

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/23/2022
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NAME OF PROVIDER OR SUPPLIER BROOKDALE LEXINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 161 YOUNG DRIVE LEXINGTON, NC 27292
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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up and annual survey from 09/21/22 to 09/23/22.	D 000	The following is the Plan of Correction for Brookdale Lexington regarding the Statement of Deficiencies for the Annual Survey completed September 23,2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents related to medications to treat vaginal symptoms associated with menopause and a supplement for vitamin B12 deficiency (#1) and a medication used to improve urination (#3). The findings are: 1. Review of Resident #1's current FL2 dated 02/03/22 revealed diagnoses included dementia without behavioral disturbance, incontinence without sensory awareness, muscle weakness, macular degeneration, hyperglycemia, osteoporosis, gastroesophageal reflux disease, dysphasia, hyperlipidemia, hypothyroidism, cerebrovascular disease, chronic kidney disease, obstructive sleep apnea, diabetes mellitus type	D 358	Medication Technicians will be responsible for administering medications and treatments as ordered by a licensed prescribing practitioner and in accordance with state regulations and the policies of the community. Medication Technicians will receive re-training from the Health and Wellness Director (HWD)/Designee on expectations of Medication Administration, with a focus on new order follow-up no later than 10-31-2022. Monitoring of the 24 hr report will be completed daily for two months by the HWD, Health and Wellness Coordinator (HWC), Executive Director (ED) and/or designee. To assist with ongoing compliance, an audit of all medications carts, resident charts and physician orders will be completed by 10/31/2022 to verify current medication and treatment orders. This will be completed monthly for three months by the HWD/HWC and/or designee.	09-23-2022

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Elyse J. Sp...</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>10-17-2022</i>
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STATE FORM

6899

6BN611

If continuation sheet 1 of 17

Reviewed and acknowledged. 11/03/22

Catherine Prater

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D 358	<p>Continued From page 1</p> <p>2, polyneuropathy, hemiplegia, hemiparesis and hypertension.</p> <p>a. Review of Resident #1's current FL2 dated 02/03/22 revealed there was an order for vitamin B12 (cyanocobalamin) 500mcg 1 tablet once daily.</p> <p>Review of Resident #1's Primary Care Provider (PCP) orders revealed: -There was an FL2 dated 02/03/22 with orders for vitamin B12 500mcg once daily. -There was a physician's order sheet dated 04/27/22 and 09/05/22 with orders for vitamin B12 every other day. -The PCP electronically signed orders for vitamin B12 once daily on 08/21/22.</p> <p>Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin B12 on the eMAR scheduled at 6:00am one time a day every other day. -There was documentation vitamin B12 was administered every other day from 07/01/22 through 07/31/22.</p> <p>Review of Resident #1's August 2022 eMAR revealed: -There was an entry for vitamin B12 on the eMAR scheduled at 6:00am one time a day every other day. -There was documentation vitamin B12 was administered every other day from 08/01/22 through 08/31/22.</p> <p>Review of Resident #1's September 2022 eMAR revealed:</p>	D 358		

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D 358	<p>Continued From page 2</p> <p>-There was an entry for vitamin B12 on the eMAR scheduled at 6:00am one time a day every other day.</p> <p>-There was documentation vitamin B12 was administered every other day from 09/01/22 through 09/19/22.</p> <p>Observation of Resident #1's medications on hand at the facility on 09/22/22 at 3:20pm revealed:</p> <p>-Vitamin B12 was available for administration.</p> <p>-The medication label administration instructions were for every other day.</p> <p>-The order date on the label was 01/19/21.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 09/22/22 at 10:10am revealed:</p> <p>-The last order the pharmacy received for vitamin B12 was a physician's order sheet dated 04/27/22.</p> <p>-The medication instructions were to administered vitamin B12 every other day.</p> <p>-The pharmacy did not have a current order for vitamin B12 with instructions to administer the medication daily.</p> <p>-The pharmacy had never received an order for vitamin B12 daily and had never dispensed vitamin B12 as a daily medication.</p> <p>-The pharmacy accepted FL2's as a one-time medication order, which was good for one dispensing cycle of the medication.</p> <p>-If a refill was needed after the FL2 date the PCP had to write new orders.</p> <p>-A look back through the pharmacy records showed the pharmacy was not sent the FL2 dated 02/03/22.</p> <p>-If the pharmacy had received the FL2 with the order for vitamin B12 daily, the pharmacy would</p>	D 358		

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D 358	<p>Continued From page 3</p> <p>have clarified the order with the PCP prior to dispensing the medication.</p> <p>Interview with Resident #1 on 09/22/22 at 9:20am revealed: -She was not aware of her medications. -She trusted the facility staff to administer her medications correctly.</p> <p>Interview with the medication aide (MA) on 09/23/22 at 12:34pm revealed: -MA's completed the FL2's and wrote the medications from the previous FL2. -The MA should also check the eMAR for changed or new medications since the last FL2. -If the MA identified the vitamin B12 was on the previous FL2 as daily and on the eMAR as every other day, then the MA should have let the PCP know to identify which order was correct. -The MA was supposed to fax the FL2 to the pharmacy.</p> <p>Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 11:03am revealed: -The MA entered the order and faxed it to the pharmacy. -The pharmacy would reconcile the order. -She reviewed everything like a third-party note/order and reviewed all notes/orders from the PCP including PCP visit sheets. -The Health and Wellness Coordinator (HWC) completed eMAR and cart audits, but they had been without a HWC for three weeks. -The MA prepared the FL2 and had the PCP to sign the FL2. -The MA transcribed orders from the previous FL2 onto the current FL2, but should have also checked current medications on the eMAR. -She did not know Resident #1's vitamin B12 was</p>	D 358			

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D 358	<p>Continued From page 4</p> <p>being administered incorrectly.</p> <p>-Although, she checked the PCP visit sheets, she missed the vitamin B12 was ordered daily.</p> <p>-She did not realize the eMAR order entry was for the vitamin B12 to be administered as every other day and the vitamin B12 order on the current FL2 was ordered as daily.</p> <p>-The physician order sheet was printed from the eMAR.</p> <p>-If the medication was incorrect on the eMAR, then it would be incorrect on the physician order sheet.</p> <p>-The PCP signed the physician order sheet and the FL2 and she obviously did not look at the medications listed.</p> <p>Telephone interview with Resident #1's PCP on 09/22/22 at 4:04pm revealed:</p> <p>-Resident #1's vitamin B12 500mcg should be administered daily and not every other day.</p> <p>-She was not sure why there was an order for every other day.</p> <p>-She signed the physician's order sheet, but she expected facility staff to transcribe the orders on the physician's order sheet based on the current orders.</p> <p>-After each visit to the facility, she sent a PCP Visit sheet to the facility.</p> <p>-The resident's current medications were listed on the PCP Visit sheet.</p> <p>-The facility should have checked that list to ensure the resident's medications were correct.</p> <p>-If there were questions about the medication, she was in the facility weekly or the facility could have left her a message.</p> <p>Interview with the Administrator on 09/23/22 at 12:08pm revealed:</p> <p>-She expected medications to be administered</p>	D 358		

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D 358	<p>Continued From page 5</p> <p>as ordered.</p> <ul style="list-style-type: none"> -The pharmacy did not change entries on the eMAR. -The MA was responsible for changing entries on the eMAR to match the current orders. -The MA should have noticed the order was different for vitamin B12 on the FL2 and the eMAR and contacted the PCP to check which order was correct. <p>b. Review of Resident #1's current FL2 dated 02/03/22 revealed there was no order for a vaginal cream on the FL2.</p> <p>Review of Resident #1's hospital discharge summary report for May 2022 revealed the resident was treated for a urinary tract infection (UTI).</p> <p>Review of Resident #1's physician's order dated 08/09/22 revealed an order to check the resident's urinalysis (UA) and send the culture to the urologist.</p> <p>Review of Resident #1's Primary Care Provider's (PCP) orders revealed:</p> <ul style="list-style-type: none"> -There was an order dated 06/01/22 for estrace cream 0.1mg insert 1 application vaginally at bedtime on Monday, Wednesday and Friday (used to treat vaginal symptoms associated with menopause). -There was an order dated 08/09/22 for estrace vaginal cream 2 to 3 days per week. -There was an order dated 08/21/22 for estrace cream 0.1mg three times per week. -The PCP documented a dose reduction attempted and/or reduction would cause decompensation of the resident. 	D 358		

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D 358	<p>Continued From page 6</p> <p>Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for estrace vaginal cream 0.1mg Monday, Wednesday and Friday scheduled at 6:00pm. -There was documentation estrace was not administered 6 out of 14 opportunities from 07/01/22 through 07/31/22. -The medication was not documented as administered by the same medication aide (MA) for each of the 6 missed dosages. -There was documentation the medication aide (MA) did not attempt to administer estrace cream. -The MA documented Resident #1 made comments that were uncomfortable to her, and she refused to apply the cream. -There was no documentation of the comments made by the resident. -There was no documentation the resident's PCP was notified of the MA's refusal to administer estrace cream as ordered. <p>Review of Resident #1's August 2022 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for estrace vaginal cream 0.1mg Monday, Wednesday and Friday scheduled at 6:00pm. -There was documentation estrace was not administered 6 out of 14 opportunities from 08/01/22 through 08/31/22. -There was documentation the MA did not attempt to administer estrace cream. -There was documentation this was the same MA that refused to administer estrace cream in July 2022. -The MA documented Resident #1's comments were uncomfortable, and she did not apply the 	D 358		

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D 358	<p>Continued From page 7</p> <p>cream.</p> <p>-There was no documentation of the comments made by the resident.</p> <p>-There was no documentation the resident's PCP was notified of the MA refused to apply estrace cream as ordered or the reason why she refused.</p> <p>Review of Resident #1's September 2022 eMAR revealed:</p> <p>-There was an entry for estrace vaginal cream 0.1mg Monday, Wednesday and Friday scheduled at 6:00pm.</p> <p>-There was documentation estrace was not administered 3 out of 8 opportunities from 09/01/22 through 09/19/22.</p> <p>-There was documentation the same MA as in July and August 2022 did not attempt to administer estrace cream.</p> <p>-The MA documented Resident #1's comments were uncomfortable, and she refused to apply the cream.</p> <p>-There was no documentation of the comments made by the resident.</p> <p>-There was no documentation the resident's PCP was notified that estrace cream as not administered as ordered.</p> <p>Observation of Resident #1's medications on hand at the facility on 09/22/22 at 3:20pm revealed:</p> <p>-Estrace cream was available for administration.</p> <p>-The dispensed date on the medication was 06/01/22.</p> <p>-One-fourth of the tube had been used.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 09/22/22 at 10:13am revealed:</p> <p>-Estrace cream came in a tube and included a</p>	D 358		

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D 358	<p>Continued From page 8</p> <p>plastic applicator. -The recommended way to administer estrace cream was to fill the plastic applicator to the desired line and insert the application vaginally. -Pressure had to be used to dispense the medication out of the tube and into the resident. -One tube of estrace cream, if used as ordered, three times per week would last three months.</p> <p>Interview with Resident #1 on 09/22/22 at 9:20am revealed: -She was ordered a cream for vaginal dryness. -The MAs applied the cream but not every night. -She was unable to recall the last time the cream was applied.</p> <p>Telephone interview with Resident #1's urologist on 09/23/22 at 10:37am revealed: -Resident #1 was ordered estrace cream because she had urethral stenosis. -The estrace cream would help to re-estrogenize the vaginal tissues and help to prevent urinary tract infections (UTIs). -Without the estrace cream the resident was prone to bladder infections. -If the cream was not administered consistently it would not be as effective.</p> <p>Telephone interview with the MA that refused to administer Resident #1's vaginal cream on 09/22/22 at 2:48pm revealed: -She did not like applying creams for Resident #1. -Even when applying a topical cream to the resident's knee, Resident #1 would say things like, "O, my god, that makes me [excited]." -She did not like the resident's comments and she did not attempt to administer the vaginal cream.</p>	D 358		

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D 358	<p>Continued From page 9</p> <ul style="list-style-type: none"> -She thought that she applied the estrace cream on Resident #1 maybe 4 to 5 times, but she was not sure. -She had made the Resident Care Coordinator (RCC) aware of the resident's comments and her refusal to administer the estrace cream. -The RCC told her to just document, so it would be documented that she did not administer the cream. -She had not made Resident #1's PCP aware the cream was not administered. <p>Interview with a second shift MA on 09/22/22 at 4:58pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 made sounds when putting creams on the resident, even topical creams to the knee. -The resident would say "O, that feels good," but she understood the resident needed the medication and she put the cream on her anyway. -The resident's comments were sometimes uncomfortable but she administered the estrace cream anyway. -She did not believe Resident #1 was aware what she was saying was inappropriate. -She had made the Administrator and the RCC aware of Resident #1's comments. <p>Telephone interview with Resident #1's PCP on 09/22/22 at 4:09pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 had a history of UTIs and was seen by a urologist. -Estrace cream was ordered three times weekly and should be administered as ordered. -She was in the facility every week and no one made her aware the cream was not administered. <p>Interview with the RCC on 09/23/22 at 11:04am</p>	D 358		

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D 358	<p>Continued From page 10</p> <p>revealed:</p> <ul style="list-style-type: none"> -She had recently seen the MA's comments regarding her refusal to administer Resident #1's estrace cream. -She did not make Resident #1's PCP aware the cream was not administered as ordered. -She could change the scheduled time for the administration of Resident #1's the estrace cream so the cream was applied by another MA, but she had not thought to do so before today. <p>Interview with the Administrator on 09/23/22 at 12:08pm revealed:</p> <ul style="list-style-type: none"> -She expected medications to be administered as ordered. -If there was a problem administering the medication the PCP should be notified. -The RCC should have made Resident #1's PCP aware the cream was not administered as ordered. <p>2. Review of Resident #3's current FL2 dated 07/07/22 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included vascular dementia without behavioral disturbances, diabetes mellitus type 2, hypertension, hyperlipidemia, and polyneuropathy. -There was an order for tamsulosin 0.4mg (used to treat enlarged prostate) once daily at bedtime. <p>Review of Resident #3's physician's order sheet (POS) dated 09/05/22 revealed an order for tamsulosin 0.4mg at bedtime every other day.</p> <p>Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for tamsulosin 0.4mg scheduled at bedtime every other day for urinary 	D 358		

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D 358	<p>Continued From page 11</p> <p>retention.</p> <p>-There 16 dates that had an "X" documented on the date before the medication was administered and the date after the medication was administered.</p> <p>-There was documentation tamsulosin 0.4mg was administered 15 out of 31 days in the month of July 2022, from 07/01/22 through 07/31/22.</p> <p>Review of Resident #3's August 2022 eMAR revealed:</p> <p>-There was an entry for tamsulosin 0.4mg scheduled at bedtime every other day.</p> <p>-There 16 dates that had an "X" documented on the date before the medication was administered and the date after the medication was administered.</p> <p>-There was documentation tamsulosin 0.4mg was administered 16 out of 31 days in the month of August 2022, from 08/01/22 through 08/31/22.</p> <p>Review of Resident #3's September 2022 eMAR revealed:</p> <p>-There was an entry for tamsulosin 0.4mg scheduled at bedtime every other day.</p> <p>-There 16 dates that had an "X" documented on the date before the medication was administered and the date after the medication was administered.</p> <p>-There was documentation tamsulosin 0.4mg was administered 10 out of 20 days in the month of September 2022, from 09/01/22 through 09/19/22.</p> <p>Observation of Resident #3's medications on hand at the facility on 09/22/22 at 4:38pm revealed:</p> <p>-Tamsulosin 0.4mg was available for</p>	D 358		

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(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 358	<p>Continued From page 12</p> <p>administration.</p> <ul style="list-style-type: none"> -There were three medication cards of tamsulosin 0.4mg for Resident #3. -The first card of tamsulosin 0.4mg was dispensed on 04/03/22. -The medication label had instructions to administer tamsulosin 0.4mg once daily at bedtime. -A quantity of 30 capsules were dispensed on 04/03/22, and there were 9 capsules remaining. -The second card of tamsulosin 0.4mg was dispensed on 06/22/22. -The medication label had instructions to administered 1 capsule at bedtime every other day. -A quantity of 8 capsules were dispensed on 06/22/22, and there were 8 capsules remaining. -The third card of tamsulosin 0.4mg was dispensed on 07/04/22. -The medication label had instructions to administered 1 capsule at bedtime every other day. -A quantity of 8 capsules were dispensed on 07/04/22, and there were 8 capsules remaining. <p>Review of Resident #3's progress notes and physician visit notes revealed:</p> <ul style="list-style-type: none"> -Tamsulosin 0.4mg should have been administered daily from 07/07/22 through 09/05/22. -There was no documentation Resident #3's PCP was contacted to clarify the tamsulosin order for every other day on the Physician Order Sheet dated 09/05/22. -There was no documentation the PCP was contacted to clarify the tamsulosin order for every day on the FL2 dated 07/07/22. <p>Interview Resident #3's PCP on 09/22/22 at</p>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2022
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D 358	<p>Continued From page 13</p> <p>4:03pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was on hospice and they controlled the majority of the resident's medications -The PCP ordered tamsulosin 0.4mg and the medication should be administered daily, not every other day. -The Physician Order Sheet was a copy of the eMAR. -The eMAR should have the resident's current orders listed. -When the PCP signed the Physician Order Sheet, it was her understanding the eMAR had the current and correct orders. <p>Telephone interview with a representative from the facility's contracted pharmacy on 09/23/22 at 12:24pm revealed:</p> <ul style="list-style-type: none"> -Tamsulosin 0.4mg was generally not ordered to be administered every other day. -To receive the effectiveness of the medication it was usually prescribed daily. -Resident #3's tamsulosin 0.4mg was last dispensed to the facility on 07/04/22 for quantity of 8 capsules. -The pharmacy had a Physician Order Sheet signed on 09/05/22 with orders for tamsulosin 0.4mg every other day. -The pharmacy did not receive the FL2 dated 07/07/22. -If the pharmacy had received the FL2 dated 07/07/22 with orders for tamsulosin 0.4mg once daily at bedtime and then received the Physician Order Sheet dated 09/05/22 with orders to administer tamsulosin 0.4mg every other day; the pharmacy would have clarified the order with the resident's PCP. -The Physician Order Sheet was a printout of the eMAR that was signed by the resident's PCP. -The pharmacy had no control of the orders 	D 358		

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D 358	<p>Continued From page 14</p> <p>entered on the eMAR.</p> <p>-The facility entered orders on the eMAR, the pharmacy was not able to see orders listed on the eMAR.</p> <p>-If a facility staff made a mistake or changed a medication order on the eMAR, the pharmacy would not be able to see the error.</p> <p>-If the PCP did not identify the error made and signed the Physician Order Sheet, then that would have changed the resident's medication accidentally.</p> <p>-The medication orders listed on the FL2 and signed by the PCP was considered medication orders and should be sent to the pharmacy.</p> <p>-However, FL2 orders were only good for 30 day and one time dispensing of medication.</p> <p>-The orders on the Physician Order Sheets were good for six months because the Physician Order Sheet included documentation as follows; "these orders are to be followed for six months."</p> <p>Interview with the medication aide (MA) on 09/23/22 at 12:34pm revealed:</p> <p>-MAs were responsible to faxed orders to the pharmacy and enter the orders on the eMAR.</p> <p>-When the pharmacy sent the medication, the MA should check to make sure all matched up.</p> <p>-If the order and the medication label matched, the MA should link the medication to the system and she could document the administration of the medication on the eMAR.</p> <p>-She was not sure why Resident #3's tamsulosin 0.4mg was not changed to once daily as ordered on the FL2 dated 07/07/22.</p> <p>-It was possible the medication was once ordered every other day and the eMAR was never updated to the every day.</p> <p>-Honestly, she did not know what happened.</p> <p>-The MA should have contacted the PCP to</p>	D 358			

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D 358	<p>Continued From page 15</p> <p>clarify the order.</p> <p>Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 11:03am revealed:</p> <ul style="list-style-type: none"> -The MAs were responsible for faxing orders to the pharmacy and entering orders on the eMAR. -The pharmacy would reconcile the order by filling and dispensing the medication. -She reviewed the everything including a third-party note/order. She reviewed all notes/orders from the PCP. -She reviewed the PCP Visit sheets with medication orders. -When new or changed orders were entered on the eMAR, she checked to ensure they were accurate. -She did not realize Resident #3's 07/07/22 FL2 ordered tamsulosin 0.4mg once daily. -The MA prepared the FL2 and had the PCP to sign. -The MA transcribed orders from the previous FL2, but should have also checked current medications on the eMAR. -She did not know if the MA accidentally changed tamsulosin to every other day because she did not realize the entry on the eMAR was different from the FL2 order dated 07/07/22. -The Physician Order Sheet was printed from the eMAR. If the medication was incorrect on the eMAR, then the medication would be incorrect on the Physician Order Sheet. -The PCP signed the Physician Order Sheet and the FL2 and she obviously did not look at the medications listed. <p>Interview with the Administrator on 09/23/22 at 12:08pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #3's tamsulosin was administered incorrectly. 	D 358		

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D 358	Continued From page 16 -She expected medications to be administered as ordered. -The pharmacy did not change the eMAR. -The MA was responsible for entering medication orders on the eMAR to match the current orders. -When a new or changed order was received, the MA was supposed to check medications with orders prior to signing off on the eMAR. -The RCC was supposed to verify orders and ensure they were entered on the eMAR correctly. -Resident #3 was on hospice and they stopped and/or changed a lot of his medications. -If orders were not clear the PCP or hospice should be notified. Based on observations, record reviews, and interviews it was determined that Resident #3 was not interviewable.	D 358			