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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on December 7, 2022.	D 000		
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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#5) during the observation of medication pass and 1 of 5 sampled residents (#3) for record review including medications used as vitamin supplements (#5), used as a blood thinner (#5), and finger stick blood sugars and insulin used to control and decrease elevated blood sugars (#3). The findings are: Review of the facility's policy for Administration Procedures for All Medications dated November 2018 revealed: -Medications were to be administered per the 6 rights (right resident, medication, dose, route,	D 358		

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time, and documentation).
-All medication changes would be updated on the resident's medication administration record (MAR) and in the resident's record.
-Notify the resident's Primary Care Provider (PCP) of any medication errors or consistent refusals.
-If at any point a staff member was unsure or had questions on medication administration or medication orders, they were to stop immediately and ask for clarification for assistance.

1. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00am medication pass on 12/07/22.

Review of Resident #5's current FL-2 dated 08/02/22 revealed:
-Diagnoses included Parkinson's disease, dementia, hypothyroidism, history of a cardiovascular accident, and arthritis.
-There was an order for Aspirin 81mg (used as a blood thinner) chewable tablet once daily.
-There was an order for Calcium 600mg (used as a vitamin supplement) once daily.
-There was an order for Vitamin C 250mg (used as a vitamin supplement), two tablets once daily.

a. Review of Resident #5's current physician orders dated 09/06/22 revealed there was an order for Aspirin 81mg chewable tablet once daily.

Observation of administration of Resident #5's medication on 12/07/22 from 7:45am to 7:51am revealed:
-A medication aide (MA) prepared the resident's medication by placing an Aspirin 81mg enteric coated tablet in a medication cup at 7:45am.
-The Aspirin 81mg was in an over-the-counter pill

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bottle that had a handwritten label with Resident #5's name and an open date of 06/01/22.
-The MA compared the medications she prepared to the list of medications on the resident's medication administration record (MAR) as she pulled them and placed them in a medication cup.
-The resident was administered 1 enteric coated Aspirin.

Review of Resident #5's December 2022 MAR revealed:
-There was an entry for Aspirin 81mg chewable tablet once daily.
-The resident's Aspirin 81mg chewable tablet was documented as administered from 12/01/22-12/07/22.

Attempted interview with the medication aide (MA) that administered Resident #5's medication on 12/07/22 at 2:12pm revealed she was not available and left the facility earlier than scheduled.

Interview with different MA on 12/07/22 at 2:13pm revealed:
-MAs were trained to compare the order on the MAR to what they prepare for the resident to take 3 times prior to administering medications to a resident ensuring it is the right medication, dose, route, person, time, and documentation.
-She had previously administered Resident #5's Aspirin but did not realize the order was written for chewable and the ones being administered to the resident were enteric coated.

Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 2:45pm revealed:
-MAs were expected to and were trained to administer medications accurately per the order on the MAR.

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-Resident #5's family member brought the Aspirin 81mg into the facility and she (RCC) was the person responsible to ensure that the medication was accurate prior to labeling it and placing it on the medication cart for administration.
-When outside medications were brought into the facility, it was her responsibility to ensure the medication was accurate per the resident's physician orders, then place it on the medication cart and add it to the MAR to be used for administration.
-She did not realize that the order was for chewable Aspirin and the bottle was enteric coated and should have been more aware.
-Even though she missed the error, she would have expected the MAs to catch the error as well.

Interview with the Administrator on 12/07/22 at 3:13pm revealed:
-She was not aware Resident #5 was being administered enteric coated Aspirin instead of chewable Aspirin as ordered.
-She expected medications to be administered accurately as ordered and per the MAR by MAs.
-She expected the RCC to ensure medications were accurate upon receipt prior to placing the medication on the medication cart for administration.

Telephone interview with Resident #5's primary care provider (PCP) on 12/07/22 at 4:22pm revealed:
-She was not aware Resident #5 had been receiving Aspirin enteric coated instead of chewable as ordered.
-The Aspirin was ordered to thin her blood due to a chronic condition and it was important to administer medications as ordered to treat the diagnosis and symptoms.
-Not getting medication accurately as ordered

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could negatively effect residents' health.
-She expected the facility to ensure medications were on hand and administered accurately as ordered.
-She expected to be notified of medication errors so she could provide new orders and guide care.

b. Review of Resident #5's current physician orders dated 09/06/22 revealed there was an order for Calcium 600mg once daily. (Used as a supplement for low calcium levels.)

Observation of administration of Resident #5's medication on 12/07/22 from 7:45am to 7:51am revealed:
-A medication aide (MA) prepared the resident's medication by placing a Calcium 600mg with Vitamin D3 20 mcg tablet in a medication cup at 7:45am. (Used as a supplement for low calcium and vitamin D levels.)
-The Calcium 600mg with Vitamin D3 20 mcg was in an over-the-counter pill bottle that had a handwritten label with Resident #5's name and an open date of 06/17/22.
-The MA compared the medications she prepared to the list of medications on the resident's electronic medication administration record (MAR) as she pulled them and placed them in a medication cup.
-The resident was administered 1 tablet of Calcium 600mg with Vitamin D3 20 mcg at 7:51am.

Review of Resident #5's December 2022 MAR revealed:
-There was no entry for Calcium 600mg or Calcium 600mg with Vitamin D3 20 mcg.
-There was no documentation for Calcium 600mg or Calcium 600mg with Vitamin D3 20 mcg.

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D 358	Continued From page 5 Attempted interview with the medication aide (MA) that administered Resident #5's medication on 12/07/22 at 2:12pm revealed she was not available and left the facility earlier than scheduled. Interview with different MA on 12/07/22 at 2:13pm revealed: -MAs were trained to compare the order on the MAR to what they prepare for the resident to take 3 times prior to administering medications to a resident ensuring it is the right medication, dose, route, person, time, and documentation. -She had previously administered Resident #5's Calcium but did not realize it also contained Vitamin D3. -The resident did not have an order for Vitamin D3. Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 2:45pm revealed: -MAs were expected to and were trained to administer medications accurately per the order on the MAR. -The MA should not have administered a medication that was not on the MAR without clarification. -Resident #5's family member brought the Calcium with Vitamin D3 into the facility and she (the RCC) was the person responsible to ensure that the medication was accurate prior to labeling it and placing it on the medication cart for administration. -She did not realize that the Calcium contained Vitamin D3 and that there was not an order for the Vitamin D3 and she should have been more aware. -Even though she missed the error, she would have expected the MAs to catch the error as well.	D 358		

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Interview with the Administrator on 12/07/22 at 3:13pm revealed:
-She was not aware Resident #5 was being administered Calcium with Vitamin D3 instead of plain Calcium as ordered.
-She expected medications to be administered accurately as ordered and per the MAR by MAs.
-She expected the RCC to ensure medications were accurate upon receipt prior to placing the medication on the medication cart for administration.

Telephone interview with Resident #5's primary care provider (PCP) on 12/07/22 at 4:22pm revealed:
-She was not aware Resident #5 had been receiving Calcium with Vitamin D3 in it instead of plain Calcium as she ordered.
-She expected the facility ensure medications were on hand and administered accurately as ordered.
-She expected to be notified of medication errors so she could provide new orders and guide care.

c. Review of Resident #5's current medication physician orders dated 09/06/22 revealed there was an order for Vitamin C 250mg, two tablets once daily. (Used as a supplement for low vitamin C levels or to help boost the immune system.)

Observation of administration of Resident #5's medication on 12/07/22 from 7:45am to 7:51am revealed:
-A medication aide (MA) prepared the resident's medication by placing one Vitamin C 250mg gummy in a medication cup at 7:45am.
-The Vitamin C 250mg gummy was in an over-the-counter pill bottle that had a handwritten label with Resident #5's name and an open date of 08/01/22.

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-The MA compared the medications she prepared to the list of medications on the resident's electronic medication administration record (MAR) as she pulled them and placed them in a medication cup.
-The resident was administered 1 Vitamin C gummy at 7:53am.

Review of Resident #5's December 2022 MAR revealed:
-There was an entry for Vitamin C 250mg, two tablets once daily.
-The resident's Vitamin C 250mg, two tablets once daily was documented as administered from 12/01/22-12/07/22.

Interview with Resident #5 on 12/07/22 at 2:32pm revealed she used to receive 2 Vitamin C gummies when she first started taking them, but had only received 1 gummy each morning for about the last month.

Attempted interview with the medication aide that administered Resident #5's medication on 12/07/22 at 2:12pm revealed she was not available and left the facility earlier than scheduled.

Interview with a different MA on 12/07/22 at 2:13pm revealed:
-Resident #5 was supposed to receive two Vitamin C gummies each morning which was what she normally administered when she gave the resident her medications.
-She did not administer Resident #5's Vitamin C that day and did not know why the resident only received one gummy that morning (12/07/22).
-MAs were trained to compare the order on the MAR to what they prepare for the resident to take 3 times prior to administering medications to a

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resident ensuring it is the right medication, dose, route, person, time, and documentation.

Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 2:45pm revealed:
-She was not aware Resident #5 was administered 1 Vitamin C gummy instead of 2 that day (12/07/22).
-MAs were expected to and were trained to administer medications accurately per the order instructions on the MAR and orders.

Interview with the Administrator on 12/07/22 at 3:13pm revealed:
-She was not aware Resident #5 was administered 1 Vitamin C gummy instead of 2 on 12/07/22.
-She expected medications to be administered accurately as ordered and per the MAR by MAs.

Telephone interview with Resident #5's primary care provider (PCP) on 12/07/22 at 4:22pm revealed:
-She was not aware Resident #5 had received one Vitamin C gummy instead of 2 as ordered.
-It was important for the resident to receive the Vitamin C as ordered because the resident needed it to boost her immune system due to COVID-19..
-She expected the facility ensure medications were on hand and administered accurately as ordered.
-She expected to be notified of medication errors so she could provide new orders and guide care.

2. Review of Resident #3's current FL-2 dated 06/07/22 revealed:
-Diagnoses included Alzheimer's disease, diabetes, chronic kidney disease stage 3, and hypertension.

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D 358	Continued From page 9 -He was a resident of the special care unit (SCU). -He was constantly disoriented.. Review of Resident #3's physician order dated 11/02/22 revealed there was an order to start Novolog 5 units before meals. Review of Resident #3's physician order dated 11/15/22 revealed: -There was an order to obtain a finger stick blood sugar (FSBS) before meals and before insulin was administered. -There was an order to hold insulin if the FSBS was less than 150. Review of Resident #3's physician order dated 11/25/22 revealed: -There was an order to discontinue Novolog 5 units three times daily. -There was an order to begin Novolog 7 units before meals and to hold if FSBS was less than 150. Review of Resident #3's November 2022 medication administration record (MAR) revealed: -There was an entry beginning on 11/06/22 for Novolog 5 units before meals. -The Novolog 5 units was documented as administered on 11/06/22 at 4:00pm, three times daily from 11/07/22-11/27/22, and on 11/28/22 at 11:00am, except on 11/17/22 at 7:00am, 11/18/22 at 7:00am and 11:00am, 11/19/22-11/23/22 at 7:00am, 11/24/22-11/26/22 at 7:00am and 4:00pm, and 11/28/22 at 7:00am in which it was documented to see nurse's medication notes on the back of the MAR. -There was no documentation of the Novolog 5 units in the nurse's notes on 11/18/22 at 11:00am and 11/19/22 at 7:00am. -There was an entry for FSBS beginning on	D 358		

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11/16/22 three times daily before meals at 7:00am, 11:00am, and 4:00pm, hold Novolog if less than 150.
-The FSBS were signed off as completed three times daily from 11/16/22-11/30/22 but there were no results documented on 11/16/22, 11/17/22 at 11:00am and 4:00pm, 11/18/22 at 11:00am, 11/20/22 at 11:00am and 4:00pm, 11/21/22 at 11:00am and 4:00pm, 11/22/22 at 11:00am and 4:00pm, 11/23/22 at 11:00am and 4:00pm, 11/24/22 at 11:00am, 11/25/22 at 11:00am, 11/26/22 at 11:00am and 4:00pm, 11/27/22, 11/28/22 at 11:00am and 4:00pm, 11/29/22 at 11:00am and 4:00pm, 11/30/22 at 11:00am and 4:00pm.
-There was an entry beginning on 11/28/22 at 11:00am for Novolog 7 units before meals; initiated 3 days after the physician order to increase the Novolog to 7 units dated 11/25/22.
-The Novolog 7 units was documented as administered from 11/28/22-11/30/22 at 11:00am and 4:00pm and documented as see nurse's medication notes on 11/29/22-11/30/22.
-There was no documentation of the Novolog 7 units in the nurse's notes on 11/29/22 and 11/30/22 at 11:00am and 4:00pm.
-There was no other documentation regarding how much Novolog the resident received or what his FSBS were outside of the nurse's medication notes which did not include all the dates administered.
-There were 26 out of 44 opportunities in which a FSBS was documented as completed but there were no results documented on the MAR or nurse's notes.
-There were 29 out of 44 opportunities in which a FSBS results were not documented and the resident received insulin.
-There were 6 opportunities from 11/25/22-11/28/22 in which insulin 5 units was

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documented as administered when the resident should have received 7 units of insulin if his FSBS were greater than 150, but the FSBS results were not documented.

Review of Resident #3's December 2022 MAR revealed:
-There was an entry for FSBS three times daily before meals at 7:00am, 11:00am, and 4:00pm, hold Novolog if less than 150.
-The FSBS were signed off as completed three times daily from 12/01/22-12/06/22, and 12/07/22 at 7:00am, except on 12/02/22 at 11:00am which was left blank.
-There were no FSBS results documented on the MAR or the MAR nurse's notes.
-There was an entry for Novolog 7 units before meals.
-The Novolog 7 units was documented as administered from 12/01/22 at 11:00am and 4:00pm, 12/02/22 at 11:00am and 4:00pm, 12/03/22 at 7:00am, 11:00am, and 4:00pm, 12/04/22 at 11:00am and 4:00pm, 12/05/22 at 7:00am, 11:00am, and 4:00pm, 12/06/22 at 7:00am, 11:00am, and 4:00pm, and 12/07/22 at 7:00am; on 12/01/22 and 12/02/22 it was documented as see nurse's medication notes and on 12/04/22 it was left blank.
-There was no other documentation regarding how much Novolog the resident received or what his FSBS on the MAR or the nurse's medication notes.
-There were 18 out of 18 opportunities in which a FSBS was documented as completed but there were not results documented on the MAR or nurse's notes.
-There were 15 out of 16 opportunities in which a FSBS were not documented in which it was documented that the resident received insulin if FSBS were greater than 150.

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D 358	Continued From page 12 Review of Resident #3's November 2022 blood sugar record sheet revealed: -There were FSBS results documented on 11/16/22 at 11:00am and 4:00pm, and three times daily at 7:00am, 11:00am, and 4:00pm from 11/17/22-11/30/22. -On 11/23/22 at 4:00pm the FSBS was documented as 144 which was less than 150 but the MAR documentation showed the resident received 5 units of insulin when he should not have received any insulin. -On 11/24/22 at 4:00pm the FSBS was documented at 202 which was greater than 150 but the MAR documentation showed a FSBS of 140 with no insulin administered. -On 11/26/22 at 4:00pm the FSBS was documented as 186 which was greater than 150 but the MAR documentation showed a FSBS of 135 with no insulin administered. Review of Resident #3's December 2022 blood sugar record sheet revealed: -There were FSBS results documented three times daily at 7:00am, 11:00am, and 4:00pm from 12/01/22-12/06/22 and on 12/07/22 at 7:00am and 11:00am. -On 12/03/22 the FSBS was documented as 103 which was less than 150 but the MAR documentation showed the resident received 7 units of insulin. -On 12/05/22 the FSBS was documented as 123 which was less than 150 but the MAR documentation showed the resident received 7 units of insulin. -On 12/06/22 the FSBS was documented as 124 which was less than 150 but the MAR documentation showed the resident received 7 units of insulin. -On 12/07/22 the FSBS was documented as 137	D 358		

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D 358	Continued From page 13 which was less than 150 but the MAR documentation showed the resident received 7 units of insulin. Review of Resident #3's glucometer on 12/07/22 at 2:02pm revealed: -The date and time on the glucometer were not accurate and did not align with the current date and time. -The results in the glucometer had gaps in the date and did not have results for consecutive dates. -The results in the glucometer did not consecutively match the results documented on the MAR or the blood sugar record sheet for Resident #3. Review of the facility's "house" glucometer on 12/07/22 at 2:02pm revealed: -The date and time on the glucometer were not accurate and did not align with the current date and time. -The results in the glucometer had gaps in the date and did not have results for consecutive dates. -The results in the glucometer did not consecutively match the results documented on the MAR or the blood sugar record sheet for Resident #3. Interview with a medication aide (MA) on 12/07/22 at 3:41pm revealed: -Resident #3 was supposed to receive FSBS before every meal and then to receive insulin before meals if his FSBS were greater than 150 per his orders. -MAs were supposed to document Resident #3's FSBS on the nurse's medication notes or the blood sugar sheets immediately after obtaining the result.	D 358		

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D 358	Continued From page 14 -If Resident #3's FSBS was less than 150, MAs were supposed hold the insulin and to document to see the nurse's medication notes then document on the back of the MAR in the nurse's medication notes what the FSBS was and that the insulin was held. -It was important to obtain FSBS and administer insulin accurately as ordered with accurate documentation to ensure the resident received care as ordered and to be able to track if there were any adverse events and for the provider to guide care. -She must have forgotten to document on the blood sugar sheet and the nurse's medication notes when she administered Resident #3's insulin and could not recall if she administered the insulin accurately. Attempted interview with another MA on 12/07/22 at 2:12pm revealed she was not available and left the facility earlier than scheduled. Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 2:45pm and 3:55pm revealed: -Resident #3 had run out of glucometer test strips at some point in the past couple of weeks and the staff sometimes used the "house glucometer" to test his FSBS. -The house glucometer could be used on any resident and she was not sure if all the results on the history of the house glucometer belonged to Resident #3. -She created the blood sugar record sheets that afternoon (12/07/22) after the surveyor requested documentation of Resident #3's FSBS results by looking at the house glucometer and the resident's glucometer because the FSBS had not been documented on the MAR as expected. -She could not guarantee accuracy of the results	D 358		

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she recoreded on the blood sugar record sheets because the dates on both of the glucometers were not accurate and she was not sure if all the results even belonged to Resident #3 from the house glucometer.
-The MAR was expected to be accurate, and what documentation was present on the MAR should be considered accurate and correct to her knowledge.
-She was a registered nurse (RN) and it was her responsibility to oversee the MAs and ensure medications were administered accurately.
-There had been some on-going issues with the administration and documentation of Resident #3's FSBS and insulin and it was frustrating to have continued issues because the MAs had been trained and re-trained as recently as last week to administer and document the FSBS and insulin accurately.
-The delay in implementing the increase of Resident #3's Novolog from 5 units to 7 units was her fault because she had been out sick and did not want anyone else to implement orders until she could ensure accuracy.
-She did not realize that Resident #3 was receiving inaccurate dosages of insulin based on the FSBS that were documented on the MAR.
-It was important to administer and document FSBS and insulin accurately as ordered to provide proper care.
-It was hard to know if the remaining insulin dosages that had been administered to Resident #3 was accurate due to the missing documentation of FSBS on the MAR since he was on sliding scale insulin and she could not guarantee the results she pulled to supplement the missing results were accurate or Resident #3's results or if they belonged to another resident.
-Residents with diabetes could be sensitive to

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insulin and inaccurate insulin administration could lead to the resident having FSBS that were too high or too low which could lead to adverse issues such as diabetic coma or altered mental status.

Interview with the Administrator on 12/07/22 at 2:56pm revealed:
-She was not aware there were issues with the administration and documentation of Resident #3's FSBS and insulin.
-She expected residents to receive "top notch care" and for MAs to stop medication administration if there were any questions or confusion.
-She expected MAs to accurately administer medication and document it on the MAR.
-It was important for accurate administration and documentation to reduce the risk of errors and potential harm to the residents.
-She expected the RCC to identify and correct any on-going issues such as inaccurate medication administration or documentation and come to her for help in correcting the issue.
-She expected new medication orders to be implemented the same day of receiving the order.

Telephone interview with Resident #3's primary care provider (PCP) on 12/07/22 at 4:22pm revealed:
-She was not aware Resident #3 was possibly not receiving his insulin as ordered and that it was not being documented accurately or thoroughly.
-She expected insulin to be administered accurately per parameters as ordered and documented accurately and thoroughly.
-The resident was usually very spunky and talkative, but she had noticed the last few weeks and couple of mornings that the resident seemed lethargic and sleepy and she questioned the

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facility staff about the concern at her last visit (12/06/22) and prompted her to order additional blood work to include an A1C (measures the average blood sugar level over the previous 3 months) to assess the resident.
-If the resident was not receiving his insulin accurately, it could explain the change in the resident's behavior because getting too much or too little could cause the FSBS to be too high or too low which could result in altered mental status or other adverse outcomes such as increased risk of infection or urinary tract infections, diabetic coma, seizures, falls, passing out, and lethargy.
-Not getting medication accurately as ordered could negatively effect residents' health.
-She expected the facility ensure medications were on hand and administered and documented accurately as ordered to guide resident's care.
-She expected to be notified of medication errors so she could provide new orders and guide care.

Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable.

_____

The facility failed to administer medications accurately as ordered and per facility policy and procedures for 2 of 5 residents (#3, #5) including vitamin supplements and a blood thinner used to treat Resident #5's chronic conditions and boost her immune system and Resident #3's administration and documentation of FSBS and insulin with parameters in which he had a recent change in behavior and mental status which caused the provider to run further testing for assessment and in which inaccurate insulin administration could lead to adverse outcomes such as increased risk of infection or urinary tract infections, diabetic coma, seizures, falls, passing out and lethargy. The failure was detrimental to

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D 358	Continued From page 18 the health, safety and welfare of the residents and constitutes a Type Unabated B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/07/22 for this violation.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medication administration records (MAR) were complete and accurate for 2 of 5 sampled residents (#1, #5) related to a medication for	D 367		

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anxiety and the administration of an enema that were not documented on the medication administration record (#1) and for the ommission of a medication entry on the MAR in which the medication was being adminsitered and not documented (#5).

1. Review of Resident #1's current FL-2 dated 07/19/22 revealed:
-Diagnoses included end-stage congestive heart failure, myocardial infarction, diaphragmatic hernia and esophagitis with bleeding.
-She was intermittently disoriented.

Review of Resident #1's Resident Register revealed she was admitted on 02/10/22.

Review of Resident #1's record revealed she was admitted to hospice service on 07/15/22.

a.Review of Resident #1's physician's order dated 09/06/22 revealed there was an order for clonazepam 0.5mg to be administered three times each day as needed. (Clonazepam is a medication used to treat anxiety and agitation.)

Review of Resident #1's psychiatric visit note dated 09/07/22 revealed:
-Resident #1's diagnoses included anxiety, depression and memory problems.
-There was an order for Clonazepam 0.5mg, on half tablet to be administered twice daily as needed.

Review of Resident #1's MAR for October 2022 revealed there was a computerized entry for clonazepam 0.5mg to be administered three times each day as needed for agitation with no documentation of administration.

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D 367	Continued From page 20 Review of Resident #1's MAR for November 2022 revealed there was a computerized entry for clonazepam 0.5mg to be administered three times each day as needed for agitation with no documentation of administration. Review of Resident #1's MAR for December 2022 revealed: -There was a computerized entry for clonazepam 0.5mg 1 tablet to be administered three times daily as needed for agitation. -There was documentation clonazepam 0.5mg was administered on 12/05/22 and 12/06/22. (No time of administration was documented.) Review of Resident #1's control log revealed: -It was labeled clonazepam 0.5mg, take one half tablet twice daily as needed for anxiety. -30 tablets (60 half tablets) were dispensed on 08/30/22. -There was documentation clonazepam 0.5 mg, one half tablet was administered at 6:00pm on 10/31/22. -There was documentation clonazepam 0.5 mg, one half tablet was administered at 6:00pm on 11/03/22 through 11/05/22. -There was documentation clonazepam 0.5 mg, two one half tablets were administered at 6:00pm on 11/06/22 for a total of 0.5mg. -There was documentation clonazepam 0.5 mg, one half tablet was administered at 6:00pm on 11/07/22 and 11/08/22. -There was documentation clonazepam 0.5 mg, one half tablet was administered at 6:00pm on 11/14/22. -There was documentation clonazepam 0.5 mg, one half tablet was administered at 5:00pm on 12/05/22. -There was documentation clonazepam 0.5 mg, one half tablet was administered at 7:00am on	D 367		

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D 367	Continued From page 21 12/06/22 and 12/07/22. -There was documentation 48 doses remained. Observation of Resident #1's medications on hand on 12/07/22 at 2:05pm revealed: -There was a bubble pack labeled clonazepam 0.5mg, take one half tablet twice daily as needed for anxiety. -There were 48 half tablets remaining out of 60 that were dispensed on 08/30/22. Telephone interview with the pharmacy technician with the facility's contracted pharmacy on 12/07/22 at 5:00pm revealed: -They dispensed 30 tablets (60 half tablets) on 08/30/22 for the previous order of clonazepam 0.5mg one half tablet to be administered twice daily as needed. Refer to interview with the medication aide (MA) on 12/07/22 at 2:46pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/07/22 at 4:05pm. b.Review of Resident #1's physician's order dated 11/29/22 revealed an order to administered enema now then daily as needed. Review of Resident #1's MAR for November 2022 revealed there was no documentation of an enema being ordered or administered. Interview with Resident #1 on 12/07/22 at 8:15am revealed: -Her stomach bothered her often and she had no appetite. -She had an enema about a week prior that seemed to help with the stomach discomfort.	D 367		

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D 367	Continued From page 22 Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 4:05pm revealed: -She and a medication aide (MA) administered the enema as ordered on 11/29/22 and she expected the MA to transcribe to the MAR and document administration. -She wrote the order on an unsigned physician's order sheet for November 2022 and she thought she had written the order on the MAR. Refer to interview with the medication aide on 12/07/22 at 2:46pm. Refer to interview with the RCC on 12/07/22 at 4:05pm. _____ Interview with a medication aide (MA) on 12/07/22 at 2:46pm revealed MAs were responsible for documenting medications ordered as needed on the MAR at the time of administration and document effectiveness within 1 hour. Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 4:05pm revealed she expected medications that were administered to be documented on the MAR at the time of administration. 2. Review of Resident #5's current FL-2 dated 08/02/22 revealed: -Diagnoses included Parkinson's disease, dementia, hypothyroidism, history of a cardiovascular accident, and arthritis. -There was an order for Calcium 600mg (used as a vitamin supplement) once daily. Review of Resident #5's current medication physician orders dated 09/06/22 revealed there	D 367		

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D 367	Continued From page 23 was an order for Calcium 600mg once daily. Observation of administration of Resident #5's medication on 12/07/22 from 7:45am to 7:51am revealed: -A medication aide (MA) prepared the resident's medication by placing a Calcium 600mg with Vitamin D3 20 mcg tablet in a medication cup at 7:45am. -The Calcium 600mg with Vitamin D3 20 mcg was in an over-the-counter pill bottle that had a handwritten label with Resident #5's name and an open date of 06/17/22. -The MA appeared to compare the medications she prepared to the list of medications on the resident's electronic medication administration record (MAR) as she pulled them and placed them in a medication cup. Review of Resident #5's December 2022 MAR revealed: -There was no entry for Calcium 600mg or Calcium 600mg with Vitamin D3 20 mcg. -There was no documentation for Calcium 600mg or Calcium 600mg with Vitamin D3 20 mcg. Attempted interview with the medication aide (MA) that administered Resident #5's medication on 12/07/22 at 2:12pm revealed she was not available and had to leave the facility earlier than scheduled. Interview with another MA on 12/07/22 at 2:13pm revealed: -MAs were trained to compare the order on the MAR to what they prepare for the resident to take 3 times prior to administering medications to a resident ensuring it is the right medication, dose, route, person, time, and documentation. -She had previously administered Resident #5's	D 367		

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D 367	Continued From page 24 Calcium but did not realize it was not listed on the MAR. Interview with the Resident Care Coordinator (RCC) on 12/07/22 at 2:45pm revealed: -She was responsible for ensuring MARs were accurate and was not aware Resident #5's Calcium was not on her MAR as ordered. -MAs were expected to and were trained to administer medications accurately per the order on the MAR. -Even though she missed the error, she would have expected the MAs to catch the error as well since they knew the resident was supposed to receive the medication. Interview with the Administrator on 12/07/22 at 3:13pm revealed: -She was not aware Resident #5 MAR was inaccurate and missing her Calcium as ordered. -She expected medications to be administered accurately as ordered and per the MAR by MAs. -She expected the RCC to ensure MARs were accurate as ordered. Telephone interview with Resident #5's primary care provider (PCP) on 12/07/22 at 4:22pm revealed: -She was not aware Resident #5's MAR was inaccurate and missing her Calcium entry as ordered. -She expected the facility ensure MARs were accurate and medications were on hand and administered accurately as ordered. -She expected to be notified of medication errors so she could provide new orders and guide care.	D 367		