry for quetiapine 50mg every day as needed for agitation.
-Quetiapine 50mg as needed was not

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documented as administered from 06/01/22 to 06/30/22.

Interview with a personal care aide (PCA) on 09/15/22 at 10:56am revealed Resident #1 would sometimes push staff members if he did not want to do something such as take his bath.

Telephone interview with a medication aide (MA) on 09/15/22 at 10:24am revealed Resident #1 sometimes pushed staff members when they tried to give him a bath.

Interview with the lead MA on 09/15/22 at 11:05am revealed Resident #1 was sometimes verbally aggressive with staff but not physically aggressive.

Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed:
-She knew when a medication should be discontinued because she read medication orders when they were received.
-The facility's mental health provider emailed resident's progress notes with orders to her after each visit.
-It was her responsibility to make sure medications were discontinued on the eMAR as ordered.

Interview with the Administrator on 09/15/22 at 3:37pm revealed:
-It was the SCC's responsibility to make sure medications were discontinued on the eMAR.
-He expected primary care provider (PCP) orders to be followed and all medications discontinued as ordered.

Telephone interview with Resident #1's mental health provider on 09/15/22 at 2:05pm revealed:

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D 358	Continued From page 32 -She expected resident's medications to be discontinued the same day it was ordered to be discontinued or at least by the next day. -She discontinued Resident #1's rivastigmine because it could have been contributing to worsening of behavioral concerns due to his dementia. -Continuing to receive rivastigmine after she had discontinued the medication could have made Resident #1 agitated and verbally and physically aggressive towards others. _____ The facility failed to ensure medications were administered as ordered including failing to discontinue Namenda for Resident #2 with compromised kidney function that could have further caused harm to her kidneys and for Resident #1 that continued to receive a medication that was discontinued which could have caused further aggressive verbal behaviors. The facility failed to ensure a full course of antibiotics was administered for Resident #1 which could have prevented resolution of a urinary tract infection. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 15, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 30, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 33 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 reviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 4 residents (#2 and #5) during the morning medication pass on 09/14/22. The findings are: 1. Review of Resident #2's current FL-2 dated 07/18/22 revealed diagnoses included hypertension and coronary artery disease. a. Review of Resident #2's physician's orders dated 08/15/22 revealed there was an order for Aspirin 81mg to be given once daily (Aspirin is a preventative anti-inflammatory medication used	D 367		

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D 367	Continued From page 34 for heart health). Observation of the morning medication pass on 09/14/22 at 8:31am revealed Resident #2 did not receive her ordered Aspirin 81mg with her morning medications. Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg daily, scheduled for administration at 8:00am. -Aspirin 81mg was documented as administered on 09/14/22 at 8:00am. Observation of Resident #2's medications on hand on 09/14/22 at 10:55am revealed Resident #2 did not have any Aspirin 81mg on the medication cart. Interview with the medication aide (MA) on 09/14/22 at 10:56am revealed: -Resident #2 did not have any Aspirin on the medication cart. -She should have charted on the eMAR as not administered under the 09/14/22 Aspirin dose since the resident did not receive it. Refer to telephone interview with a MA on 09/15/22 at 10:25am. Refer to interview with the lead MA on 09/15/22 at 10:55am. Refer to interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm. Refer to interview with the Administrator on 09/15/22 at 3:37pm.	D 367		

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Refer to telephone interview with a facility contracted mental health provider on 09/15/22 at 2:06pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/15/22 at 2:40pm.

b. Review of Resident #2's physician orders dated 08/15/22 revealed there was an order for Vitamin D3 25mcg daily (Vitamin D3 is a vitamin used to replace Vitamin D3 deficiency).

Observation of the morning medication pass on 09/14/22 at 8:31am revealed Resident #2 did not receive her ordered Vitamin D3 25mcg with her morning medications.

Observation of Resident #3 medications on hand on 09/14/22 at 10:55am revealed Resident #2 had Vitamin D3 25mcg on the medication cart available for administration in a bubble packet card.

Interview with the medication aide (MA) on 09/14/22 at 10:56am revealed:
-She clicked off Vitamin D3 on the eMAR for Resident #2 but only pulled out two bubble packets and forgot the third which was her Vitamin D3.
-She should not have charted administered on the eMAR for Resident #2's Vitamin D3 but was nervous and thought that she had given it with her other medications.

Refer to telephone interview with a MA on 09/15/22 at 10:25am.

Refer to interview with the lead MA on 09/15/22 at 10:55am.

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D 367	Continued From page 36 Refer to interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm. Refer to interview with the Administrator on 09/15/22 at 3:37pm. Refer to telephone interview with a facility contracted mental health provider on 09/15/22 at 2:06pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/15/22 at 2:40pm. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #5's current FL-2 dated 02/07/22 revealed diagnoses included dementia, diabetes, and a history of falls. Review of Resident #5's physician's orders dated 08/15/22 revealed there was an order for Restasis 0.05% eye drops, 1 drop in each eye twice a day (Restasis is a solution used to increased tear production which helps prevent inflammation). Observation of the morning medication pass on 09/14/22 at 8:40am revealed Resident #5 did not receive her ordered Restasis eye drops. Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Restasis 0.05%, with instructions to instill 1 drop into both eyes twice a day, scheduled for administration at 8:00am and	D 367		

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8:00pm.
-Restasis 0.05% was documented as administered on 09/14/22 at 8:00am.

Observation of Resident #5's medications on hand on 09/14/22 at 10:45am revealed Resident #5 had a container of Restasis 0.05% single dose vials available for administration on the medication cart.

Interview with Resident #5 on 09/14/22 at 9:30am revealed she did not receive her eye drops this morning.

Interview with the medication aide (MA) on 09/14/22 at 10:56am revealed:
-She forgot to administer Resident #5's Restasis eye drops because she went to get some facial tissues for the medication cart and when she got back, she was distracted.
-She should not have documented administered on the eMAR for Resident #5's Restasis until she administered them.

Refer to telephone interview with a MA on 09/15/22 at 10:25am.

Refer to interview with the lead MA on 09/15/22 at 10:55am.

Refer to interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm.

Refer to interview with the Administrator on 09/15/22 at 3:37pm.

Refer to telephone interview with a facility contracted mental health provider on 09/15/22 at 2:06pm.

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D 367	Continued From page 38 Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/15/22 at 2:40pm. Telephone interview with a medication aide (MA) on 09/15/22 at 10:25am revealed: -MAs were responsible for documenting medication administration on the electronic medication administration record (eMAR). -If a medication was not available for administration, the MA was responsible for documenting not given on the eMAR and also responsible for documenting the reason the medication was not available for administration. -If a resident refused a medication, the MA was responsible for documenting not given on the eMAR and state the reason. Interview with the lead MA on 09/15/22 at 10:55am revealed it was the MAs responsibility to accurately document on the eMAR. Interview with the Special Care Coordinator (SCC) on 09/15/22 at 3:00pm revealed: -She expected MAs to document accurately on the eMAR. -If a resident did not receive a medication, the MA should document not administered and the reason it was not given. -There was no current audit process in place to review eMARs for accuracy and completeness. Interview with the Administrator on 09/15/22 at 3:37pm revealed: -It was the MAs responsibility to document accurately and completely on the eMAR. -He expected MAs to document accurately and completely on the eMAR. Telephone interview with a facility contracted	D 367		

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D 367	Continued From page 39 mental health provider on 09/15/22 at 2:06pm revealed she reviewed the residents' eMAR during her visit and she expected the staff to document accurately and completely on the eMAR. Telephone interview with the facility's contracted primary care provider (PCP) on 09/15/22 at 2:40pm revealed: -She expected the eMAR to be complete and accurate. -She reviewed the resident's eMAR during her visits and adjusted treatment plans for the residents based on information collected including the eMAR.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 3	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	R 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(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
D912	Continued From page 40 sampled resident's (#1, #2) orders were implemented related to lab work (#1, #2) and vital signs (#2). [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#2, #5) observed during the medication pass used for heart health, Vitamin D deficiency and iron replacement (#2), a pain medication that was discontinued (#2), and eye drops (#5) and for 2 of 3 sampled residents (#1, #2) medications that were administered after being discontinued by the mental health provider (#1,#2), and a medication that was discontinued after hospitalization (#2). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		