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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 02/15/23 through 02/17/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (Staff B and C) who administered medications met the requirements related to previous employment verification as a medication aide (Staff B); and passed the state written medication aide examination within 60 days of hire as a medication aide (Staff C). The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed:	D 125		

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D 125	Continued From page 1 -There was documentation Staff B was hired on 03/17/22. -There was documentation Staff B completed the 5 and 10 hour training for a total of 15 hours MA training course on 03/25/22. -There was documentation Staff B completed the medication aide competency validation clinical skills checklist on 03/17/22. -There was no documentation Staff B had taken and passed the medication aide examination. Review of a resident's December 2022 and February 2023 electronic medication administration record (eMAR) revealed: -Staff B administered medications on 8 days from 12/01/22 through 12/31/22. -Staff B administered medications on 3 days 02/01/23 through 02/15/23 Telephone interview with Staff B on 02/17/23 at 9:09am revealed: -She worked as a MA at the facility since last year. -When she worked, she administered medications, checked FSBS and administered insulin. -She completed the medication aide 15-hour training course and the MA competency validation clinical skills checklist. -She took the MA written test in November 2022 and failed the test. -The facility's contracted nurse checked her off again last month so she would have 60 more days to pass the medication aide examination. Telephone interview with the facility's contracted nurse on 02/17/23 at 3:51pm revealed: -She had provided MA training to Staff B. -Staff B took the MA written test and failed. -She provided the MA training again last month.	D 125		

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D 125	Continued From page 2 Interview with the Executive Director (ED) on 02/17/23 at 1:43pm revealed: -Staff B took the written medication aide examination test and failed in November 2022. -She thought if the MA did the 15-hour training again, the MA would have 60 days to retake the MA examination. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired as a MA on 09/20/19. -There was documentation Staff C completed the medication aide competency validation clinical skills checklist on 12/05/19. -There was documentation of an incomplete employee verification of prior employment as a MA. -There was documentation Staff C passed the MA written examination on 07/26/18. -There was no documentation Staff C had completed the 15-hour medication aide training. Review of a resident's January 2023, and February 2023 electronic medication administration records (eMAR) revealed: -Staff C administered medications on 2 days from 01/01/23-01/31/23. -Staff C administered medication on 2 days from 02/01/23-02/15/23. Interview with a resident on 02/16/23 at 3:15pm revealed: -Staff C sometimes worked at the facility. -When Staff C worked at the facility she administered medications to the resident. Interview with Staff C on 02/16/23 at 3:58pm revealed: -She worked as a MA at the facility.	D 125		

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D 125	Continued From page 3 -When she worked, she administered medications to the residents. -She had previous training as a MA from another facility, but had no training at this facility. Interview with the facility's contracted nurse on 02/17/23 at 3:51pm revealed: -She provided medication aide training at the facility monthly. -She checked her records and did not find any training for Staff C. Interview with the Executive Director (ED) on 02/17/23 at 2:53pm revealed: -Staff C completed the 15-hour training course from a previous employer. -She tried to obtain the training, but was unsuccessful. -She thought the employment verification that was provided had been completed.	D 125		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure 1 of 3 sampled staff (Staff A) had documentation of completed Tuberculosis	D 131		

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D 131	Continued From page 4 (TB) testing upon hire. The findings are: Review of Staff A's, medication aide (MA)/personal care aide (PCA). personnel record revealed: -Staff A was hired on 01/03/23. -There was documentation Staff A had a TB skin test administered on 03/22/22 and read with negative results 03/24/22. -There was no documentation of a TB skin upon hire. Interview with Staff A on 02/16/23 at 2:10pm revealed: -She recalled being administered a TB skin test. -She thought the test was read by the facility's nurse. Interview with the facility's Nurse Consultant on 02/17/23 at 3:51pm revealed: -She was at the facility monthly for training. -She was unable to recall if she administered and read Staff A's TB skin test. Telephone interview with the facility Executive Director from a conversation on 02/17/23 at 3:43pm revealed: -Staff A's TB skin test was placed in January 2023, but not read. -The previous Office Manager would have been responsible for ensuring TB skin test were obtained.	D 131		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of	D 164		

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D 164	Continued From page 5 Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 3 sampled medication aides (Staff A) had completed training on the care of diabetic residents prior to the administration of insulin. The findings are: Review of Staff A, medication aide (MA) personnel record revealed: -She was hired on 01/03/23.	D 164		

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-There was documentation Staff A completed the MA competency validation clinical skills checklist on 01/17/23.
-There was documentation Staff A completed the 15-hour MA training on 01/17/23.
-There was no documentation of training on the care of diabetic residents.

Review of a resident's February 2023 electronic medication administration record:
-Staff A documented she checked fingerstick blood sugar (FSBS) and administered insulin on 02/02/23 and 02/09/23.

Interview with Staff A on 02/16/23 at 2:10pm revealed:
-When she worked, she checked FSBS and administered insulin to a resident.
-She received some diabetic training, but as part of the 15-hour MA training.
-She had not completed any separate diabetic training.

Telephone interview with the facility's contract nurse on 02/17/23 at 2:51pm revealed:
-She provided diabetic training as part of the 15-hour MA training.
-The MAs were supposed to complete the online diabetic training provided by the pharmacy.
-There should be documentation the training was completed.
-She had no way to validate Staff A completed the training.

Interview with the Executive Director (ED) on 02/17/23 at 2:43pm revealed:
-She provided the MAs a list of required trainings that needed to be completed online that were designed and set-up by the pharmacy.
-The MAs were responsible for scheduling and

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D 164	Continued From page 7 completing the required trainings. -The diabetic training was one of the required trainings. -After the training was completed the staff had to print their own certificate. -She had no way to validate the training was completed unless the staff provided the certificate.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 2 of 3 sampled residents (#1 and #2) related to notifying primary care providers (PCPs) for a resident refusing doses of a long-acting insulin and an anti-depressant and pain medication (#1), and a resident refusing an anti-seizure medication and eye drops (#2). The findings are: Review of the facility Policy and Procedure Manual (no date noted) related to Resident Refusal of Medication revealed actual refusal was when a person directly refused to take a medication. Review of the Medication aide (MA) steps to take when a resident refused medication listed	D 273		

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included:
-If a resident refuses and gives no reason, wait a few minutes and then offer the medication again.
-If the resident refuses the medication the second offer, notify the Resident Care Director (RCD) of the resident's refusal.
-Upon the first refusal of a medication, the RCD shall notify the physician of the refusal and ask the physician how often to notify the physician for future refusals.
-Consider changing the time of administration if taking the medication interferes with an activity or sleep.
-If the refusals continue, explore other options with the resident's physician and document in the resident's record.

1. Review of Resident #2's current FL2 dated 04/06/22 revealed diagnoses included mood disorder, post-traumatic stress disorder (PTSD), epilepsy and glaucoma.

a. Review of Resident #2's current FL2 dated 04/06/22 revealed there was an order for levetiracetam (used to treat seizures) 750mg one tablet twice a day.

Review of Resident #2's after-visit summary from a encounter at the local emergency room (ER) dated 11/07/22 revealed:
-Resident #2 was seen at the ER for treatment of a seizure.
-Resident #2's levetiracetam was listed on the medication summary for levetiracetam 1000mg twice a day.

Review of Resident #2's signed physician's orders dated 12/28/22 and 02/03/23 revealed levetiracetam 1000mg twice a day was ordered.

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D 273	Continued From page 9 Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry levetiracetam 1000mg twice a day scheduled for 8:00am and 8:00pm. -On 02/01/23 at 8:00pm, levetiracetam 1000mg was documented as not administered with out of the facility documented for the reason not administered. -On 02/05/23 at 8:00am, levetiracetam 1000mg was documented as not administered with no reason for why not administered documented. -On 02/05/23 at 8:00pm, levetiracetam 1000mg was documented as not administered with out of the facility documented for the reason not administered. -02/14/23 at 8:00am, levetiracetam 1000mg was documented as not administered with refused documented for the reason not administered. -02/15/23 at 8:00am, levetiracetam 1000mg was documented as not administered with refused documented for the reason not administered. Review of Resident #2's progress notes revealed there was no documentation for notification of Resident #2's PCP for any missed doses on levetiracetam 1000mg. Interview with Resident #2's PCP on 02/15/23 at 10:45am revealed: -Resident #2 had a history of seizures. -Resident #2 had a recent hospital ER visit for seizure activity (11/07/22). -The facility had not informed Resident #2 was refusing or had missed any doses of levetiracetam 1000mg. -Based on the metabolism of levetiracetam 1000mg being fairly quick, she was concerned that any missed doses of levetiracetam 1000mg could affect the therapeutic levels in Resident	D 273		

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#2's body and trigger a seizure.
-She would have expected the facility to contact her for even one missed dose.
-She might need to change the time of his morning medication administration if he was refusing because he was not up yet. She had done that for other residents.

Interview with a morning medication aide (MA) on 02/16/23 at 9:15am revealed:
-She administered medications at the facility when she was scheduled to work.
-She did not know the facility's policy for missed or refused medications.
-She routinely documented the missed dose and the reason for the missed dose, including refused.

Interview with Resident #2 on 02/16/23 at 9:50am revealed:
-He refused morning medications, including seizure medications, sometime because he was not a morning person.
-He was incoherent of what was going on a lot of mornings.
-If staff tried to wake him up and he was half aroused he may be refusing the medications.
-He had not been having any symptoms he experienced with seizures like slurred speech or dizziness, but he had been having headaches.
-He would like to try moving his morning medications to later in the morning instead of 8:00am, but he had not spoken to his PCP regarding rescheduling morning medications.

Interview with the Resident Care Director (RCD) on 02/16/23 at 4:50pm revealed:
-She had been back at the facility since December 2022 after being away for a while.
-The previous Administrator had assumed

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responsibility for processing physicians' orders, faxing the orders to the contracted pharmacy and releasing medication orders to show up on the eMAR for medication administration.
-She had assumed this responsibility since 02/06/23.
-There was currently no system for routinely auditing the residents' eMARs for missed or refused doses and reporting missed medications to the PCP prior to last week (02/06/23).

Interview with the RCD on 02/17/23 at 2:15pm revealed:
-On 02/06/23, she had taken over auditing residents' records for incomplete eMAR documentation, reviewing medications refused or not administered after the previous Administrator had left.
-When she worked at the facility previously, the MAs filled out a facility's physician notification form and placed it in a folder for the contracted primary care provider (PCP) to review on her next visit.
-She had not notified Resident #2's PCP related to Resident #2 not receiving levetiracetam 1000mg on 02/01/23 at 8:00pm, on 02/05/23 at 8:00am, on 02/05/23 at 8:00pm.
-On 02/14/23 at 8:00am, levetiracetam 1000mg was documented as not administered with refused documented for the reason not administered.
-She had not notified Resident #2's PCP related to Resident #2 not receiving levetiracetam 1000mg on 02/14/23 at 8:00am and 02/15/23 at 8:00am because she did not know the facility's policy regarding missed medications.
-She thought it was 3 doses missed before notifying the provider.

Interview with the facility's Executive Director

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(ED) on 02/16/23 at 1:43pm revealed:
-The Office Manager was responsible for reviewing "care suite" (a report generated in the eMAR system) reports daily to identify refusal of medications.
-The Office Manager was responsible to inform the Administrator of the refusals.
-The Office Manager and/or the Administrator were supposed to contact the residents' PCPs with refusal of medications after 3 doses refused.

Interview with the facility's ED on 02/17/23 at 3:00pm revealed She did not know Resident #2's PCP had not been notified regarding missed doses of levetiracetam 1000mg.

b. Review of Resident #2's the after visit summary from a encounter at local emergency department (ER) dated 11/07/22 revealed:
-Resident #2 was seen at the ER for treatment of a seizure.
-Resident #2's had an order for topiramate (used to treat seizures) 50mg twice a day listed on routine medications.

Review of Resident #2's signed physician's orders dated 12/28/22 and 02/03/23 revealed an order for topiramate 50mg twice a day

Review of Resident #2's February 2023 eMAR revealed:
-There was an entry topiramate 50mg twice a day scheduled for 8:00am and 8:00pm.
-On 02/01/23 at 8:00pm, topiramate 50mg was documented as not administered with out of the facility documented for the reason not administered.
-On 02/05/23 at 8:00am, topiramate 50mg was documented as not administered with no reason for why not administered documented.

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D 273	Continued From page 13 -On 02/05/23 at 8:00pm, topiramate 50mg was documented as not administered with out of the facility documented for the reason not administered. -On 02/14/23 at 8:00am, topiramate 50mg was documented as not administered with refused documented for the reason not administered. -On 02/15/23 at 8:00am, topiramate 50mg was documented as not administered with refused documented for the reason not administered. Review of Resident #2's progress notes revealed there was no documentation for notification of Resident #2's primary care provider (PCP) for any missed doses on topiramate 50mg. Interview with Resident #2's PCP on 02/15/23 at 10:45am revealed: -Resident #2 had a history of seizures and recently had a hospital ER visit for seizure activity (11/07/22). -The facility had not informed her Resident #2 was refusing or had missed any doses of topiramate 50mg. -Resident #2 had a combination of medications to help control seizures and missed doses could affect the therapeutic levels of the medications in Resident #2's body and trigger a seizure. -She would have expected the facility to contact her for even one missed dose. -She might need to change the time of his morning medication administration if he was refusing because he was not up yet and had done that for other residents. Interview with a morning medication aide (MA) on 02/16/23 at 9:15am revealed: -She administered medications at the facility when she was scheduled to work. -She did not know the facility's policy for missed	D 273		

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or refused medications.
-She routinely documented the missed dose and the reason for the missed dose, including refused.

Interview with Resident #2 on 02/16/23 at 9:50am revealed:
-He refused morning medications, including seizure medications, sometime because he was not a morning person.
-He was incoherent of what was going on a lot of mornings.
-If staff tried to wake him up and he was half aroused, he may be refusing the medications.
-He had not been feeling symptoms he experienced with seizures like slurred speech or dizziness, but he had been having headaches.
-He would like to try moving his morning medications to later in the morning instead of 8:00am, but he had not spoken to his PCP regarding rescheduling morning medications.

Interview with the Resident Care Director (RCD) on 02/16/23 at 4:50pm revealed:
-She had been back at the facility since December 2022 after being away for a while.
-The previous Administrator had assumed responsibility for processing physicians' orders, faxing the orders to the contracted pharmacy and releasing medication orders to show up on the eMAR for medication administration.
-She had assumed this responsibility since 02/06/23.
-There was currently no system for routinely auditing the residents' eMARs for missed or refused doses and reporting missed medications to the PCP prior to last week (02/06/23).

Interview with the RCD on 02/17/23 at 2:15pm revealed:

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-On 02/06/23, she had taken over auditing residents' records for incomplete eMAR documentation, reviewing medications refused or not administered after the previous Administrator had left.
-When she worked at the facility previously, the MAs filled out a facility's physician notification form and placed it in a folder for the contracted primary care provider (PCP) to review on her next visit.
-She had not notified Resident #2's PCP related to Resident #2 not receiving topiramate 50mg on 02/01/23 at 8:00pm, on 02/05/23 at 8:00am, on 02/05/23 at 8:00pm.
-She had not notified Resident #2's PCP related to Resident #2 not receiving topiramate 50mg on 02/14/23 at 8:00am and 02/15/23 at 8:00am, because she did not know the facility's policy regarding missed medications.
-She thought it was 3 doses missed before notifying the provider.

Interview with the facility's Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-The Office Manager was responsible for reviewing "care suite" (a report generated in the eMAR system) reports daily to identify refusal of medications.
-The Office Manager was responsible to inform the Administrator of the refusals.
-The Office Manager and/or the Administrator were supposed to contact the residents' PCPs with refusal of medications after 3 refusals.

Interview with the facility's ED on 02/17/23 at 3:00pm revealed She did not know Resident 2's topiramate 50mg was not being administered as ordered or the PCP was not notified for missing doses.

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D 273	Continued From page 16 c. Review of Resident #2's physician's orders dated 12/20/22 for timolol (used to treated elevated pressure in the eye) 0.5% ophthalmic drops one drop in each eye every morning. Review of Resident #2's signed physician's orders dated 12/28/22 and 02/03/23 revealed orders for timolol 0.5% ophthalmic drops one drop in each eye every morning. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for timolol 0.5% ophthalmic drops instill one drop in both eyes every morning. -Timolol 0.5% ophthalmic drops was scheduled for administration at 8:00am daily. -Timolol 0.5% ophthalmic drops was documented as not administered for 8 out of 15 opportunities at 8:00am from 02/01/23 to 02/15/23. -On 02/05/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with out of facility the reason documented. -On 02/06/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with no reason documented on the eMAR. -On 02/07/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with refused documented as the reason. -On 02/08/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with refused documented as the reason. -On 02/12/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with refused documented as the reason. -On 02/13/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with refused documented as the reason. -On 02/14/23 at 8:00am, timolol 0.5% ophthalmic drops was documented as not administered with	D 273		

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refused documented as the reason.
-On 02/15/23 at 8:00am, timolol 0.5% ophthalmic drops was documented not administered with refused documented as the reason.

Observation of medication on hand for administration for Resident #2 on 02/17/23 at 2:30pm revealed there was a partial bottle of timolol 0.5% ophthalmic drops dispensed on 12/14/22 on the medication cart for administration.

Telephone interview with a pharmacist at the contracted pharmacy provider on 02/17/23 at 11:30am revealed:
-Ttimolol 0.5% ophthalmic drops was last dispensed on 12/14/22 for a one month supply.
-Timolol was not cycle filled and was reordered by the facility when needed.

Review of Resident #2's faxed notifications and progress notes revealed there was no documentation Resident #2's Ophthalmologist was notified for Resident #2 refusing timolol 0.5% drops 8 of 15 opportunities in February 2023.

Interview with Resident #2 on 02/16/23 at 9:50am revealed:
-He refused morning medications sometime because he was not a morning person.
-He was incoherent of what was going on a lot of mornings.
-If staff tried to wake him up and he was half aroused he may be refusing the medications.
-He had been refusing his timolol eye drop,s because he did not feel like he had elevated pressure in his eyes and the eye drops burned.

Interview with the Resident Care Director (RCD) on 02/16/23 at 10:00am revealed:

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-She had been passing medications in the facility for the last two morning (02/14/23 and 02/15/23) due staffing shortages.
-She had not notified Resident #2's Ophthalmologist for refusing timolol 0.5% ophthalmic drops, because she was not sure about numbers for the facility's policy for missing or refused medication and provider notification.
-She had not seen any paperwork for notifying providers about refusal of medications.

Interview with the Resident Care Director (RCD) on 02/16/23 at 4:50pm revealed:
-She had been back at the facility since December 2022 after being away for a while.
-The previous Administrator had assumed responsibility for processing physicians' orders, faxing the orders to the contracted pharmacy and releasing medication orders to show up on the eMAR for medication administration.
-She had assumed this responsibility since 02/06/23.
-There was currently no system for routinely auditing the residents' eMARs for missed or refused doses and reporting missed medications to the PCP prior to last week (02/06/23).

Telephone interview with a nurse at Resident #2's Ophthalmologist office on 02/17/23 at 10:49am revealed:
-There was no documentation regarding the facility notifying the office for Resident #2's refusing timolol 0.5% ophthalmic drops since the office visit on 12/20/22.
-There was documentation in the office notes dated 12/20/22 regarding the resident told the physician he sometimes did not use the eye drops because they would sting and burn.
-Not using the timolol drops could cause the eye pressure to increase and increased eye pressure

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could damage the eye resulting in poor vision and even damage to the optic nerve.
-The facility would not be expected to notify the physician for each time the resident refused his eye drops, but would expect to be notified for repeated refusals.
-The Ophthalmologist might recommend a different time of day to administer if a resident did not want the morning administration.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-The Office Manager was responsible for reviewing the "care suite" daily to identify refusal of medications. Care Suite was a computer generated printout of missed medication administration.
-The Office Manager was to let the contracted PCP know when a resident refused medications using the communication sheet from the PCP's workbook.
-The Office Manager should document communication with the PCP regarding the resident's refusal of medication in the resident's record.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She printed a report from the eMAR system weekly.
-She reviewed the report to identify medication refusals.
-She informed the previous Administrator of refusals, and the previous Administrator was supposed to contact the PCP.
-She did not document when she identified refusal and she did not document when she informed the Administrator of the refusals.

Interview with the facility's Executive Director

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(ED) on 02/17/23 at 3:00pm revealed there was no documentation for notifying Resident #2's Ophthalmologist for missed timolol 0.5% drops in February 2023.

3. Review of Resident #1's current FL2 dated 07/20/22 revealed:
-Diagnoses included diabetes mellitus type II, stroke, hypertension, vitamin B deficiency anemia, gastro-esophageal reflux disease, vitamin D deficiency, moderate depression, insomnia and anxiety.

a. Review of Resident #1's current FL2 dated 07/20/22 revealed there was an order for lantus 15 units at bedtime (long acting insulin used to decrease and control blood sugar).

Review of Resident #1's physician's orders revealed:
-There was a physician's order dated 12/15/22 by the Veteran's Administration Primary Care Provider (VA PCP) for lantus 25 units subcutaneously at bedtime.
-There was a physician's progress note with medication orders dated and signed by the facility's PCP on 01/25/23 for lantus 25 units subcutaneously twice a day.
-There was a physician's order dated 02/08/23 for lantus inject 25 units subcutaneously twice a day.

Review of Resident #1's laboratory test dated 11/30/22 revealed:
-Resident #1 had a glycated hemoglobin A1c (HBA1c) (a blood test that measures your average blood sugar levels over the past 3 months) with results of 8.0 (normal range for HBA1c was 4.8 to 5.6).
-The glycemic control for adults with diabetes was less than 7.0.

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D 273	Continued From page 21 Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for lantus (glargine solostar) 25 units subcutaneously twice a day scheduled for administration at 8:00am and 8:00pm. -There was documentation with staff circled initials indicating lantus was not administered and reason documented as "resident refused." -There was documentation Resident #1 refused lantus 18 times from 12/01/22 through 12/31/22. -There no documentation Resident #1's PCP was contacted regarding the refusal of lantus. Review of Resident #1's January 2023 eMAR revealed: -There was an entry for lantus 25 units subcutaneously twice a day scheduled for administration at 8:00am and 8:00pm. -There was documentation with staff circled initials indicating lantus was not administered and reason documented as "resident refused." -There was documentation Resident #1 refused lantus 16 times from 01/01/23 through 01/31/23. -There no documentation Resident #1's PCP was contacted regarding the refusal of lantus. Review of Resident #1's February 2023 eMAR revealed: -There was an entry for lantus 25 units subcutaneously twice a day scheduled for administration at 8:00am and 8:00pm. -There was documentation with staff circled initials indicating lantus was not administered and reason documented as "resident refused." -There was documentation Resident #1 refused lantus 9 times from 01/01/23 through 01/31/23. -There no documentation Resident #1's PCP was contacted regarding the refusal of lantus.	D 273		

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Interview with Resident #1 on 02/16/23 at 10:44am revealed:
-He was administered insulin in the morning and in the evening.
-He was not sure of the names of the insulin.
-When his blood sugars were about "120's" he refused all insulin because he was afraid of his blood sugar dropping low.

Telephone interview with Resident #1's PCP on 02/15/23 at 4:20pm revealed:
-She was aware Resident #1 refused Novolog and fingerstick blood sugar (FSBS), but she did not know the resident also refused lantus.
-She wanted to be made aware after one refusal if a resident refused a medication.
-She was in the facility every week and staff should have made her aware Resident #1 refused lantus.
-She had given parameters to hold Resident #1's Novolog for blood sugars less than 100, but she did not intend for the lantus to be withheld.
-Resident #1 was a diabetic and his blood sugars were up and down, she wanted lantus long acting to be administered to stabilize the blood sugars.
-Without lantus being administered there was less control of blood sugars, eventually causing diabetic complications like loss limbs, neuropathy, blindness and heart disease.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-When she worked, she administered Resident #1's lantus twice daily.
-There were times when Resident #1 refused all insulin due to fear of his blood sugar dropping.
-She did not contact the PCP and she did not let anyone know the resident refused the lantus because the resident had a right to refuse

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D 273	Continued From page 23 medications. Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed: -Resident #1 often refused insulin when his FSBS was in the 120's or less because he was afraid of his blood sugar falling low. -She did not let the PCP know the resident refused lantus. -The Office Manager was supposed to check a daily report called "care suite." -The care suite showed refusals of medications. -If a resident refused a medication for 3 days, then the PCP should be notified. -There should be documentation to show the PCP was notified. Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed: -The Office Manager was responsible for reviewing the "care suite" daily to identify refusal of medications. -The Office Manager was to let the PCP know when a resident refused medications. -The Office Manager should document communication with the PCP regarding the resident's refusal of medications. Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed: -She printed a report from the eMAR system weekly. -She reviewed the report to identify medication refusals. -She informed the Administrator of refusals, and the Administrator was supposed to contact the PCP. -She did not document when she identified refusal, and she did not document when she informed the Administrator of the refusals.	D 273		

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Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-The previous Office Manager was responsible for reviewing care suite reports daily to identify refusals of medications.
-The Office Manager should inform the Administrator of the refusals.
-The Office Manager and/or the Administrator were to contact the resident's PCP with refusals of medications after the resident refused 3 doses or 3 days.

b. Review of Resident #1's current FL2 dated 07/20/22 revealed there were medication orders which included duloxetine 40mg 1 capsule in the morning (used to treat depression and anxiety).

Review of Resident #1's physician's orders revealed:
-There was a physician's order dated 12/15/22 by the veteran's administration primary care provider (VA PCP) for duloxetine 20mg take 2 capsules in the morning for depression/anxiety.
-There was a physician's progress note with medication orders dated and signed by the facility's mental health provider (MHP) dated 01/25/23 for duloxetine 40mg 1 capsule every morning.
-There was a physician's order dated 02/08/23 for duloxetine 40mg every morning.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for duloxetine 40mg 1 capsule every morning scheduled for administration at 8:00am.
-There was documentation with staff circled initials 6 times indicating duloxetine 40mg was

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not administered from 12/01/22 through 12/31/22.
-For 4 of the 6 times, there was documentation Resident #1 refused duloxetine 40mg.
-For 2 of the 6 times, there was documentation duloxetine 40mg was "out of stock - waiting on the VA" (12/04/22 and 12/27/22).
-There was no documentation Resident #1's MHP was contacted regarding the refusals of duloxetine 40mg.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for duloxetine 40mg 1 capsule every morning scheduled for administration at 8:00am.
-There was documentation with staff circled initials 8 times indicating duloxetine 40mg was not administered and reason documented as "resident refused" from 01/01/23 through 01/31/23.
-There was no documentation Resident #1's MHP was contacted regarding the refusals of duloxetine.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for duloxetine 40mg 1 capsule in the morning scheduled for administration at 8:00am.
-There was documentation with staff circled initials 6 times indicating duloxetine 40mg was not administered and reason documented as "resident refused" from 02/01/23 through 02/15/23.
-There was no documentation Resident #1's MHP was contacted regarding the refusals of duloxetine 40mg.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 8:43am

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revealed:
-Duloxetine 20mg 2 tablets once daily was available for administration.
-The medication was filled and dispensed for a quantity of 60 tablets on 01/03/23, and there were 40 tablets remaining.

Interview with Resident #1 on 02/16/23 at 10:44am revealed:
-He did not fully understand the names and purpose of his medications.
-He remembered that he had a medication that was a stool softener which started with the letter "D" something, but he was unable to recall the exact name.
-He continually refused the stool softener because he did not need a stool softener.

Interview with Resident #1 on 02/17/23 at 2:45pm revealed:
-He had continuous pain in his back.
-The pain in his back never went away.
-He did not know he had a medication for back pain other than ibuprofen.
-The MAs gave him ibuprofen for the pain, when it was available.
-The ibuprofen helped make him comfortable so he could sleep, but it did not take the pain away.

Telephone interview with Resident #1's MHP on 02/17/23 at 2:33pm revealed:
-Duloxetine was an antipsychotic medication that was also used to treat nerve pain.
-She ordered Resident #1 duloxetine because he continually complained of pain in his back.
-She was not aware Resident #1 refused duloxetine 40mg once daily.
-Resident #1 also had a diagnoses of major depression and mood disorder, so the medication was beneficial for treating both.

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-The medication should be administered as ordered.
-She was in the facility weekly and expected to be notified if a resident refused medications.
-Mentally, Resident #1 would probably be alright, but he would have increased pain.

Telephone interview with Resident #1's primary care provider (PCP) on 02/15/23 at 4:20pm revealed:
-She did not order Resident #1's duloxetine.
-No one at the facility made her aware Resident #1 refused duloxetine or a stool softener.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-Resident #1 refused duloxetine because he did not want a stool softener.
-She did not know duloxetine was not a stool softener.
-She did not tell the resident's MHP or the facility PCP the resident refused the stool softener.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-When she administered Resident #1's medications he refused duloxetine because the resident thought the medication was a stool softener.
-She was not aware duloxetine was not a stool softener, and she had not made the MHP aware Resident #1 refused the medication.
-The Office Manager was supposed to review "care suite" daily to identify refusals and notify the PCP.
-She did not know if the Office Manager notified the PCP of the resident's refusals of duloxetine.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:

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-She was aware that Resident #1 refused duloxetine because it was a stool softener.
-She did not realize the medication was used for depression and anxiety.
-The Office Manager was responsible for reviewing "care suite" daily to identify refusal of medications.
-The Office Manager should have let Resident #1's PCP know the resident refused medications.
-There should be documentation corresponding to contact with Resident #1's PCP.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She did not recall notifying Resident #1's PCP or MHP regarding the resident's refusal of duloxetine.
-She printed a report from the eMAR system weekly.
-She reviewed the report to identify medication refusals.
-She informed the Administrator of refusals and the Administrator was supposed to contact the PCP.
-She did not document when she identified refusals, and she did not document when she informed the Administrator of the refusals.

Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-The PCP should be notified after at least 3 refusals.
-There should be documentation the PCP was notified and the PCP's response.
-The previous Office Manager was responsible for reviewing care suite reports daily to identify refusals of medications.
-The Office Manager should inform the Administrator of the refusals.
-The Office Manager and/or the Administrator

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D 273	Continued From page 29 were to contact the resident's PCP with refusal of medications after 3 refusals. __________________ The facility failed to ensure the provider was contacted for 2 of 3 sampled residents (#1 and #2) for a resident with a history of seizures, refusals of levetiracetam 1000mg and topiramate 50mg which could decrease therapeutic levels in the blood and trigger seizures, and refusals of timolol placing the resident at risk for optic nerve damage and decreased or loss of vision (#2); and a resident's refusals of duloxetine resulting in the resident experiencing increased back pain, and refusals of a insulin which placed the resident at risk for heart disease, blindness and loss of limbs (#1). This failure was detrimental to the resident's health, safety and welfare which constitutes a Type B Violation. ___________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/23 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2023.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon	D 344		

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D 344	Continued From page 30 admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on the observation, record review and interview the facility failed to contact the resident's primary care provider (PCP) for 1 of 3 sampled residents (#1) to clarify medication changes with a pain medication, an anti-hypertensive medication and a nerve pain medication. The findings are: Review of Resident #1's current FL2 dated 07/20/22 revealed diagnoses included hypertension and diabetes mellitus type II. a. Review of Resident #1's current FL2 dated 07/20/22 revealed there was an order for ibuprofen 800mg 1 tablet three times daily (used to treat pain). Review of Resident #1's physician's orders revealed: -There was a physician's order dated 12/15/22 by the Veteran Administration primary care provider (VA PCP) for ibuprofen 400mg 1 tablet three times daily as need (prn) for severe pain (take with food). -There was a physician's progress note with medication orders dated and signed by the facility's PCP on 01/25/23 for ibuprofen 800mg take 1 tablet three times daily. -There was a physician's order dated 02/08/23 for ibuprofen 800mg take 1 tablet three times daily.	D 344		

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-There was a new physician's order dated 02/08/23 to start ibuprofen 400mg tablet every 12 hours prn for pain.

Review of Resident #1's physician progress note dated 01/25/23 revealed Resident #1 had severe back pain and neurological headaches.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for ibuprofen 800mg 1 tablet three times daily scheduled for administration at 8:00am, 1:00pm and 8:00pm.
-There was documentation ibuprofen 800mg 1 tablet three times daily was administered from 12/01/22 through 12/31/22.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for ibuprofen 800mg 1 tablet three times daily scheduled for administration at 8:00am, 1:00pm and 8:00pm.
-There was documentation ibuprofen 800mg 1 tablet three times daily was administered from 01/01/23 through 01/31/23.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for ibuprofen 800mg 1 tablet three times daily scheduled for administration at 8:00am, 1:00pm and 8:00pm.
-There was documentation ibuprofen 800mg 1 tablet three times daily was administered from 02/01/23 through 02/15/23.
-There was an entry for ibuprofen 400mg 1 tablet every 12 hours as needed for pain.
-There was no documentation ibuprofen 400mg had been administered.

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Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Ibuprofen 400mg was available for administration.
-The medication was filled and quantity of 100 tablets were dispensed on 02/09/23 with instructions to administer 1 tablet three times daily prn for severe pain.
-There was no 800mg ibuprofen available for administration.

Telephone interview with Resident #1's social worker from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-The last order the pharmacy had for ibuprofen was 400mg 1 tablet three times daily prn for severe pain.
-The VA had not received the order dated 01/25/23 for ibuprofen 800mg take 1 tablet three times daily.
-There was a physician's order dated 02/08/23 for ibuprofen 800mg take 1 tablet three times daily.
-There was a physician's order dated 02/08/23 to start ibuprofen 400mg tablet every 12 hours as needed for pain.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He was always in pain in his back and legs.
-He had pain medication, it was ibuprofen.
-He did not know the strength of the ibuprofen.
-When he told staff that he needed something for pain, they gave him ibuprofen, when it was available.
-Sometimes the ibuprofen was out and staff borrowed the ibuprofen from another resident.
-When the ibuprofen was available it helped with the pain; enough for him to sleep, but when he woke up, he was in pain.

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D 344	Continued From page 33 Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed: -She was not aware there was a discrepancy in Resident #1's ibuprofen. -She did not receive or review medication orders. -She read the eMAR when administering medications, but did not realize the order on the eMAR for ibuprofen did not match the medication instructions. -She had not clarified the ibuprofen with the PCP. -The Office Manager or Administrator were responsible for clarifying medication orders with the PCP. Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:20pm revealed: -She ordered an increase in Resident #1's ibuprofen from 400mg to 800mg three times daily because the resident always complained about the pain in his back. -Resident #1 should be administered ibuprofen 800mg three times daily scheduled, not prn. -She recently added ibuprofen 400mg prn every 12 hours, but that was in addition to the routine ibuprofen. Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed: -When the facility PCP wrote a new or changed medication order for Resident #1, the order should be sent to the VA PCP for approval. -The MA, Office Manager or Administrator was responsible for sending orders to the VA PCP. -The VA PCP had to review and approve the order. -After approving the order, the order was sent to the VA pharmacy. -The order should also be sent to the facility's pharmacy for profile and printing on the eMAR.	D 344		

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-The MA should be reading the eMAR and comparing the medication instructions when administering medications.
-If the eMAR did not match the medications on hand there should be clarification with the PCP.
-There should be documentation to show the PCP was contacted and the PCP's response.
-She had administered Resident #1's ibuprofen and had not realized there was a discrepancy.

Telephone interview with a previous MA on 02/17/23 at 9:50am revealed:
-When she administered medications, she compared the medication instructions with what was on the eMAR.
-If there was a discrepancy, she did not administer the medication, but informed the Office Manager and the Administrator.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-The facility did not have a system for comparing medications on hand with the orders on the eMAR.
-The MA should be looking at the eMAR when administering medications.
-If the MA found a discrepancy, the PCP should be contacted to clarify the order.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She reviewed the eMAR exception report to identify when staff documented a medication was not available.
-She did not compare medications on the cart with the eMAR.
-If a MA identified the eMAR and the medication instructions did not match, then the PCP should be contacted.

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Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-She expected medications to be administered as ordered.
-If medication did not match the current orders, the order should be clarified with the PCP.
-There should be documentation to show the PCP's response.

Attempted telephone interview with Resident #1's Veteran's Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

b. Review of Resident #1's current FL2 dated 07/20/22 revealed an order for lisinopril 5mg 1 tablet once daily (used to treat high blood pressure).

Review of a Resident #1's previous physician's orders revealed:
-There was a physician's order dated 12/15/22 by the Veteran's Administration primary care provider (VA PCP) for lisinopril 10mg 1 tablet daily.
-There was a physician's progress note with medication orders dated and signed by the facility's PCP on 01/25/23 for lisinopril 5mg 1 tablet by once daily.
-There was a physician's order dated 02/08/23 for lisinopril 5mg once daily.
-There was a current physician's medication list from the VA dated 01/12/23 which included an order for lisinopril 10mg 1 tablet once daily.

Review of Resident #1's December 2022 electronic medication administration record

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(eMAR) revealed:
-There was an entry for lisinopril 5mg 1 tablet once daily at 8:00am.
-There was documentation lisinopril 5mg was administered daily from 12/01/22 through 12/31/22.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for lisinopril 5mg 1 tablet once daily at 8:00am.
-There was documentation lisinopril 5mg was administered daily from 01/01/23 through 01/31/23.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for lisinopril 5mg 1 tablet once daily at 8:00am.
-There was documentation lisinopril 5mg was administered daily from 02/01/23 through 02/15/23.

Observation of Resident #1's medications on hand on 02/15/23 at 2:21pm revealed:
-Lisinopril 10mg was available for administration.
-The instructions on the bottle of lisinopril were to administer 10mg one tablet once daily.
-The medication was filled on 01/20/23 for a quantity of 90 tablets.
-There were greater than 45 tablets remaining.

Telephone interview with Resident #1's social worker for the VA from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-The last order the VA pharmacy had for lisinopril was dated 12/15/22.
-There were instructions to administer 10mg once daily.
-There were no other orders for lisinopril.

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Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He was administered medication daily.
-He had high blood pressure and his blood pressure was sometimes checked by facility staff.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-When she administered Resident #1's lisinopril, she did not realize there was a difference in the order on the eMAR and the instructions on medication on hand.
-When a discrepancy was identified it should be clarified with the PCP.
-She read the eMAR and the medication, but overlooked the medication on hand was 10mg, but on the eMAR instructions were lisinopril 5mg.
-When orders were received, they should be clarified by the RCD, Administrator or Office Manager.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:20pm revealed:
-She ordered Resident #1 lisinopril 5mg once daily.
-Resident #1's blood pressure was up lately, she did not think the 10mg was harmful.
-The staff should not administer medications without clarifying the medication order.
-She was in the facility weekly, and the MA should clarify orders before administering medications.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-When the facility PCP wrote a new or changed medication order for Resident #1, the order should be sent to VA PCP for approval.
-The VA PCP had to review and approve the order.

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-After approving the order, the order was sent to the VA pharmacy.
-The order should also be sent to the facility's pharmacy for profile and printing on the eMAR.
-The MA administering Resident #1's medications should read the eMAR and medication instructions prior to administering medications.
-If the eMAR and medication instructions did not match, the MA should clarify the order with the PCP.
-There should be documentation to show the PCP was contacted and the PCP's response.

Telephone interview with a previous MA on 02/17/23 at 9:50am revealed:
-When she administered medications, she compared the medication instructions with what was printed on the eMAR.
-If there was a discrepancy, she did not administer the medication, she contacted the Office Manager and the Administrator.
-She did not clarify orders and had not realized she administered lisinopril 10mg instead of 5mg on the eMAR.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-The facility did not have a system for comparing medications on hand with the orders on the eMAR.
-The MA should be looking at the eMAR when administering medications.
-If the MA found a discrepancy, the PCP should be contacted to clarify the order, and there should be documentation to show the PCP's response.

Interview with the ED on 02/16/23 at 1:43pm revealed:
-She expected medications to be administered as ordered.

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-If medication did not match the current orders, the order should be clarified with the PCP.
-There should be documentation to show the PCP's response.

Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

c. Review of Resident #1's current FL2 dated 07/20/22 revealed an order for gabapentin 300mg 2 capsules (600mg) twice daily (used to treat nerve pain).

Review of a pervious physician's orders revealed:
-There was a physician's order dated 12/15/22 by the Veteran's Administration primary care provider (VA PCP) for gabapentin 300mg 2 capsules twice a day.
-There was a medication order list dated 01/12/23 gabapentin 300mg 2 capsules (600mg) three times daily for nerve pain.
-There was a physician's progress note with medication orders dated and signed by the facility's PCP on 01/25/23 for gabapentin 300mg take 2 capsules twice daily.
-There was a physician's order dated 02/08/23 for gabapentin 300mg 2 capsules (600mg) twice daily.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 300mg take 2 capsules (600mg) twice daily scheduled for administration at 8:00am and 8:00pm.

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-There was documentation gabapentin 300mg 2 tablets (600mg) was administered daily from 12/01/22 through 12/31/22.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for gabapentin 300mg take 2 capsules (600mg) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation gabapentin 300mg 2 tablets (600mg) was administered daily from 01/01/23 through 01/31/23.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for gabapentin 300mg take 2 capsules (600mg) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation gabapentin 300mg 2 tablets (600mg) was administered daily from 02/01/23 through 02/15/23.

Observation of Resident #1's medications on hand on 02/15/23 at 2:21pm revealed:
-Gabapentin was available for administration.
-The instructions on the bottle of gabapentin were 300mg 2 capsules (600mg) three times daily.
-The medication was filled on 01/07/23 for a quantity of 180 tablets.
-There were greater than 100 capsules left.

Telephone interview with Resident #1's social worker from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-The last time the VA pharmacy dispensed gabapentin was on 01/05/23.
-There were instructions to administer 300mg 2 capsules (600mg) three times daily.

Interview with Resident #1 on 02/15/23 at 8:44am

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revealed:
-He had pain in back.
-He was often out of gabapentin.
-He did not know the dosage for quantity order for his gabapentin.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-When she administered Resident #1's gabapentin read the eMAR and the instructions on the medication bottle.
-If she identified a discrepancy the PCP should be notified.
-She had not clarified the gabapentin with the PCP because she had not noticed the discrepancy.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:20pm revealed:
-Resident #1 was diabetic and had nerve pain in his feet and legs.
-She ordered Resident #1 gabapentin.
-The last order she had was the physician's order sheet (POS) signed on 02/08/23.
-She was not aware Resident #1 had an order for gabapentin 300mg 2 capsules (600mg) three times daily.
-She was not opposed to gabapentin being administered three times daily, but the order should be clarified and should match the eMAR prior to administration of the medication.
-She was in the facility weekly, and staff were able to contact her via text and fax 24/7.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-She administered Resident #1's medications and did not realize the instructions on the medication were different from the eMAR.
-The PCP should be notified to clarified

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medication orders that did not match or discrepancies between the medication and eMAR.
-The had not notified PCP regarding the difference in Resident #1's gabapentin on the eMAR and the medication instructions.

Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-She expected medications to be administered as ordered.
-If medication instructions did not match the current orders, the order should be clarified with the PCP.
-There should be documentation to show the PCP's response.

Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

D 358 10A NCAC 13F .1004(a) Medication Administration D 358

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:

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TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 residents (Residents #1, #3, and #6) including errors with a medication used to reduce decrease blood sugar, a B-12 supplement, a pain medication, an iron supplement, multivitamin, and an anti-reflux medications (#1); an inhaler #(6), a nerve pain medication and a dementia medication (#3).

The findings are:

Review of the facility's medication administration policy (undated) revealed:
-The medication aide (MA) shall check medications three times before giving the medication to a resident.
-The Resident Care Director (RCD) shall randomly review medication administration records (MARs) monthly to ensure that medication was administered as ordered within the guidelines of the policies and procedures.
-Staff identified as not following policies and procedures shall receive corrective action which shall include: (1) additional training; (2) verbal and/or written warning up to termination.
-The RCD shall make quarterly random unannounced observations of staff administering medication to ensure staff are administering medication as ordered and within the guidelines of the facility's policies and procedures.

1. Review of Resident #1's current FL2 dated 07/20/22 revealed:
-Diagnoses included diabetes mellitus type II, neuropathy, stroke, hypertension, vitamin B deficiency anemia, gastro-esophageal reflux disease, vitamin D deficiency, moderate

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depression, insomnia and anxiety.
-Medication orders included fingerstick blood sugar (FSBS) twice daily.
-There was no order for Novolog listed on the FL2.

a. Review of Resident #1's physician's orders revealed:
-There was a physician's order dated 12/15/22 by the Veteran's Administration primary care provider (VA PCP) for Novolog inject 3 units three times a day with meals (short acting insulin used to decrease and control blood sugar). Hold if FSBS was less than 100 or resident not eating.
-There was also an order dated 12/15/22 for Novolog 5 units four times a day as needed if FSBS was 450 or greater. Recheck in 1 hour, notify provider if not lower.
-There was a physician's progress note with medication orders dated and signed by the facility's Primary Care Provider (PCP) on 01/25/23 for Novolog flexpen inject 6 units subcutaneously three times a day with meals. Hold for FSBS less than 100 or if the resident was not eating a meal.
-There was a physician's order dated 02/02/23 for Novolog flexpen inject 4 units subcutaneously three times a day with meals. Hold if FSBS was less than 100 and/or resident was not eating.
-There was a physician's order dated 02/08/23 for Novolog flexpen 2 units subcutaneously three times a day with meals. Hold if FSBS was less than 100 and/or resident was not eating.

Review of Resident #1's hospital visit report dated 01/31/23 revealed:
-Resident #1 was seen in the emergency department on 01/31/23 for altered mental status due to hypoglycemia.
-Upon initial arrival at the hospital the resident's

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FSBS was 63.
-Emergency Medical Services (EMS) reported upon arrival at the facility Resident #1's FSBS was 40.
-Staff reported Resident #1 was given insulin when his blood sugar was 80 and the resident had not eaten within the past 48 hours due to diarrhea in the past 48 hours.
-The resident was administered dextrose (sugar used to medically in intravenous solutions to raise a person's blood sugar level) intravenously.

Review of an order dated 01/31/23 by Resident #1's facility's PCP revealed instructions to reinforce and educate staff to "read the insulin order" prior to administration of insulin.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry for Novolog flexpen 6 units subcutaneously 3 times a day with meals with instructions to hold insulin for FSBS less than 100 and/or the resident was not eating scheduled for administration at 7:30am, 11:30am and 4:30pm.
-There was documentation Resident #1's FSBS was checked 58 out of 93 opportunities.
-There was documentation Resident #1 had 10 FSBS that were less than 100 from 12/01/22 through 12/31/22.
-There was documentation Resident #1 was administered Novolog when his FSBS was less than 100 for 5 of 10 opportunities as follows:
-On 12/08/22 at 7:30am, FSBS was 98, 6 units of Novolog was documented as administered, and 0 units should have been administered.
-On 12/09/22 at 7:30am, FSBS was 78, 6 units of

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D 358	Continued From page 46 Novolog was documented as administered, and 0 units should have been administered. -On 12/11/22 at 7:30am, FSBS was 85, 6 units of Novolog was documented as administered, and 0 units should have been administered. -On 12/22/22 at 7:30am, FSBS was 85, 6 units of Novolog was documented as administered, and 0 units should have been administered. -On 12/26/22 at 4:30pm, FSBS was 94, 6 units of Novolog was documented as administered, and 0 units should have been administered. -There was no documentation why Novolog was not withheld per the PCP's instructions. Review of Resident #1's January 2023 eMAR revealed: -There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Novolog flexpen 6 units subcutaneously 3 times a day with meals with instructions to hold insulin for FSBS less than 100 and/or the resident was not eating scheduled for administration at 7:30am, 11:30am and 4:30pm. -There was documentation Resident #1's FSBS was checked 68 out of 93 opportunities. -There was documentation Resident #1 had 26 FSBS that were less than 100 from 01/01/23 through 01/31/23. -There was documentation Resident #1 was administered Novolog when his FSBS was less than 100 for 4 of 26 opportunities as follows: -On 01/28/23 at 4:30pm, FSBS was 97, 6 units of Novolog was documented as administered, and 0 units should have been be administered. -On 01/29/23 at 11:30am, FSBS was 97, 6 units of Novolog was documented as administered, and 0 units should have been administered. -On 01/30/23 at 7:30am, FSBS was 89, 6 units of Novolog was documented as administered, and 0	D 358		

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D 358	Continued From page 47 units should have been administered. -On 01/31/23 at 7:30am, FSBS was 80, 6 units of Novolog was documented as administered, and 0 units should have been administered. -There was no documentation why Novolog was not withheld per the PCP's instructions. Review of Resident #1's February 2023 eMAR from 02/01/23 to 02/17/23 revealed: -There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Novolog flexpen 6 units subcutaneously 3 times a day with meals with instructions to hold insulin for FSBS less than 100 and/or the resident was not eating, scheduled for administration at 7:30am, 11:30am and 4:30pm from 02/01/23 through 02/02/23. -There was an entry for Novolog flexpen 4 units subcutaneously three times a day with meals - Hold for FSBS less than 100 from 02/03/23 through 02/10/23. -There was an entry for Novolog flexpen 2 units subcutaneously three times a day with meals - Hold for FSBS less than 100 from 02/11/23 through 02/14/23. -There was documentation Resident #1's FSBS was checked 29 out of 42 opportunities. -There was documentation Resident #1 had 5 FSBS that were less than 100 from 02/01/23 through 02/15/23. -There was documentation Resident #1 was administered Novolog when his FSBS less than 100 for 2 of 5 opportunities as follows: -On 02/04/23 at 7:30am, FSBS was 90, 6 units of Novolog was documented as administered, and 0 units should have been administered. -On 02/06/23 at 11:30am, FSBS was 43, 4 units of Novolog was documented as administered, and 0 units should have been administered.	D 358		

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-There was no documentation why Novolog was not withheld per the PCP's instructions.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-Some days, his FSBS was low, in the 40's.
-When his FSBS was low he felt like he was going to pass out.
-Two weeks ago (unable to recall the exact date), he went to the hospital for a low blood sugar.
-A day or two before the hospital visit, he started feeling bad, but he did not tell staff.
-He started feeling light-headed, a little dizzy and sometimes dazed.
-The day he went to the hospital, the MA from a sister facility came to his facility and checked his FSBS and administered his insulin.
-After the MA gave him the insulin, he started to feel worse than he had been feeling, and he thought that he was going to pass out.
-He did not know what was happening to him, but he knew that he did not feel well.
-The MA noticed he was "acting different" and running into the walls with his motorized wheelchair.
-He was unable to respond when asked a question.
-He felt as if he was in a fog and was unable to comprehend anything.
-His blood sugar was in the 40's and the MA sent him to the hospital.
-At the hospital, he was given something to bring his blood sugar up.
-Now he was afraid and often refused insulin when his FSBS was in the 120's.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-Resident #1's blood sugars sometimes dropped low, which was why she gave instructions to hold

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Novolog insulin for FSBS less than 100.
-She was not aware the facility staff were administering Novolog when FSBS was less than 100.
-After the incident on 01/31/23, she had serious discussion with the Office Manager and the MA reinforcing the importance of holding Resident #1's Novolog when FSBS was less than 100.
-It was dangerous for Resident #1's blood sugar to be in the 40's.
-A low blood sugar could cause dizzy, blurred vision and passing out and even unresponsiveness.
-She preferred if staff would read instructions and administered medications as ordered.

Telephone interview with the medication aide (MA) (initials on the eMAR as administering Resident #1's insulin on 01/31/23) on 02/16/23 at 3:30pm revealed:
-She worked as a MA at the facility from January 2023 until she quit on 02/13/23.
-Although she was titled a MA she had not been checked off for clinical skills and medication aide training by a nurse.
-The Administrator who was not a nurse checked her off and told she to administer medications to the residents.
-The Administrator put her name in the eMAR system, but she was not comfortable administering medications.
-When she worked, she usually asked other MAs to administer medications to the residents in her facility.
-On 01/31/23, she called another MA to come to her facility to administer Resident #1's medications, which included checking the resident's FSBS and administering insulin if needed.
-The MA checked Resident #1's FSBS and

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administered his Novolog.
-Although, her initials were on the eMAR for administering Resident #1's insulin and checking his FSBS it was not her that administered the insulin.
-She did not know how to read the eMAR and she did not know Resident #1's orders for insulin.
-Some time, after the MA administered Resident #1's insulin, the resident started to act delirious and confused; he backed his motorized wheelchair into the walls and he appeared sluggish.
-She called the MA to come back to her facility.
-The MA and another MA came to her facility and they checked Resident #1's FSBS; it was in the 40's.
-The MA called the Administrator and 911.
-When the paramedics arrived, they checked Resident #1's FSBS and it was still in the 40's.
-She heard one of the paramedics say the resident was administered too much insulin.
-Resident #1 was taken to the hospital.

Telephone interview with a second previous MA (who administered Resident #1's insulin on 01/31/23) on 02/16/23 at 3:03pm revealed:
-She usually administered medications for the MA that worked in Resident #1's facility because the MA was inexperienced and afraid to administer medications.
-On 01/31/23, she checked Resident #1's FSBS.
-She was aware if the resident's FSBS was less than 100 he should not get any insulin.
-If her initials were on the eMAR administering Resident #1's insulin , then she administered the medication.
-She was unable to explain why she administered Resident #1's Novolog when his FSBS was less than 100 on 01/28/23, 01/29/23 and 01/30/23 and on 01/31/23, resulting in the resident being

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hospitalized on 01/31/23.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-On the day Resident #1 was sent to the hospital (01/31/23), the MA from another facility called her to come to the facility where Resident #1 resided.
-The MA told her Resident #1 was not doing good and was running into the walls.
-When she got to Resident #1's facility, she checked the resident's FSBS and it was 46.
-The MA told her that she had given Resident #1 Novolog 6 units and lantus 25 units even when the eMAR stated to hold the Novolog for FSBS less than 100.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She had seen on the eMAR that MAs sometimes administered Resident #1's insulin when it should be held for FSBS less than 100.
-Back in January 2023 (unable to recall the exact date), she made the Administrator aware that the MA in the facility was administering Resident #1's insulin when his blood sugar was too low for insulin, but nothing was done.
-After Resident #1 went to the hospital on 01/31/23, his PCP was upset about the MAs giving Resident #1 insulin when his FSBS was less than 100.
-The PCP voiced her discontentment with the MAs not following her instructions to hold Resident #1's Novolog and the resident ending up in the hospital with hypoglycemia that could have lead to the resident being in a coma or death.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-On 01/31/23, she was in another facility and the MA called her to come to the facility where

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D 358	Continued From page 52 Resident #1 resided. -The MA said she administered Resident #1's insulin when his FSBS was less than 100. -There were two MAs with Resident #1, both said they had given the resident orange juice with sugar but Resident #1 still appeared delirious. -She checked Resident #1's FSBS and it was 57. -She did not investigate or ask the MA why she administered Resident #1's insulin when there were instructions on the order to hold the resident's insulin for FSBS less than 100. Interview with the ED on 02/16/23 at 1:43pm revealed: -She was aware Resident #1 had been sent to the hospital for hypoglycemia. -She was not aware staff administered Novolog when the resident's FSBS was less than 100. -A report was printed daily called "care suite"; the report showed medication errors, refused medication and "waiting on VA/pharmacy." -The previous Office Manager was to review the care suite report to identify missed medications, medication refusals, medication errors and when a resident was out of medications. -When the Office Manager identified errors she was supposed to notify the Administrator of the errors. -The Administrator should follow through with the MAs and make sure they understood the PCP's orders. -She was not aware if the previous Administrator had been made aware the MAs were administering Resident #1's Novolog when for FSBS less than 100. -She did not know the previous Administrator had told a staff to administer medications that had not been trained or checked off by the facility's contracted nurse.	D 358		

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Attempted telephone interview with Resident #1's Veteran's Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

b. Review of Resident #1's current FL2 dated 07/20/22 revealed:
-Diagnoses included diabetes mellitus type II.
-There was an order for lantus 15 units subcutaneously at bedtime (long acting insulin used to decrease and control blood sugar).

Review of Resident #1's physician's orders revealed:
-There was a physician's order dated 12/15/22 by the veteran's primary care provider (VA PCP) for lantus 25 units subcutaneously at bedtime (long acting insulin used to decrease and control blood sugar).
-There was a physician's progress note with medication orders dated and signed by the facility's primary care provider (PCP) on 01/25/23 for lantus 25 units subcutaneously twice a day.
-There was a physician's order dated 02/08/23 for lantus inject 25 units subcutaneously twice a day.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lantus (glargine solostar) 25 units subcutaneously twice a day scheduled for administration at 8:00am and 8:00pm.
-There was documentation with staff circled initials indicating lantus was not administered at

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8:00am on 12/12/22, 12/13/22 and 12/17/22.
-There was documentation lantus was "withheld per DR/RN orders."
-There was no documentation or instructions with the lantus order on the eMAR to withhold Resident #1's lantus.
-There was no documentation with staff initials or reason why lantus was not administered or withheld on 12/01/22 at 8:00pm.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for lantus (glargine solostar) 25 units subcutaneously twice a day scheduled for administration at 8:00am and 8:00pm.
-There was documentation with staff circled initials indicating lantus was not administered at 8:00pm on 01/10/23; at 8:00am on 01/11/23; 01/20/23; and on 01/22/23.
-There was documentation lantus was "withheld per DR/RN orders."
-There was no documentation for the administration of lantus at 8:00am on 02/05/23 and at 8:00pm on 02/07/23.
-There was no documentation or instructions with the lantus orders on the eMAR to withhold Resident #1's lantus.

Review of Resident #1's February 2023 eMAR from 02/01/23 to 02/17/23 revealed:
-There was an entry for lantus (glargine solostar) 25 units subcutaneously twice a day scheduled for administration at 8:00am and 8:00pm.
-There was documentation with staff circled initials indicating lantus was not administered at 8:00am on 02/08/23; at 8:00am on 02/10/23; and at 8:00am on 02/15/23.
-There was documentation lantus was "withheld per DR/RN orders."
-There was no documentation on the eMAR to

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withhold Resident #1's lantus.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Lantus was available for administration.
-The pharmacy instructions on the container were to administer 25 units of lantus twice a day.
-There were no instructions to hold lantus.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He was administered insulin most days two times per day.
-He was not sure if the insulin was Novolog or lantus.
-He sometimes refused insulin, and sometimes staff did not administer insulin.
-He refused insulin when his FSBS was 120 or less because he was afraid of his blood sugar dropping low, which made him feel very sick.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed:
-The pharmacy did not fill and dispense Resident #1's medications and insulin.
-Resident #1's medication orders were sent to the pharmacy usually for profile for printing eMARs.
-The pharmacy had not received any orders to withhold lantus with parameters.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-When she worked, she administered Resident #1's lantus twice daily.
-If the resident's blood sugar was less than 100 she withheld the lantus.
-There were times when Resident #1 refused lantus because he was afraid of his blood sugar

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dropping.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:20pm revealed:
-Resident #1 had two PCP's, she ordered the resident's insulin.
-She had parameters on the Novolog to hold for blood sugars less than 100 but did not have parameters to hold the lantus.
-Lantus was a long acting insulin and should be administered when the blood sugars were less than 100.
-She was not aware facility staff were holding lantus when the resident's blood sugars were less than 100.
-She was in the facility weekly and available 24/7 by telephone; if the facility staff were not sure how to implement the order, they should have contacted her to ensure they were administering the medications as ordered.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-When she administered Resident #1's medications, if the resident's blood sugar was less than 100 she held the lantus.
-Resident #1 had orders to hold Novolog when his blood sugars were less than 100.
-She took that to mean she should hold all the resident's insulin when his blood sugars were less than 100.
-She had not contacted the PCP to ensure lantus was administered as ordered.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-She did not review eMARs and she was not aware staff were withholding the resident's lantus.
-The RCC and MAs should contact the PCP if they were not sure how to administer

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medications.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available, refusals and residents out of the facility.
-She had not realized the MAs were withholding lantus when Resident #1's blood sugars were less than 100.
-If the MAs were not sure how administer lantus they should contact the resident's PCP.

Interview with the ED on 02/16/23 at 1:43pm revealed:
-If there were no instructions to withhold lantus, then the medication should be administered as ordered.
-The MA should not withhold a medication until they contact the PCP to ensure the medication order was clear.

Attempted telephone interview with Resident #1's Veteran's Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

c. Review of Resident #1's current FL2 dated 07/20/22 revealed there was an order for

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ibuprofen 800mg 1 tablet three times daily (used to treat pain).

Review of Resident #1's physician's orders revealed:
-There was a physician's order dated 12/15/22 by the Veteran's Administration primary care provider (VA PCP) for ibuprofen 400mg 1 tablet three times daily as need for severe pain (take with food).
-There was a physician's progress note with medication orders dated and signed by the facility's PCP on 01/25/23 for ibuprofen 800mg take 1 tablet three times daily.
-There was a physician's order dated 02/08/23 for ibuprofen 800mg take 1 tablet three times daily.
-There was a new physician's order dated 02/08/23 to add ibuprofen 400mg tablet every 12 hours as needed for pain.

Review of Resident #1's physician progress note dated 01/25/23 revealed Resident #1 had severe back pain and neurological headaches.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was no entry for ibuprofen 400mg 1 tablet three times daily as needed for severe pain.
-There was an entry for ibuprofen 800mg 1 tablet three times daily scheduled for administration at 8:00am, 1:00pm and 8:00pm.
-There was documentation with staff circled initials indicating ibuprofen 800mg was not administered as ordered 5 times from 12/01/23 through 12/31/23 on the following dates: 12/15/22, 12/23/22, 12/27/22, and 12/30/22 (2 times).
-There was documentation ibuprofen was "out of stock."

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Review of Resident #1's January 2023 eMAR revealed:
-There was no entry for ibuprofen 400mg 1 tablet three times daily as needed for severe pain.
-There was an entry for ibuprofen 800mg 1 tablet three times daily scheduled for administration at 8:00am, 1:00pm and 8:00pm.
-There was documentation with staff circled initials indicating ibuprofen 800mg was not administered 6 times from 01/01/23 through 01/31/23 on the following dates: 01/02/23, 01/04/23, 01/06/23 (2 times), 01/07/23 and 01/09/23.
-There was documentation ibuprofen was "out of stock - waiting on VA."

Review of Resident #1's February 2023 eMAR from 02/01/23 to 02/17/23 revealed:
-There was no entry for ibuprofen 400mg 1 tablet three times daily as needed for severe pain.
-There was an entry for ibuprofen 800mg 1 tablet three times daily scheduled for administration at 8:00am, 1:00pm and 8:00pm.
-There was documentation with staff circled initials indicating ibuprofen 800mg was not administered 7 times from 02/01/23 through 02/15/23 on the following dates: 02/02/23 (three times), 02/03/22, 02/09/23 (three times).
-There was documentation ibuprofen was "out of stock - waiting on VA."
-There was an entry for ibuprofen 400mg 1 tablet every 12 hours as needed for pain.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Ibuprofen 400mg was available for administration.
-The medication was filled and a quantity of 100

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tablets were dispensed on 02/09/23 with instructions to administer 1 tablet three times daily as needed (prn) for severe pain.
-There were no other bottles of ibuprofen available for administration.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He was always in pain in his back and legs.
-When he complained of pain, the medication aide (MA) gave him ibuprofen.
-Sometimes, ibuprofen was not available and he had no ibuprofen.
-If he had no ibuprofen sometimes the MA would borrow the medication from another resident.
-The MA told him 2 to 3 days per week that he was out of his pain medication.
-Sometimes, he had ibuprofen to take for pain.
-When the ibuprofen was available it helped with the pain; enough for him to sleep, but when he woke up he was in pain.

Telephone interview with Resident #1's social worker at the VA from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-Resident #1's ibuprofen 400mg was filled and dispensed on the following dates:
-On 11/08/22, for a quantity of 100 tablets.
-On 12/27/22, for a quantity of 100 tablets.
-O 02/06/23, for a quantity of 100 tablets.
-Two and one-half weeks ago a staff at the facility contacted him regarding Resident #1's medications not being available.
-He told the staff that he needed to see the medication orders in order to check why the medications had not been dispensed and mailed to the facility.
-Last week, he got another call from the facility's RCD; and he told her that he had requested the staff two and one-half weeks ago to send him

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orders, so he could check and find out why Resident #1's medications were not dispensed.
-The staff were able to send the requested orders by email or fax to him.
-As of today's date, he still had not received the requested orders from the staff or the RCD.
-This issue with the facility was a systematic problem with this facility regarding Resident #1's medications.
-The problem was the facility's failure to communicate and follow through with getting medications to VA residents.
-Resident #1 was seen by the facility's PCP and the VA PCP so when the resident got new orders the facility had to send the orders to the VA PCP.
-The VA PCP had to approve the orders, then send the orders to the VA pharmacy.
-The pharmacy was in another state so Resident #1's medications had to be mailed to the facility.
-This process could sometimes take several days.
-To refill Resident #1's medications, he had advised the MA numerous times to request a refill immediately upon receipt of the medication.
-He suggested to refill the medication immediately upon receipt of the medication in case there were issues refilling the medication.
-Requesting the refill 90 days in advance allowed the facility time to take care of any issues before the medication ran out.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-When she worked, she had noticed that Resident #1 was out of some of his medications.
-Resident #1 had medications on the medication cart and in the facility's medication storage closet.
-Sometimes the MA did not check the overstock closet for the medication.
-Resident #1 should not be out of ibuprofen.

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Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:20pm revealed:
-She ordered Resident #1's ibuprofen because the resident was always complaining of being in pain, especially in his back.
-Resident #1 was diabetic and he had nerve pain and also had back pain from a previous injury.
-She was not aware the resident was not getting ibuprofen as ordered.
-She recently added ibuprofen 400mg twice as needed because Resident #1 was still complaining of pain.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-Resident #1 got his medications from the VA pharmacy.
-Sometimes it took up to 10 days to have the resident's medications refilled.
-She had observed that some MAs did not check the overstock closet before documenting the medication was out of stock.
-She thought Resident #1 had ibuprofen and should not be out of the medication.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-She did not review eMARs and she was not aware Resident #1's ibuprofen was out of stock.
-The MA on the cart should check the overstock and the medication cart before marking on the eMAR a medication was not available.
-If the medication was not available the MA should contact the pharmacy to reorder the medication.
-The Office Manager was responsible for checking the "care suite" system daily to see when the MAs documented a medication was out of stock.

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-The Office Manager should follow-up with the MAs to see if they contacted the pharmacy about a medication not being available.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available.
-She had made the previous Administrator aware that Resident #1 had been out of medications longer than 10 days.
-She was not sure if she had noticed the ibuprofen was out, but it was not likely it was out.
-The MA should check the overstock closet before documenting a medication was not available.

Interview with the ED on 02/16/23 at 1:43pm revealed:
-She expected medications to be administered as ordered.
-If medication was not available and the MA could not get the medication from the pharmacy, then the Office Manager and the Administrator should be notified.
-There should be documentation to show the pharmacy was contacted and the response.
-The MA should also check the overstock closet before assuming the medication was out of stock.

Attempted telephone interview with Resident #1's Veteran's Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

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Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

d. Review of Resident #1's current FL2 dated 07/20/22 revealed diagnoses included vitamin B deficiency.

Review of Resident #1's physician's order dated 12/07/22 revealed and order cyanocobalamin (vitamin B-12) 2,000mcg one tablet once daily (used to treat B-12 deficiency).

Review of Resident #1's primary care provider (PCP) electronically signed medication list dated 01/25/23 revealed Resident #1's current medications included vitamin B-12 2,000mcg once a day.

Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed and order for vitamin B12 1,000mcg 2 tablets (2,000mcg) once daily.

Review of a physician's progress note date 01/25/23 revealed Resident #1 complained of being frequently nauseated early in the morning for the past few weeks.

Review of Resident #1's vitamin B-12 laboratory results dated 11/30/22 revealed:
-Resident #1 had a vitamin B-12 value of 116 (the normal range for vitamin B-12 was 188 to 914).
-Resident #1's vitamin B-12 value was considered low.

Review of Resident #1's December 2022 electronic medication administration record

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(eMAR) revealed:
-There was an entry for vitamin B-12 1,000mcg, take 2 tablets =2000mcg once daily scheduled for administration at 8:00am.
-There was documentation with staff initials circled indicating being B12 was not administered with reason being "out of stock - waiting on VA" for 5 of 24 opportunities from 12/07/22 through 12/31/22.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for vitamin B-12 1,000mcg 2 tablets =2000mcg once daily scheduled for administration at 8:00am.
-There was documentation with staff circled initials indicating vitamin B-12 was not administered and the reason "out of stock - waiting on VA" for 17 of 31 opportunities from 01/01/23 through 01/31/23.

Review of Resident #1's February 2023 eMAR from 02/01/23 through 02/15/23 revealed:
-There was an entry for vitamin B-12 1,000mcg 2 tablets =2000mcg once daily scheduled for administration at 8:00am.
-There was documentation with staff circled initials indicating vitamin B-12 was not administered and the reason "out of stock - waiting on VA" for 6 of 15 opportunities from 02/01/23 through 02/15/23.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Vitamin B-12 was available for administration.
-There were 2 tablets remaining in a 3-tablet bubble package.
-The medication label instructions documented vitamin B-12 was filled and 3 tablets were

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dispensed on 02/15/23 (first day of survey).

Telephone interview with Resident #1's social worker at the Veteran's Administration (VA) from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-Vitamin B-12 had never been filled and dispensed by the VA pharmacy.
-It was hard to say when or if the order was received by the pharmacy.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He was seen by two primary care providers (PCPs); the facility's PCP and the PCP at the VA.
-He was not aware of his medications ordered.
-He did not know that he had been ordered vitamin B-12.
-He was cold a lot and thought maybe that was why he was ordered vitamin B-12.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed:
-Generally, the pharmacy did not fill and dispense Resident #1's medications.
-Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's B-12 vitamin.
-The pharmacy had an order dated 12/07/23 for vitamin B-12, but until yesterday (02/15/23) Resident #1's vitamin B-12 had not been filled and dispensed by the pharmacy.
-Resident #1's orders were usually for profile only for eMAR documentation and instructions for administration of medications.
-Resident #1's medications were usually dispensed by the VA pharmacy.

Interview with a medication aide (MA) on

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02/16/23 at 9:19am revealed:
-When she worked at the facility if a medication was not available for administration she told the Administrator or the supervisor.
-She recalled that she told the Administrator a couple of weeks ago that Resident #1 did not have vitamin B-12 available for administration.
-Prior to 02/15/23, Resident #1 did not have vitamin B-12 available for administration.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-She ordered Resident #1 vitamin B12 back in December 2022 because the resident had a low B-12 level.
-She was not aware the resident currently was not being administered vitamin B-12.
-If the facility was unable to obtain Resident #1's medication after one week they should have let her know.
-Resident #1's medications came from the VA pharmacy and it might take longer than the facility's contracted pharmacy, but it should not take from 12/07/22 (date she wrote the order) until today's date (02/15/23) to get the vitamin B-12.
-A low B-12 level could lead to anemia, which Resident #1 had.
-It could also cause the resident to experience tiredness, weakness and nausea.
-Last month, Resident #1 started to complain about being nauseated, especially in the morning.
-She expected Resident #1's medications to be administered as ordered.

Telephone interview with a second previous MA on 02/16/23 at 3:03pm revealed:
-She was aware Resident #1 did not have vitamin B-12 available.
-She last worked at the facility on 02/01/23 and

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Resident #1 did not have vitamin B-12 available for administration.
-She made the Administrator and the Resident Care Director (RCD) aware in January 2023.
-Resident #1 got his medications from the VA pharmacy and it sometimes took up to 10 days to get the medications, but it did not take two months to get medications.
-She had not made Resident #1's PCP aware the vitamin B-12 was not available for administration.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-Resident #1 did not have vitamin B-12 available for administration prior to 02/15/23.
-Yesterday (02/15/23), the ED paid for and filled Resident #1's vitamin B-12 for a three-day supply.
-She did not know why the ED filled the vitamin B-12 for 3 days only.
-She noticed last month that Resident #1 did not have his vitamin B-12 available for administration.
-The order for the vitamin B-12 was written by the facility's PCP on 12/07/22.
-The MA or the Office Manager should have faxed the order for vitamin B-12 to the VA PCP for approval and the facility's pharmacy.
-Resident #1's medications came from the VA pharmacy and when the facility's PCP wrote an order, the order had to be sent to the PCP at the VA.
-The PCP at the VA had to approve the order; and the PCP sent the order to the VA pharmacy.
-The VA pharmacy would fill and dispense the medication via mail to the facility.
-It sometimes took 10 days to receive Resident #1's medications.
-She did not know why it had been almost 3 months and Resident #1 still did not have vitamin B-12.

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D 358	Continued From page 69 Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed: -She was not aware that some of Resident #1's medications were not in the facility. -The previous Office Manager was responsible for checking to ensure the medications were in the facility and on the medication cart. -The Office Manager was to review reports from the eMAR system daily to identify when staff documented on Resident #1's eMAR "waiting on VA pharmacy." -The Office Manager was then supposed to contact the VA pharmacy to identify what the holdup was with Resident #1's medications. -Sometimes it took the VA pharmacy up to 10 days to send a medication because they mailed Resident #1's medications, but it should not take 3 months. Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed: -She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available, refusals and resident out of the facility. -She did not review the reports daily, but weekly. -When she checked the eMAR exceptions and saw "waiting on the VA", she called the MA to find out if the MA had checked with the VA pharmacy to see why the medication was not available. -Resident #1 received his medications from the VA pharmacy and sometimes it took days to get the resident's medication in the facility. -The MAs were able to contact the VA pharmacy directly and reorder or follow-up to find out what was taking so long to dispense medications. -She had told the MAs multiple times to not wait until Resident #1's medications were completely out before they reordered medications. -When Resident #1 got a new order; the MA or	D 358		

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the Office Manager should fax the order to the PCP at the VA for approval.
-The PCP at the VA had to approve the order and then should send the order to the VA pharmacy.
-The VA pharmacy filled and dispensed Resident #1's the medications to the facility.
-The facility's pharmacy printed the medication order on the eMAR.
-She was not aware Resident #1's vitamin B-12 had not been filled and the medications obtained since 12/07/22.

Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-She filled Resident #1's medications with a 3-day supply of vitamin B-12
-She had hoped the VA pharmacy would dispense the medication.
-The RCD was following-up with the social worker at the VA to find why Resident #1's medications had not been dispensed.
-She did not realize it had been over 2 months since the PCP ordered vitamin B-12.
-Prior to yesterday (02/15/23), she did not know Resident #1 did not have the vitamin B-12 available.

Attempted telephone interview with Resident #1's Veteran Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

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e. Review of Resident #1's current FL2 dated 07/20/22 revealed diagnoses included iron deficiency.

Review of Resident #1's physician's order dated 12/07/22 revealed and order ferrous sulfate 325mg tablet, take 1 tablet twice daily (used to treat iron deficiency).

Review of Resident #1's primary care provider (PCP) electronically signed medication list dated 01/25/23 revealed Resident #1's current medications included ferrous sulfate 325mg 1 tablet twice a day with orange juice.

Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed ferrous sulfate 325mg 1 tablet twice daily.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for ferrous sulfate 325mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation with staff circled initials indicating ferrous sulfate 325mg was not administered for 13 of 49 opportunities from 12/07/22 through 12/31/22, with reason documented as "out of stock - waiting on VA".
-There were two dates (12/07/22 at 8:00pm and 12/08/22 at 8:00am) with no documentation why the ferrous sulfate was not administered.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for ferrous sulfate 325mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.

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-There was documentation with staff circled initials indicating ferrous sulfate 325mg was not administered for 36 of 62 opportunities from 01/01/23 through 01/31/23, with reason documented as "out of stock - waiting on VA".

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for ferrous sulfate 325mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation with staff circled initials indicating ferrous sulfate 325mg was not administered for 14 of 29 opportunities from 02/01/23 through 02/15/23, with reason documented as "out of stock - waiting on VA".
-There were three dates (02/05/23 at 8:00am, 02/05/23 at 8:00pm and 02/07/23 at 8:00pm) with no documentation why ferrous sulfate was not administered.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Ferrous sulfate 325mg was available for administration.
-The medication label included instructions ferrous sulfate was filled for 6 tablets and dispensed on 02/15/23 with 5 tablets remaining.

Telephone interview with Resident #1's social worker at the Veteran Administration (VA) from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-Ferrous sulfate had never been filled and dispensed by the VA pharmacy.
-It was possible the pharmacy did not receive the order.

Interview with Resident #1 on 02/15/23 at 8:44am

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D 358	Continued From page 73 revealed: -Both the facility's PCP and the VA's PCP ordered medications for him. -He was not aware of his medications ordered. -He did not know he had been ordered ferrous sulfate and did not know what the medication was used to treat. -He was cold a lot and had a diagnosis associated with being cold, he thought maybe the medication was ordered to help with that. Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed: -She recalled a couple of weeks ago making the Administrator aware that Resident #1 did not have ferrous sulfate available for administration. -The Administrator would have been responsible for finding out why the medication was not available for administration. -She only worked at the facility on Thursdays, and she administered Resident #1's medications. -When she worked last week, ferrous sulfate was not available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed: -Generally, the pharmacy did not fill and dispense Resident #1's medications. -Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's ferrous sulfate. -The pharmacy had an order dated 12/07/23 for Resident #1's ferrous sulfate, but until yesterday (02/15/23) the pharmacy had never dispensed any of the resident's medications. -Resident #1's medication orders were usually profile only for eMAR documentation and instructions for administration of medications. -Resident #1's medications were usually	D 358		

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dispensed by the VA pharmacy.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-She ordered Resident #1's ferrous sulfate on 12/07/22 due to the resident's iron deficiency.
-She was not aware the resident was not being administered ferrous sulfate.
-If the facility was unable to obtain Resident #1's medication after one week they should have let her know.
-Resident #1's medications were filled and dispensed by the VA pharmacy.
-She expected Resident #1's medications to be administered as ordered.

Telephone interview with a previous MA on 02/16/23 at 3:03pm revealed:
-She was aware Resident #1 did not have ferrous sulfate available for administration.
-The medication was on the eMAR, but the medication was not in the facility.
-She made the Administrator and the Resident Care Director (RCD) aware in January 2023.
-Resident #1 received his medications from the VA pharmacy and it sometimes took up to 10 days to get the medications; it did not take two months to get medications.
-She had not made Resident #1's PCP aware the ferrous sulfate was not available for administration.

Interview with the RCD on 02/16/23 at 11:46am revealed:
-Resident #1 did not have ferrous sulfate available for administration prior to 02/15/23.
-Yesterday (02/15/23), the ED paid for and had the local pharmacy fill and dispense a 3-day supply of ferrous sulfate for Resident #1.
-She did not know why the ED had the ferrous

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D 358	Continued From page 75 sulfate filled for 3-days only. -She noticed last month that Resident #1 did not have ferrous sulfate available for administration. -The order for the ferrous sulfate was written by the facility's PCP on 12/07/22. -Resident #1's medications came from the VA pharmacy. -When the facility's PCP wrote an order, the MA or the Office Manager were responsible for faxing the order to the PCP at the VA. -The PCP at the VA had to approve the order; and the PCP sent the order to the VA pharmacy. -The VA pharmacy would fill and dispense the medication via mail to the facility. -It sometimes took 10 days to receive Resident #1's medications. -She did not know why it had been almost 3 months and Resident #1 still did not have ferrous sulfate. Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed: -She was not aware that some of Resident #1's medications were not in the facility. -The previous Office Manager was responsible for checking to ensure the medications were in the facility and on the medication cart. -The Office Manager was to review reports from the eMAR system daily and to identify when staff documented on Resident #1's eMAR "waiting on VA pharmacy." -The Office Manager was supposed to contact the VA pharmacy to identify what the holdup was with Resident #1's medications. -Sometimes it took the VA pharmacy up to 10 days to send a medication because they mailed Resident #1's medications, but it should not take from December 2022 to get the medications. Telephone interview with the previous Office	D 358		

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Manager on 02/17/23 at 6:03pm revealed:
-She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available, refusals and resident out of the facility.
-She did not review the reports daily, but weekly.
-When she checked the eMAR exceptions and saw "waiting on the VA", she called the MA to find if the MA had checked with the VA pharmacy to see why the medication was not dispensed.
-For the VA, the VA PCP and VA pharmacy should be notified.
-She told the Administrator, Resident #1 did not have ferrous sulfate last month.
-Resident #1 received his medications from the VA pharmacy and sometimes it took days to get the resident's medication in the facility.
-The MAs that worked in Resident #1's facility was able to contact the VA pharmacy directly to follow-up and find out what was taking so long to dispense the ferrous sulfate.
-Multiple times, she told the MAs to not wait until Resident #1's medications were completely out before they reordered medications, because it took the VA pharmacy so long to dispense medications.
-When Resident #1 got a new order; the order should be sent to the PCP at the VA for approval.
-After approval, the PCP at the VA sent the order to the VA pharmacy to be filled and dispensed to Resident #1 at the facility.
-The facility's local pharmacy printed the medication order on the eMAR.
-She was not aware Resident #1's ferrous sulfate had not been filled and the medication not obtained since 12/07/22.

Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-She filled a 3-day supply of Resident #1's ferrous

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sulfate in hopes the VA pharmacy would dispense the medications.
-The RCD was following-up with the social worker at the VA to find why Resident #1's medications had not been dispensed.
-Prior to yesterday (02/15/23), she did not know Resident #1 did not have the ferrous sulfate available for administration.
-Currently, the facility did not have an Administrator.
-The previous Administrator would have been responsible for making sure residents had medications available for administration.

Attempted telephone interview with Resident #1's Veteran Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

f. Review of Resident #1's current FL2 dated 07/20/22 revealed medication orders did not include an order for a multivitamin.

Review of Resident #1's physician's order dated 12/28/22 revealed and order multivitamin 1 tablet once a day (used to treat nutritional deficiencies).

Review of Resident #1's primary care provider (PCP) electronically signed medication list dated 01/25/23 revealed Resident #1's current medications included multivitamin 1 tablet once

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D 358	Continued From page 78 daily. Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed an order for multivitamin 1 tablet once a day. Review of Resident #1's physician's order revealed there was an order dated 02/08/23 that changed multivitamin to a one-a-day men's 50 plus vitamin 1 tablet once a day. Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for multivitamin 1 tablet once daily scheduled for administration at 8:00am. -There no documentation multivitamin was administered from 12/28/22 through 12/31/22, and there was no reason why the medication was not administered. Review of Resident #1's January 2023 eMAR revealed: -There was an entry for multivitamin 1 tablet once daily scheduled for administration at 8:00am. -There was documentation with staff circled initials indicating multivitamin was not administered 11 of 31 opportunities from 01/01/23 through 01/31/23 with reason documented as "out of stock - waiting on VA." -There no documentation multivitamin was administered two dates (01/01/23 and 01/02/23) from 01/01/23 through 01/31/23. Review of Resident #1's February 2023 eMAR revealed: -There was an entry for multivitamin 1 tablet once daily scheduled for administration at 8:00am. -There was documentation with staff circled initials indicating multivitamin was not	D 358		

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administered 3 of 8 opportunities from 02/01/23 through 02/08/23 with reason documented as "out of stock - waiting on VA".
-There no documentation multivitamin was administered from 02/01/23 through 02/08/23.
-There was documentation multivitamin was discontinued on 02/08/23.
-There was an entry centrum silver men 50 plus scheduled for administration at 8:00am.
-There was no documentation one-a-day men's 50 plus 400mcg vitamin was administered 02/08/23 through 02/15/23.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Centrum silver men's 50 plus vitamin was available for administration.
-Centrum silver was filled by the facility's pharmacy on 02/15/23 for 3 tablets.
-There were 2 tablets of centrum silver remaining.
-There was no multivitamin available for administration.

Telephone interview with Resident #1's social worker at the Veteran Administration (VA) from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-Multivitamin had never been filled and dispensed by the VA pharmacy.
-It appeared the order for multivitamin was never received by the pharmacy.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-Both the facility's PCP and the VA's PCP ordered medications for him.
-He was not aware he was ordered a multivitamin.
-He had discussed with the PCP that sometimes

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he was tired and had no energy.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-She recalled two weeks ago making the previous Administrator aware Resident #1 was out of various medications.
-She was not sure if multivitamin was one of the medications.
-If she signed on the eMAR the medication was not available, then multivitamin was not available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed:
-The pharmacy usually did not fill and dispense Resident #1's medications.
-Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's centrum men's 50 plus multivitamin.
-The pharmacy had an order dated 02/08/23 for Resident #1's multivitamin, but had not filled and dispensed the multivitamin until yesterday.
-Resident #1's medication orders were usually profile only for eMAR documentation and instructions for administration of medications.
-Resident #1's medications were usually dispensed by the VA pharmacy.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-She ordered Resident #1's multivitamin due to the nutritional decline.
-She was not aware Resident #1 was not being administered the multivitamin as ordered.
-If the facility was unable to obtain Resident #1's medication after one week they should have let her know.

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D 358	Continued From page 81 -She expected Resident #1's medications to be administered as ordered. Telephone interview with a previous MA on 02/16/23 at 3:03pm revealed: -She was aware Resident #1 did not have multivitamin available for administration. -When she last worked at the facility on 02/01/23, multivitamin was not available for administration. -She made the Administrator and the Resident Care Director (RCD) aware in January 2023 the multivitamin was not available for administration. -Resident #1 received his medications from the VA pharmacy and it sometimes took up to 10 days to get the medications in the facility. -She continually told the MAs not to wait until Resident #1's medications were completely out before they reordered, because the VA pharmacy took so long to send the resident's medication. -She had not made Resident #1's PCP aware the multivitamin was not available for administration. Interview with the RCD on 02/16/23 at 11:46am revealed: -Resident #1's multivitamin was not available for administration prior to 02/15/23. -Yesterday (02/15/23), the ED paid for and had the local pharmacy fill and dispense a 3-day supply of a one-a-day multivitamin for Resident #1. -She did not know why the ED had the one-a-day multivitamin yesterday and for a 3-days. -She was unable to recall the last time Resident #1 was administered multivitamin. -The order for the multivitamin was written by the facility's PCP. -Resident #1's medications came from the VA. -When the facility's PCP wrote an order, the order had to be sent to the PCP at the VA. -The PCP at the VA had to approve the order; and	D 358		

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D 358	Continued From page 82 the PCP sent the order to the VA pharmacy. -The VA pharmacy would fill and dispense the medication via mail to the facility. -It sometimes took up to 10 days to receive Resident #1's medications via mail from the VA pharmacy. -She did not know why the multivitamin had not been in the facility since ordered 12/28/22. Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed: -She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available, refusals and resident out of the facility. -She did not review the reports daily, but weekly. -When she checked the eMAR exceptions and saw "out of stock - waiting on the VA", she called the MA to find if the MA had checked with the pharmacy to see why the medication was not administered. -The VA PCP and pharmacy should be notified. -She told the Administrator Resident #1 did not have multivitamin and nothing was done to obtain the medication. -Resident #1 received his medications from the VA pharmacy and sometimes it took days to get the resident's medication in the facility because the VA pharmacy mailed Resident #1's medications. -It sometimes took up to 10 days to Resident #1's medications from the VA pharmacy. -When Resident #1 got a new order; the order should be sent to the PCP at the VA for approval. -After approval, the PCP at the VA sent the order to the VA pharmacy to be filled and dispensed to Resident #1 at the facility. -The facility's local pharmacy printed the medication order on the eMAR and usually did not dispense Resident #1's medications.	D 358		

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Interview with the ED on 02/16/23 at 1:43pm revealed:
-She filled a 3-day supply of Resident #1's centrum silver men's 50 plus multivitamin in hopes the VA pharmacy would dispense the medication soon.
-The RCD was in the process of following-up with the social worker at the VA to find why Resident #1's medications had not been dispensed.
-The previous Administrator no longer worked at the facility.
-It would have been the Administrator's responsibility to find out why Resident #1's multivitamin was not available for administration.
-There should also be documentation to show the Administrator inquired why Resident #1's medications were not in the facility.
-Prior to yesterday (02/15/23), she did not know Resident #1 did not have the multivitamin available for administration.

Attempted telephone interview with Resident #1's Veteran Administration primary care provider (VA PCP) on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

g. Review of Resident #1's current FL2 dated 07/20/22 revealed diagnoses included gastroesophageal reflux disease (GERD).

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D 358	Continued From page 84 Review of Resident #1's physician's order dated 01/25/23 revealed: -Resident #1 complained to the facility's primary care provider (PCP) that he had signs and symptoms of GERD. -There was an order pantoprazole 40mg, delayed release 1 tablet every morning for GERD (used to treat gastroesophageal reflux disease). Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed an order for pantoprazole 40mg 1 tablet every morning. Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for pantoprazole 40mg 1 tablet every morning scheduled for administration at 7:00am. -There was documentation with staff circled initials indicating pantoprazole 40mg was not administered 2 of 6 opportunities from 01/26/23 through 01/31/23 with reason documented as "out of stock - waiting on VA." Review of Resident #1's February 2023 eMAR revealed: -There was an entry for pantoprazole 40mg 1 tablet every morning scheduled for administration at 7:00am. -There was documentation with staff circled initials indicating pantoprazole 40mg was not administered 6 of 15 opportunities from 02/01/23 through 02/15/23 with reason documented as "out of stock - waiting on VA." -There was no documentation on 02/05/23 if pantoprazole was or was not administered as ordered. Observation of Resident #1's medications on	D 358		

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hand at the facility on 02/16/23 at 2:21pm revealed:
-There was pantoprazole 40mg available for administration.
-Pantoprazole 40mg was filled and dispensed by the facility's pharmacy on 02/15/23 for 3 tablets.
-There were 2 tablets of pantoprazole 40mg remaining.

Telephone interview with Resident #1's social worker at the Veteran Administration (VA) from a return telephone call placed on 02/16/23 at 12:40pm revealed:
-Pantoprazole had never been filled and dispensed by the VA pharmacy.
-It appears the order was not sent from the facility.
-Two and one-half weeks ago a staff at the facility contacted him regarding Resident #1's medications not being available.
-He told the staff that he needed to see the medication orders in order to check why the medications had not been dispensed and mailed to the facility.
-There was lack of communication from the facility with the VA primary care provider (PCP) and pharmacy.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He had some uncomfortableness in his stomach.
-The facility's PCP said she was going to give him something for his stomach.
-He did not know if he was administered the medication because he did not know his medications.
-He was still having the same issues with his stomach and it had not improved.

Telephone interview with a pharmacist at the

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facility's contracted pharmacy on 02/16/23 at 8:43am revealed:
-The pharmacy usually did not fill and dispense Resident #1's medications.
-Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's pantoprazole 40mg 1 tablet every morning.
-The pharmacy had an order dated 01/25/23 for Resident #1's pantoprazole 40mg, but had not filled and dispensed the medication until yesterday.
-Resident #1's medication orders were usually profile only for eMAR documentation and instructions for administration of medications.
-Resident #1's medications were usually dispensed by the VA pharmacy.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-She ordered Resident #1's pantoprazole 40mg 1 tablet every morning due to the resident complaining about reflux in this stomach.
-She was not aware the resident was not being administered pantoprazole 40mg as ordered.
-She was at the facility weekly, and the facility was able to contact her and her office 24/7, the facility staff should have made her aware they were not administering pantoprazole.
-If the facility was unable to obtain Resident #1's the medication after one week they should have let her know.
-She expected Resident #1's medications to be administered as ordered.

Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed:
-When she worked she observed Resident #1 had medications that were not available for administration.

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D 358	Continued From page 87 -Pantoprazole was one of the medications that was not available for administration. -She made the Administrator and the Resident Care Director (RCD/supervisor) aware the medications were not available. Telephone interview with a previous MA on 02/16/23 at 3:03pm revealed: -She was aware Resident #1 was not administered pantoprazole 40mg. -She had made the Administrator and the Resident Care Director (RCD) aware in January 2023 that Resident #1's pantoprazole 40mg was not available for administration. -Resident #1 received his medications from the VA pharmacy and it sometimes took up to 10 days to get the medications in the facility. -She had not made Resident #1's PCP aware the pantoprazole was not available for administration. Interview with the RCD on 02/16/23 at 11:46am revealed: -Pantoprazole was not available for administration prior to 02/15/23. -Yesterday (02/15/23), the ED paid for and had the local pharmacy fill and dispense a 3-day supply of pantoprazole 40mg for Resident #1. -She did not know why the ED had the pantoprazole 40mg filled and dispensed yesterday and for only 3-days. -She was unable to recall the last time Resident #1 was administered pantoprazole. -Resident #1's medications came from the VA pharmacy. -When the facility's PCP wrote an order, the order had to be sent to the PCP at the VA. -The PCP at the VA had to approve the order; and the PCP sent the order to the VA pharmacy. -The VA pharmacy would fill and dispense the medication via mail to the facility.	D 358		

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D 358	Continued From page 88 -It sometimes took up to 10 days to receive Resident #1's medications via mail from the VA pharmacy. -She had checked, but had no documentation to show why Resident #1's pantoprazole 40mg was not available for administration. Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed: -She was responsible for reviewing Resident #1's eMAR exception reports to identify when staff documented a medication was out of stock or waiting on the VA or pharmacy. -When she checked the eMAR exceptions and saw "out of stock - waiting on the VA", she called the MA to find if the MA had checked with the pharmacy to see why the medication was not administered. -She told the Administrator Resident #1 did not have pantoprazole available for administration and nothing was done. -Resident #1 received his medications from the VA pharmacy and sometimes it took days to get the resident's medication in the facility because the VA pharmacy mailed Resident #1's medications. -It sometimes took up to 10 days to get Resident #1's medications from the VA pharmacy. -The reason it took so long to get Resident #1's medications was because when a new order came from the facility's PCP; the order had to be sent to the PCP at the VA for approval. -After approval, the PCP at the VA sent to order to the VA pharmacy to be filled and dispensed to Resident #1 at the facility. -The order should also be sent to the facility's local pharmacy to be printed on the eMAR. -Because the medication was on the eMAR, it was possible whoever got the order did not follow through and contact the VA PCP.	D 358		

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SHULER HEATH CARE/STOREY VILLA	**250 PITT STREET KERNERSVILLE, NC 27284**

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-Resident #1's medications were not dispense by the local pharmacy because they were free from the VA pharmacy.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-The Office Manager was responsible for checking "care suites" daily to see when the MAs documented "waiting on VA or pharmacy."
-The Office Manager was responsible for contacting the pharmacy to determine why the medication was not dispensed.
-There should be documentation by the Office Manager showing contact with the pharmacy and why the medication was not dispensed.
-If needed the Office Manager should notify the resident's PCP.
-She did not recall being made aware Resident #1 had several medications that were not available for administration.

Interview with the Executive Director (ED) on 02/16/23 at 1:43pm revealed:
-She filled a 3-day supply of Resident #1's pantoprazole 40mg in hopes the VA pharmacy would dispense the medication soon.
-The RCD was in the process of following-up with the social worker at the VA to find why Resident #1's medications had not been dispensed.
-Prior to yesterday (02/15/23), she did not know Resident #1 did not have the pantoprazole 40mg available for administration.

Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

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Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

2. Review of Resident #6's current FL2 dated 11/02/22 revealed:
-Diagnoses included obesity, diabetes mellitus, hypertension and high cholesterol.
-There was an order for Symbicort 160-4.5 aerosol inhaler (a combination ingredient bronchial dilator to treat chronic obstructive pulmonary disease) inhale 2 puffs twice a day.

Review of Resident #6's signed physician's orders dated 02/08/23 revealed Symbicort 160-4.5 aerosol inhaler 2 puffs twice a day for chronic obstructive pulmonary disease (COPD) was ordered.

Observation of medication administration on 02/17/23 at 8:10am revealed Resident #6 was administered 8 oral medications, one inhaler, and was not administered Symbicort 160-4.5 aerosol inhaler.

Review of medications on hand for administration on 02/17/23 at 8:10am revealed there was no Symbicort available for administration to Resident #6.

Interview with the Resident Care Director (RCD) on 02/17/23 at 8:10am revealed:
-The RCD was passing medications due to the facility's staff shortage.
-Resident #6's Symbicort 160-4.5 was not on the medication cart to administer.
-Resident #6 did not receive Symbicort 160-4.5

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inhaler last night as well.
-She had reordered the Symbicort 160-4.5 inhaler and it should be coming from the contracted pharmacy today (12/17/23) around 9:00am.
-She would administer the Symbicort 160-4.5 inhaler as soon as it was delivered from the pharmacy.

Review of Resident #6's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 160-4.5 inhaler 2 puffs twice a day for COPD.
-Symbicort 160-4.5 inhaler was scheduled for administration at 8:00am and 8:00pm.
-Symbicort 160-4.5 inhaler was documented as not administered 5 times with"out of stock" documented for the reason not administered beginning on 02/15/23 at 8:00am and 8:00pm, on 02/16/23 at 8:00am and 8:00pm, and 02/17/23 at 8:00am.

Second interview with the RCD on 02/17/23 at 9:40am revealed:
-Resident #6's Symbicort 160-4.5 inhaler did not come from the contracted pharmacy in the order today.
-The medication aides (MAs) routinely ordered medications not on cycle fill when there was about one week supply remaining.
-She was filling in on the medication cart this morning and ordered the inhaler from the facility's contracted pharmacy (a local location) at 8:10am this morning (02/17/23) to be sent to the facility around 9:15am.
-The medication was not in the pharmacy delivery at 9:20am.

Interview with Resident #6 on 02/17/23 at 10:20am revealed:

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-He needed all his inhalers because he had COPD.
-He was short of breath when he tried to walk very far if he did not have his inhalers, including Symbicort 160-4.5 inhaler.(He was observed sitting on the front porch with no signs of labored breathing).
-Sometimes he used more than 2 puffs at a dose because he thought it made him breath easier.
-He had been out of the Symbicort 160-4.5 inhaler for a few days, maybe because his insurance was the hold up.

Telephone interview with a pharmacist at the contracted pharmacy on 02/17/23 at 12:55pm revealed:
-Resident #6's Symbicort 160-4.5 inhaler was refilled last on 01/09/23 for a 30 days supply.
-The pharmacy was working on a refill request made today (02/17/23) and Symbicort 160-4.5 inhaler should be sent in medication delivered to the facility later today (02/17/23).

Telephone interview with Resident #6's primary care provider (PCP) on 02/17/23 at 4:50pm revealed:
-The facility had not informed her Resident #6 was out of his Symbicort 160-4.5 inhaler.
-He had COPD and the inhaler was to help him with his breathing.
-If he did not take his Symbicort inhaler he could experience shortness of breath and wheezing resulting in interruptions of daily activities.
-The facility should be administering medications as ordered and not running out of medications.

Interview with the facility's Executive Director (ED) on 02/17/23 at 2:30pm revealed:
-Resident #6 sometimes used too many puffs on his inhaler which could make him run out early.

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-The MAs were supposed to administered medications as ordered and reorder before residents ran out of medication.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

3. Review of Resident #3's current FL-2 dated 11/22/22 revealed diagnoses included multiple sclerosis (MS), Type 2 diabetes, bipolar disorder, and chronic lower back pain.

a. Review of Resident #3's readmission orders signed by the resident's Primary Care Provider (PCP) dated 12/28/22, after a hospitalization for acute cystitis, revealed there was an order for gabapentin (used to treat neuropathy pain) 800mg 4 times a day.

Review of Resident #3's physician's orders from a visit to his neurology clinic dated 01/05/23 revealed an order for gabapentin 800mg take 2 tablets (1200mg) 2 times daily, at supper and bedtime, for painful feet.

Review of Resident #3 physician's orders dated 02/08/23 signed by the PCP revealed gabapentin 800mg was ordered 2 tablets twice a day with notation "managed by neurology".

Observation of Resident #3's medication on hand for administration on 02/16/23 at 12:00pm revealed:
-Resident #3's medications were from the contracted pharmacy provider in multidose bingo cards with the medications scheduled for morning, noon, afternoon (5:00pm) and bedtime

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packaged in separate multidose bubbles.
-Resident #3 had too many medications scheduled in the morning and evening to fit in one multidose bubble so there were 2 multidose bingo cards for each time of administration.
-The multidose bingo cards were packed on one week supply cards with two cards dated 02/10/23 through 02/16/23 and 2 cards dated 02/18/23 through 02/23/23.
-There were 2 gabapentin 800mg tablets packaged in the morning multidose bubbles on the multidose bingo cards and 2 gabapentin 800mg tablets packaged in the evening multidose bubbles on the multidose bingo cards for each day from 02/16/23 to 02/23/23.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Gabapentin 800mg with directions to take 2 tablets (1600mg) twice a day at supper and bedtime for painful feet, but was scheduled for administration at 8:00am and 8:00pm.
-Gabapentin 800mg was documented as administered at 8:00am and 8:00pm daily from 01/05/23 to 01/31/23, except documented for refused at 8:00am on 01/12/23 (out of facility), 01/13/23 (out of facility), 01/18/23 (refused), 01/19/23 (refused), 01/23/23 (refused), 01/26/27 (refused), 01/27/23 (refused), and 01/30/23 (refused); there were 12 doses administered at 8:00am and should have been administered at 5:00pm as ordered.

Review of Resident #3's February 2023 eMAR from 02/01/23 to 02/15/23 revealed:
-There was an entry for gabapentin 800mg with directions to take 2 tablets (1600mg) twice a day at supper and bedtime for painful feet, but was

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scheduled for administration at 8:00am and 8:00pm that was discontinued on 02/08/23.
-Gabapentin 800mg was documented as administered at 8:00am and 8:00pm daily from 02/01/23 to 02/08/23, except documented for refused at 8:00am on 02/04/23 (refused), 02/08/23 (refused), and 02/09/23 (refused); there were 6 doses administered at 8:00am and should have been administered at 5:00pm as ordered.
-There was a second entry for gabapentin 800mg take 2 tablets (1600mg) twice a day scheduled for administration at 8:00am and 8:00pm daily.
-Gabapentin 800mg was documented as administered at 8:00am daily from 02/09/23 to 02/15/23, except documented on 02/11/23 (refused), 02/12/23 (refused), 02/13/23 (out of facility), 02/14/23 (out of facility) and 02/15/23 (out of facility); there was 1 dose administered at 8:00am and should have been administered at 5:00pm as ordered.

Observation of gabapentin 800mg on hand for administration for Resident #2 on 02/16/23 revealed there were 14 gabapentin 800mg tablets dated 02/17/23 to 02/23/23 with 2 gabapentin 800mg tablets packaged in the morning multidose bubbles on the multidose bingo cards and 2 gabapentin 800mg in the evening multidose bubbles.

Telephone interview with a pharmacist at the contracted pharmacy provider on 02/16/23 at 2:40pm revealed:
-The contracted pharmacy received Resident #3's order dated 01/05/23 for gabapentin 800mg take 2 tablets (1200mg) 2 times daily, at supper and bedtime, for painful feet and the order dated 02/08/23 from the resident's PCP.
-The order entry department at the contracted pharmacy entered the order dated 01/05/23 for

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gabapentin 800mg take 2 tablets (1200mg) 2 times daily, at supper and bedtime, for painful feet in the eMAR system correctly, but scheduled the medication administration incorrectly on the eMAR (entered as 8:00am but should have been 5:00pm).
-The gabapentin 800mg order dated 02/08/23 was received along the PCP note "managed by neurology", but the order entry staff at the pharmacy entered that order only as gabapentin 800mg 2 tablets (1600mg) twice a day and kept the scheduled administration at 8:00am and 8:00pm the same.
-The facility was responsible to review the medication orders entered on the eMAR by the pharmacy staff and consult the pharmacy for any discrepancies prior to releasing the orders to appear on the eMAR for medication aides (MA) to administer.
-The pharmacy pre-packaged Resident #3's gabapentin 800mg 2 tablets (1600mg) in the morning multidose bubbles on the multidose bingo cards beginning 01/05/23 through 02/23/17 based on the order entry at the pharmacy.

Interview with Resident #3's mental health provider (MHP) on 02/15/23 at 10:40am revealed:
-Resident #3 was seen by her, the facility's PCP, and a neurologist.
-The neurologist ordered gabapentin for Resident #3's neuropathy pain and the facility should be administering gabapentin as ordered by neurology.
-Resident #3 had mentioned to her that he was not receiving gabapentin as he thought he was supposed to be receiving.

Telephone interview with Resident #3's PCP on 02/15/23 at 4:50pm revealed:
-Resident #3's gabapentin was managed by his

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neurologist.
-She signed the latest physician's order, but had noted gabapentin was ordered by his neurologist.

Telephone interview with a previous medication aide (MA) on 02/16/23 at 3:30pm revealed:
-She did not see physician's orders or enter any physician's orders when she was working at the facility.
-Resident #3 occasionally refused morning medications.
-She administered medications as pre-packaged by the pharmacy in the residents' multidose bingo cards assuming the pharmacy had packaged the medication according to the physician's orders.
-She did not routinely read closely the directions displaying on the eMAR screen of the computer.
-She did not know Resident #3's gabapentin 1600mg dose pre-packaged at 8:00am was supposed to be administered at 5:00pm instead of 8:00am.

Telephone interview with a second previous MA on 02/16/23 at 3:50pm revealed:
-She depended on the pharmacy to pre-package residents' medications in the multidose bingo cards correctly.
-She did not know Resident #3's gabapentin 1600mg dose pre-packaged at 8:00am was supposed to be administered at 5:00pm instead of 8:00am.

Interview with the Resident Care Director (RCD) on 02/16/23 at 4:50pm revealed:
-She had been back at the facility since December 2022 after being away for a while.
-There was currently no system for routinely auditing the residents' orders compared to the medications sent in multidose bingo cards from the pharmacy and the eMARs for accuracy prior

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D 358	Continued From page 98 to auditing eMARs' documentation last week (02/06/23). -The previous Administrator had assumed responsibility for processing physicians' orders, faxing the orders to the contracted pharmacy and releasing medication orders to show up on the eMAR for medication administration. Telephone interview with Resident #3's mental health provider (MHP) on 03/17/23 at 3:10pm revealed: -The facility staff had not told her about gabapentin not administered as ordered for Resident #3. -She looked at the eMARs when she had a routine visit with the residents related to administration refusals or frequency of administration of as needed (prn) medications. -She used the eMAR documentation to help monitor medication effectiveness and help determine if an adjustment to doses was needed for best results, but not Resident #3's gabapentin since neurology ordered that medication. Interview with Resident #3 on 02/17/23 at 3:20pm revealed: -He refused his gabapentin sometimes. -The facility was not administering gabapentin as ordered by his neurologist, so he did not take it if he felt like his pain was under control. Telephone interview with a nurse at Resident #3's neurology clinic on 02/20/23 at 9:48am from a message left previously revealed: -The neurologist had ordered gabapentin 800mg 2 tablets (1600mg) twice a day at 5:00pm and bedtime on Resident #3's visit dated 01/05/23 for foot pain. -The neurologist expected the gabapentin to be administered as ordered for better managing	D 358		

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nighttime nerve related foot pain.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

b. Review of Resident #3's readmission orders signed by the resident's primary care provider (PCP) dated 12/28/22, after a hospitalization for acute cystitis, revealed there was an order for memantine (used to treat memory loss) 10mg twice a day.

Review of Resident #3's physician's orders from a visit to his neurology clinic dated 01/05/23 revealed an order for memantine 28mg ER (extended release) one capsule daily for memory.

Review of the after visit summary from Resident #3's encounter at his neurology clinic dated 01/05/23 revealed Resident #3's current memantine order was memantine 28mg ER once a day.

Review of Resident #3 physician's orders dated 02/08/23 signed by the PCP revealed Resident #3's memantine 10mg twice a day and memantine 28mg ER once a day were ordered.

Telephone interview with a pharmacist at the contracted pharmacy provider on 02/16/23 at 2:40pm revealed:
-The contracted pharmacy had an order for Resident #3 dated 12/28/22 for memantine 10mg twice a day.
-The contracted pharmacy received Resident #3's order dated 01/05/23 for memantine 28mg XR capsule faxed from the facility.

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-The order entry department at the contracted pharmacy entered the order dated 01/05/23 for memantine 28mg XR one capsule daily in the eMAR system correctly and scheduled the medication administration on the eMAR for 8:00pm.
-There was no order to discontinue memantine 10mg twice a day available at the pharmacy, but the memantine 28 XR was routinely ordered to provide once a day dosing and replaced memantine 10mg twice a day.

Telephone interview with a nurse at Resident #3's neurology clinic on 02/20/23 at 9:48am from a message left previously revealed:
-The neurologist had ordered memantine 28mg XR once a day to replace memantine 10mg twice a day.
-There was documentation the facility or contracted pharmacy contacted the neurology clinic regarding discontinuing memantine 10mg twice a day and replacing with memantine 28mg XR once a day.
-The neurologist expected the memantine 28mg XR to be administered as ordered.
-He would not expect any adverse side effects for Resident #3 receiving additional doses of memantine for a short period of time but wanted the dose corrected immediately.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for memantine 10mg twice a day scheduled for administration at 8:00am and 8:00pm.
-There were 32 doses of memantine 10mg administered at 8:00am and 8:00pm documented as administered and should not have been administered in January 2023.

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D 358	Continued From page 101 -Memantine 10mg was documented as administered at 8:00am daily from 01/05/23 to 01/31/23 except documented for refused at 8:00am on 01/13/23 (out of facility), 01/15/23 (withheld per doctor order), and 01/16/23 (withheld per doctor order). There were 20 doses administered at 8:00am that should not have been administered. -Memantine 10mg was documented as administered at 8:00pm on 01/07/23, 01/09/23, 01/10/23, 01/16/23, 01/17/23, 01/21/23, and 01/26/23 through 01/31/23. There were 12 doses documented as administered at 8:00pm and should not have been administered. -There was an entry for memantine 28mg XR one capsule daily scheduled for administration at 8:00pm. -Memantine 28mg XR capsule was documented as administered at 8:00pm daily from 01/05/23 to 01/31/23 except documented for 01/09/21 (withheld per doctor order) and 01/12/23(out of facility). -There were 24 doses of memantine 28mg XR incorrectly documented as administered at 8:00pm that were packaged in the morning multidose bingo cards and administered at 8:00am. Review of Resident #3's February 2023 eMAR revealed: -There was an entry for memantine 10mg twice a day for memory impairment scheduled for administration at 8:00am and 8:00pm beginning on 02/01/23 and discontinued on 02/08/23. -Memantine 10mg was documented as administered at 8:00am daily from 02/01/23 to 02/08/23. There were 8 doses documented on the February eMAR administered at 8:00am that should not have been administered. -Memantine 10mg was documented administered	D 358		

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D 358	Continued From page 102 on the eMAR at 8:00pm on 02/01/23, 02/03/23, 02/05/23, and 02/06/23. -Memantine 10mg was not documented as administered at 8:00am from 02/09/23 to 12/16/23. -Memantine 10mg was not documented as administered at 8:00pm from 02/09/23 to 12/16/23. -In addition, there was an entry for memantine 28mg XR capsule one capsule daily, scheduled for administration at 8:00pm. -Memantine 28mg XR capsule was documented as administered at 8:00pm daily from 02/01/23 to 02/15/23, except documented as not administered on 02/04/23 (refused). -There were 12 doses documented as administered at 8:00pm that were packaged in the morning multidose bingo cards and administered at 8:00am. Observation of Resident #3's medication on hand for administration on 02/16/23 at 12:00pm revealed: -Resident #3's medications were from the contracted pharmacy provider in multidose bingo cards with the medications scheduled for morning, noon, afternoon (5:00pm) and bedtime packaged in separate multidose bubbles. -Resident #3 had too many medications scheduled in the morning and evening to fit in one multidose bubble, so there were 2 multidose bingo cards for each time of administration. -The multidose bingo cards were packed on one week supply cards with two cards dated 02/10/23 through 02/16/23 and 2 cards dated 02/18/23 through 02/23/23. -There were one memantine 10mg capsule and one memantine 28mg ER packaged in the morning multidose bubbles on the multidose bingo cards and 1 memantine 10mg packaged in	D 358		

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the evening multidose bubbles on the multidose bingo cards for each day from 02/16/23 to 02/23/23.

Based on observation of medication on hand in prepackaged multidose bingo cards on 02/16/23, telephone interviews with a pharmacist at the contracted pharmacy and medication aides (MAs), and incomplete documentation on the February 2023 eMAR, it could not be determined if 8 doses of memantine 10mg packaged in the morning multidose bubbles of Resident #3's multidose bingo cards, and 7 doses of memantine 10mg packaged in the evening multidose bubbles of Resident #3's multidose bingo cards that were scheduled for administration at 8:00pm were removed from the pre-packaged medications prior to administering morning and evening medications from 02/09/23 to 02/15/23.

Telephone interview with a pharmacist at the contracted pharmacy provider on 02/16/23 at 2:40pm revealed:
-The facility was responsible to review the medication orders entered on the eMAR by the pharmacy staff and consult the pharmacy for any discrepancies prior to releasing the orders to appear on the eMAR for medication aides (MA) to administer.
-The pharmacy pre-packaged Resident #3's memantine 10mg and memantine 28mg XR (scheduled at 8:00pm on the eMARS) in the morning multidose bubbles on the multidose bingo cards beginning 01/05/23 through 02/23/17 based on the medication order entry at the pharmacy filling area.
-The pharmacy pre-packaged Resident #3's memantine 10mg in the evening multidose bubbles on the multidose bingo cards beginning

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01/05/23 through 02/23/17 based on the medication order entry at the pharmacy filling area.
-There was no documentation the facility had contacted the pharmacy to correct the memantine 10mg included in the multidose bingo cards or the memantine 28mg XR scheduled on the eMAR for 8:00pm and packaged in the multidose bingo cards' morning bubbles.

Interview with Resident #3's mental health provider (MHP) on 02/15/23 at 10:40am revealed:
-Resident #3 was seen by the MHP, the facility's primary care provider (PCP), and a neurologist.
-The neurologist ordered memantine for Resident #3's neuropathy and the facility should be administering memantine as ordered by neurology.

Telephone interview with a previous medication aide (MA) on 02/16/23 at 3:30pm revealed:
-She did not see physician's orders or enter any physician's orders when she was working at the facility.
-Resident #3 occasionally refused his morning medications.
-She administered medications as pre-packaged by the pharmacy in the residents' multidose bingo cards assuming the pharmacy had packaged the medication according to the physician's orders.
-She did not routinely read the directions closely displayed on the eMAR screen of the computer.
-She had not removed any medications from Resident #3's multidose bingo cards prior to administering medications.
-She did not realize Resident #3's memantine 10mg and memantine 28mg XR dose was pre-packaged at 8:00am and memantine 10mg was duplicated at 8:00pm.

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D 358	Continued From page 105 Telephone interview with a second previous MA on 02/16/23 at 3:50pm revealed: -She depended on the pharmacy to pre-package residents' medications in the multidose bingo cards correctly. -She had not removed any medications from Resident #3's multidose bingo cards prior to administering medications. -She did not know what Resident #3's memantine dose was supposed to be. Interview with the Resident Care Coordinator (RCC) on 02/16/23 at 4:50pm revealed: -She had been back at the facility since December 2022 after being away for a while. -There was currently no system for routinely auditing the residents' orders compared to the medications sent in multidose bingo cards from the pharmacy and the eMARs for accuracy prior to auditing eMARs documentation last week (02/06/23). -On 02/08/23, she recognized there was a duplicate memantine therapy documentation of memantine on the inside of Resident #3's multidose bingo cards for memantine 10mg, but was not sure all MA staff read the note and was removing the memantine 10mg prior to administering the other morning and evening medications in the multidose bubbles. -She had not contacted the contracted pharmacy to request updated multidose bingo card replacements. Interview with the Executive Director (ED) on 02/17/23 at 3:00pm revealed: -The facility had experienced turnover in 2 Administrators with the last 6 month and the ED had come back to the facility to work as the Administrator in the interim while the owner tried to secure a third Administrator.	D 358		

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-When she came back to the facility to work (a couple of weeks ago), she discovered the previous Administrator was processing all orders and the staff did not have access to the orders.
-She did not know Resident #3 was receiving pre-packaged memantine 10mg and memantine 28mg XR since 01/05/28.

Telephone interview with Resident #3's MHP on 02/17/23 at 3:10pm revealed:
-She looked at the eMARs when she had a routine visit with the residents related to administration refusals or frequency of administration of as needed (prn) medications.
-She used the eMAR documentation to help monitor medication effectiveness and help determine if an adjustment to doses was needed for best results but not Resident #3's memantine 10 mg or 28mg XR since neurology ordered that medication.

Interview with Resident #3 on 02/17/23 at 3:20pm revealed:
-The facility and the pharmacy were supposed to be monitoring his medication orders and preparing his medications as ordered.
-He did not know the current dose of all his medications.

Refer to interview with the facility's Executive Director (ED) on 02/16/23 at 2:01pm.

Refer to interview with the Owner on 02/17/23 at 3:44pm.

____
Interview with the ED on 02/16/23 at 2:01pm revealed:
-She expected all residents' medications to be administered as ordered.
-If staff had a difficult time getting a resident's

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medication the Administrator and PCP should be notified.
-The previous Administrator was responsible for overseeing and making sure medications were available for administration.
-The RCD was responsible for notifying the providers if medications were being refused or doses missed.

Interview with the Owner on 02/17/23 at 3:44pm revealed:
-He expected medication orders to be followed according to the PCP instructions.
-The MAs and Administrator should follow medication orders and if there was confusion, they should contact the PCP.

____

The facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #3, and #6) regarding not complying with the physician's order to hold Novolog insulin for blood sugars less than 100 resulting in a resident having low blood sugars in the 40's and the resident experiencing light-headedness, confusion, delirious and was sent to the hospital with hypoglycemia, not administered reflux medication resulting in discomfort to the stomach, not receiving a B-12 for a vitamin deficiency resulting in the resident experiencing nausea, vitamin B-12 laboratory values (116) below normal limits which could lead to anemia (#1); a resident not administered an inhaler resulting in the resident unable to take deep breaths and feeling short of breath (#6), and a resident not receiving a medication for nerve pain resulting in tingling and pain in the resident's feet (#3). This failure placed residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation.

____

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D 358	Continued From page 108 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/23. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2023.	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, record reviews, and interviews the facility failed to ensure the medication administration records (MAR) were accurate for 1 of 3 sampled residents (#1) related	D 367		

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to vitamin B-12, ferrous sulfate, a multivitamin, and pantoprazole.

The findings are:

Review of Resident #1's current FL2 dated 07/20/22 revealed:
-Diagnoses included diabetes mellitus type II, stroke, hypertension, vitamin B deficiency anemia, gastro-esophageal reflux disease, vitamin D deficiency, moderate depression, insomnia and anxiety.
-There was no order for vitamin B-12.

a. Review of Resident #1's physician's order dated 12/07/22 revealed and order cyanocobalamin (vitamin B-12) 2,000mcg one tablet once daily (used to treat B-12 deficiency).

Review of Resident #1's primary care provider (PCP) electronically signed medication list dated 01/25/23 revealed Resident #1's current medications included vitamin B-12 2,000mcg once a day.

Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed and order for vitamin B12 1,000mcg 2 tablets (2,000mcg) once daily.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin B-12 1,000mcg, take 2 tablets =2000mcg once daily scheduled for administration at 8:00am.
-There was documentation with staff initials circled indicating vitamin B-12 was not administered with the reason documented as "out of stock - waiting on Veteran's Administration

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(VA)" for 5 of 24 opportunities from 12/07/22 through 12/31/22.
-Vitamin B-12 was documented as administered for 19 days at 8:00am from 12/07/22 through 12/31/22.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for vitamin B-12 1,000mcg 2 tablets =2000mcg once daily scheduled for administration at 8:00am.
-There was documentation with staff circled initials that vitamin B-12 was not administered with the reason documented as "out of stock - waiting on VA" for 17 of 31 opportunities from 01/01/23 through 01/31/23.
-Vitamin B-12 was documented as administered for 14 days from 01/01/23 through 01/31/23.

Review of Resident #1's February 2023 from 02/02/23 to 02/15/23 eMAR revealed:
-There was an entry for vitamin B-12 1,000mcg 2 tablets =2000mcg once daily scheduled for administration at 8:00am.
-There was documentation with staff circled initials that vitamin B-12 was not administered and the reason documented as "out of stock - waiting on VA" for 6 of 15 opportunities 02/01/23 through 02/15/23.
-Vitamin B-12 was documented as administered for 8 days from 02/01/23 through 02/15/23.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Vitamin B-12 was available for administration.
-There were 2 tablets remaining in a 3-tablet bubble package.
-The medication label instructions listed vitamin B-12 was filled and 3 tablets were dispensed on

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02/15/23.

Telephone interview with Resident #1's social worker from the VA from a return telephone call on 02/16/23 at 12:40pm revealed:
-Vitamin B-12 had never been dispensed from the VA pharmacy.
-He did not see an order for vitamin B-12.

Interview with Resident #1 on 02/15/23 at 8:44am revealed he was administered medications, but he did not know if he was administered vitamin B-12.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed:
-Generally, the pharmacy did not fill and dispense Resident #1's medications.
-Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's B-12 vitamin.
-The pharmacy had an order dated 12/07/23 for vitamin B-12, but until yesterday (02/15/23) Resident #1's vitamin B-12 had not been filled and dispensed by the pharmacy.
-Resident #1's medications were usually dispensed by the VA pharmacy.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-She ordered Resident #1 vitamin B12 back in December 2022 because the resident had a low B-12 level.
-She was not aware the resident currently was not being administered vitamin B-12.
-If the facility was unable to obtain Resident #1's medication after one week they should have let her know.
-Resident #1's medications came from the VA

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and it might take longer than the facility's contracted pharmacy, but it should not take from December 7, 2022 (date she wrote the order) until today's date to get the vitamin B-12.
-She expected Resident #1's medications to be administered as ordered.

Telephone interview with a second previous medication aide (MA) on 02/16/23 at 3:03pm revealed:
-She was aware Resident #1's vitamin B-12 was not available since 12/07/22.
-Some MAs documented on the eMAR as if they administered the medication.
-She had not made Resident #1's PCP aware the vitamin B-12 was not available for administration.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed:
-Yesterday (02/15/23), the Executive Director (ED) paid for and filled Resident #1's vitamin B-12 for a three-day supply.
-She did not know why the ED filled the vitamin B-12 for 3 days only.
-She noticed last month that Resident #1 did not have his vitamin B-12 available for administration.
-She had contacted the Social Worker at the VA to find out why.
-She had not followed-up with the Social Worker to find out why the medication was not received.
-The MA should not document they administered a medication that was not available.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available, refusals and resident out of the facility.
-When she checked Resident #1's eMAR

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exceptions and saw "waiting on the VA", she called the MA to find if the MA had checked with the pharmacy to see why the medication was not administered.
-She was not aware Resident #1's vitamin B-12 had not been filled and the medication not obtained since 12/07/22.

Interview with the ED on 02/16/23 at 1:43pm revealed:
-She filled Resident #1's medications with a 3-day supply of vitamin B-12
-She had hoped the VA pharmacy would dispense the medication.
-She did not realize it had been over 2 months since the PCP ordered vitamin B-12.
-Prior to yesterday (02/15/23), she did not know Resident #1 did not have the vitamin B-12 available.

Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

b. Review of Resident #1's current FL2 dated 07/20/22 revealed diagnoses included iron deficiency.

Review of Resident #1's physician's order dated 12/07/22 revealed and order ferrous sulfate 325mg tablet, take 1 twice daily (used to treat iron deficiency).

Review of Resident #1's primary care provider (PCP) electronically signed medication list dated 01/25/23 revealed Resident #1's current

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D 367	Continued From page 114 medications included ferrous sulfate 325mg 1 tablet twice a day with orange juice. Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed ferrous sulfate 325mg 1 tablet twice daily. Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation with staff circled initials that ferrous sulfate 325mg was not administered for 13 of 49 opportunities with the reason documented as "out of stock - waiting on Veteran's Administration (VA)." -Ferrous sulfate was documented as administered 33 times from 12/07/22 through 12/31/22. Review of Resident #1's January 2023 eMAR revealed: -There was an entry for ferrous sulfate 325mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation with staff circled initials that ferrous sulfate 325mg was not administered for 36 of 62 opportunities with the reason documented as "out of stock - waiting on VA." -Ferrous sulfate was documented as administered 28 times from 01/01/23 through 01/31/23. Review of Resident #1's February 2023 eMAR from 02/01/23 to 02/15/23 revealed: -There was an entry for ferrous sulfate 325mg 1 tablet twice daily scheduled for administration at	D 367		

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8:00am and 8:00pm.
-There was documentation with staff circled initials that ferrous sulfate 325mg was not administered for 14 of 29 opportunities with the reason documented as "out of stock - waiting on VA."
-Ferrous sulfate was documented as administered 12 times from 02/01/23 through 02/15/23.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-Ferrous sulfate 325mg was available for administration.
-There were 5 tablets of ferrous sulfate remaining from 6 tablets.
-The medication label instructions listed the medication was filled for 6 tablets and dispensed on 02/15/23.

Telephone interview with Resident #1's social work from the VA from a return telephone call placed on 02/16/23 at 12:40am revealed:
-The VA pharmacy had never received an order for ferrous sulfate.
-Ferrous sulfate had never been dispensed from the VA pharmacy.

Interview with Resident #1 on 02/15/23 at 8:44am revealed:
-He was administered medications daily, but was not aware of all medications ordered.
-He did not know that he had been ordered ferrous sulfate and did not know what the medication was used to treat.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed:

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D 367	Continued From page 116 -Generally, the pharmacy did not fill and dispense Resident #1's medications. -Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's ferrous sulfate. -The pharmacy had an order dated 12/07/23 for Resident #1's ferrous sulfate, but until yesterday the pharmacy had never dispensed any of the resident's medications. -Resident #1's medication orders were usually profile only for eMAR documentation and instructions for administration of medications. -Resident #1's medications were usually dispensed by the VA pharmacy. Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed: -She ordered Resident #1's ferrous sulfate on 12/07/22 due to the resident's iron deficiency. -She was not aware the resident was not being administered ferrous sulfate. -She expected Resident #1's medications to be administered as ordered. Telephone interview with a previous medication aide (MA) on 02/16/23 at 3:03pm revealed: -She was aware Resident #1 did not have ferrous sulfate available for administration and made the Administrator and the RCD aware in January 2023. -She noticed that some MAs signed the eMAR that ferrous sulfate was administered, but the medication was not available on the medication cart. Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed: -Yesterday (02/15/23), the ED paid for and had the local pharmacy fill and dispense a 3-day supply of ferrous sulfate for Resident #1.	D 367		

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-She did not know why the ED had the ferrous sulfate filled for 3-days only.
-She noticed last month (January 2023) that Resident #1 did not have ferrous sulfate available for administration.
-Some MAs documented they administered the medication in the eMAR when they had not administered ferrous sulfate.
-There was no system that compared the eMAR to medications available to ensure the documentation was accurate.

Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed:
-She was not aware that some of Resident #1's medications were not in the facility.
-Although, there was no system for comparing eMAR with current medications, the Office Manager looked at the eMARs for accuracy.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available in the facility.
-When she checked the eMAR exceptions and saw "waiting on the VA"; she contacted the MA to find out if the MA had contacted the pharmacy to inquire why the medication was not delivered.
-When a medication was not available in the facility; the MA should not document on the eMAR the medication was administered.
-She did not review the eMARs for MA documentation when a medication was not available for administration.

Interview with the ED on 02/16/23 at 1:43pm revealed:
-She filled a 3-day supply of Resident #1's ferrous

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sulfate in hopes the VA pharmacy would dispense the medications.
-The MAs should not documented they administered a medication that was not in the facility.

Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

c. Review of Resident #1's current FL2 dated 07/20/22 revealed medication orders did not include multivitamin.

Review of Resident #1's physician's order dated 12/28/22 revealed and order multivitamin 1 tablet once a day (used to treat nutritional deficiencies).

Review of Resident #1's primary care provider (PCP) electronically signed medication list dated 01/25/23 revealed Resident #1's current medications included multivitamin 1 tablet once daily.

Review of Resident #1's physician's order sheet (POS) dated 02/08/23 revealed an order for multivitamin 1 tablet once a day.

Review of Resident #1's physician's order revealed there was an order dated 02/08/23 that changed multivitamin to a one-a-day men's 50 plus 400mcg vitamin 1 tablet once a day.

Review of Resident #1's January 2023 eMAR revealed:
-There was an entry for multivitamin 1 tablet once

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D 367	Continued From page 119 daily scheduled for administration at 8:00am. -Multivitamin was documented as administered 18 times from 01/01/23 through 01/31/23. Review of Resident #1's February 2023 eMAR from 02/01/23 to 02/15/23 revealed: -There was an entry for multivitamin 1 tablet once daily scheduled for administration at 8:00am. -There was documentation multivitamin was administered 18 times from 01/01/23 through 01/31/23. -There was documented multivitamin was discontinued and replaced with centrum silver men's 50 plus once daily on 02/08/23. -There was an entry for centrum silver men's 50 once daily scheduled for administration at 8:00am. -There was documentation centrum silver men's 50 plus was administered twice on 02/12/23 and on 02/13/23; and the medication was not available for administration. Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed: -There was centrum silver men's 50 plus vitamin available for administration. -Centrum silver was filled by the facility's pharmacy on 02/15/23 for 3 tablets. -There were 2 tablets of centrum silver remaining. Interview with Resident #1 on 02/15/23 at 8:44am revealed: -He was not aware he was ordered a multivitamin. -He had discussed with the PCP that sometimes he was tired and had no energy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at	D 367		

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8:43am revealed:
-The pharmacy usually did not fill and dispense Resident #1's medications.
-Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's centrum men's 50 plus multivitamin.
-The pharmacy had an order dated 02/08/23 for Resident #1's multivitamin, but had not filled and dispensed the multivitamin until yesterday.
-Resident #1's medication orders were usually profile only for eMAR documentation and instructions for administration of medications.
-Resident #1's medications were usually dispensed by the VA pharmacy.

Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed:
-She ordered Resident #1's multivitamin due to the nutritional decline.
-She was not aware the resident was not being administered the multivitamin as ordered.
-She expected Resident #1's medications to be administered as ordered.

Telephone interview with a previous medication aide (MA) on 02/16/23 at 3:03pm revealed:
-She was aware Resident #1 did not have multivitamin available for administration.
-She knew that some MAs documented they administered Resident #1's multivitamin and the medication was not in the facility.

Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed prior to 02/15/23, multivitamin was not available for administration, even though the MAs documented the medications was administered.

Telephone interview with the previous Office

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Manager on 02/17/23 at 6:03pm revealed:
-She was responsible for reviewing the eMAR exception reports to identify when staff documented a medication was not available in the facility.
-In January 2023, she told the Administrator Resident #1 did not have multivitamin available for administration.

Interview with the ED on 02/16/23 at 1:43pm revealed:
-Prior to yesterday (02/15/23), she did not know Resident #1 did not have the multivitamin or centrum silver available for administration.
-The facility did not have a system of checking eMARs with the current medications on hand instructions to ensure accuracy.

Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.

d. Review of Resident #1's current FL2 dated 07/20/22 revealed diagnoses included gastroesophageal reflux disease (GERD).

Review of Resident #1's physician's order dated 01/25/23 revealed:
-Resident #1 complained to the facility's primary care provider (PCP) that he had signs and symptoms of GERD.
-There was an order pantoprazole 40mg, delayed release 1 tablet every morning for GERD (used to treat gastroesophageal reflux disease).

Review of Resident #1's physician's order sheet

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(POS) dated 02/08/23 revealed an order for pantoprazole 40mg 1 tablet every morning.

Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for pantoprazole 40mg 1 tablet every morning scheduled for administration at 7:00am.
-Pantoprazole 40mg was documented as administered 4 times from 01/26/23 through 01/31/23.

Review of Resident #1's February 2023 eMAR from 02/01/23 to 02/15/23 revealed:
-There was an entry for pantoprazole 40mg 1 tablet every morning scheduled for administration at 7:00am.
-There was documentation with staff circled initials pantoprazole 40mg was not administered 6 of 15 opportunities with reason indicated "out of stock - waiting on VA."
-Pantoprazole 40mg was documented as administered 8 days from 01/26/23 through 01/31/23.

Observation of Resident #1's medications on hand at the facility on 02/16/23 at 2:21pm revealed:
-There was pantoprazole 40mg available for administration.
-Pantoprazole 40mg was filled and dispensed by the facility's pharmacy on 02/15/23 for 3 tablets.
-There were 2 tablets of pantoprazole 40mg remaining.

Telephone interview with Resident #1's social worker from the Veteran's Administration (VA) a telephone call placed on 02/16/23 at 12:40pm revealed:

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D 367	Continued From page 123 -The VA pharmacy did not have an order for Resident #1's pantoprazole 40mg. -The VA had never dispensed pantoprazole 40mg. Interview with Resident #1 on 02/15/23 at 8:44am revealed: -He did not know if he was administered the medication because he did not know his medications. -He some stomach issues that had not improved. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 8:43am revealed: -The pharmacy usually did not fill and dispense Resident #1's medications. -Yesterday (02/15/23), the Executive Director (ED) at the facility asked the pharmacy to fill a 3-day supply of Resident #1's pantoprazole 40mg 1 tablet every morning. -The pharmacy had an order dated 01/25/23 for Resident #1's pantoprazole 40mg but had not filled and dispensed the medication until yesterday. -Resident #1's medication orders were usually profile only for eMAR documentation and instructions for administration of medications. -Resident #1's medications were usually dispensed by the VA pharmacy. Telephone interview with Resident #1's facility's PCP on 02/15/23 at 4:15pm revealed: -She ordered Resident #1's pantoprazole 40mg 1 tablet every morning due to the resident complaining about reflux in this stomach. -She was not aware the resident was not being administered pantoprazole 40mg as ordered. -She was at the facility weekly, and the facility was able to contact her and her office 24/7, the	D 367		

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D 367	Continued From page 124 facility staff should have made her aware they were not administering pantoprazole. -She expected Resident #1's medications to be administered as ordered. Telephone interview with a previous medication aide (MA) on 02/16/23 at 3:03pm revealed: -She was aware Resident #1 was not administered pantoprazole 40mg. -She was unable to explain why her, and other MAs documented they administered pantoprazole when the medication was not in the facility. Interview with the Resident Care Director (RCD) on 02/16/23 at 11:46am revealed she did not think Resident #1 was administered pantoprazole, because prior to 02/15/23 there had been none in the facility. Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed: -She was responsible for reviewing Resident #1's eMAR exception reports to identify when staff documented a medication was out of stock or waiting on the VA. -She did not check the eMAR and compare them with medications on hand to ensure documentation was accurate. Interview with the ED on 02/16/23 at 1:43pm revealed: -Prior to yesterday, she did not know Resident #1 did not have the pantoprazole 40mg available for administration. -If a medication was not available the MA should not document the medication was administered. Attempted telephone interview with Resident #1's VA PCP on 02/16/23 at 12:02pm was unsuccessful.	D 367		

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D 367	Continued From page 125 Attempted telephone interview with Resident #1's VA pharmacy on 02/16/23 at 4:58pm was unsuccessful.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 2 of 3 sampled residents (#3 and #5) with orders for a controlled substances of an anti-anxiety medication (#3 and #5). The findings are: Review of the facility's Controlled Substances Policies and Procedures (no date available) revealed: -The purpose was to ensure proper accountability of administration of controlled substances. The record of documentation will be kept in the residents' records (controlled drug sign-out sheets or medication administration record (MAR).	D 392		

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-All controlled substances will be counted prior to medication aides (MA) receiving the keys to medication storage areas.
-Documentation of receipt of controlled substance from the pharmacy will be maintained.
-Administrator or designee will randomly monitor the procedure for tracking controlled substance and randomly count all controlled substances within the community (facility).

1. Review of Resident #3's current FL2 dated 11/22/22 revealed diagnoses included multiple sclerosis (MS), Type 2 diabetes, bipolar disorder, and chronic lower back pain.

a. Review of Resident #3's current FL2 dated 11/22/23 and signed physician's orders dated 12/07/22 and 12/28/23 revealed there were orders for clonazepam (a Scheduled IV controlled substance used to treat anxiety and panic disorders) 2mg twice a day as needed (prn).

Review of Resident #3's physicians' orders dated 01/05/23 and 02/08/23 revealed clonazepam 2mg one tablet twice a day, routinely, for anxiety was ordered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/17/22 at 9:15am revealed:
-There were 30 tablets of clonazepam 2mg dispensed for Resident #3 on 11/22/22 labeled one tablet twice a day prn.
-There were 6 tablets of clonazepam 2mg dispensed for Resident #3 on 12/06/22 labeled one tablet twice a day prn.
-There were 30 tablets of clonazepam 2mg dispensed for Resident #3 on 12/28/22 labeled one tablet twice a day prn.
-There were 60 tablets of clonazepam 2mg

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dispensed for Resident #3 on 01/05/23 labeled one tablet twice a day for anxiety and sleep.
-The pharmacy routinely sent controlled substance count sheets (CSCS) with each controlled substance medication bubble pack to assist the facility in tracking medication administration.
-There was no documentation for clonazepam 2mg returned to the pharmacy for credit.

Review of Resident #3's Controlled Substance Count Sheet (CSCS) for clonazepam 2mg dispensed on 11/22/22 and 12/06/22 revealed:
-There was no CSCS documentation available for review for the 30 tablets of clonazepam 2mg dispensed on 11/22/22.
-There was no CSCS documentation available for review for 6 clonazepam 2mg tablets dispensed on 12/06/22.

Review of Resident #3's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 2mg one tablet twice a day prn.
-Clonazepam 2mg was documented as administered for 5 doses from 12/02/22 to 12/21/22.
-Clonazepam 2mg was documented as administered for 3 dose on 12/29/22 at 8:25pm, 12/30/22 at 8:00pm, and 12/31/22 at 7:15pm.

Review of Resident #3's CSCS for clonazepam 2mg one tablet twice a day as needed for quantity of 30 tablets dispensed on 12/28/22 revealed:
-There was a beginning balance of 30 tablets on 12/28/22 and ending balance of zero(0) on 01/17/23.
-There was no clonazepam 2mg signed out on a CSCS dispensed on 12/28/22 for clonazepam

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2mg documented on the December 2022 eMAR on 12/29/22 at 8:25pm.
-There was one tablet signed out on the CSCS and 12/30/22 (no time listed) not documented as administered on the December 2022 eMAR (and one tablet signed out at 8:00pm corresponding to eMAR documentation for administration).

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for clonazepam 2mg one tablet twice a day prn beginning on 01/01/23 and discontinued on 01/04/23.
-Clonazepam 2mg twice a day prn was documented as administered for 8 doses from 01/01/23 to 01/04/23.
-There was a second entry on the eMAR for clonazepam 2mg twice a day for anxiety and sleep scheduled for administration at 8:00am and 8:00pm beginning 01/05/23.
-On 01/06/23 at 8:00pm, clonazepam 2mg was documented as administered.
-On 01/12/23 at 8:00pm, clonazepam 2mg was documented as resident out of the facility.
-On 01/14/23 at 8:00pm, clonazepam 2mg was documented as resident refused (no documentation the tablet was wasted).
-On 01/15/23 at 8:00am, clonazepam 2mg was documented as administered.
-On 01/17/23 at 8:00am, clonazepam 2mg was not documented as administered on the eMAR (left blank for documentation).

Review of Resident #3's CSCS for 30 clonazepam 2mg dispensed on 12/28/22 revealed:
-There was a beginning balance of 30 tablets on 12/28/22 and ending balance of zero(0) on 01/17/23.
-Clonazepam 2mg twice a day prn was

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documented as signed out on the CSCS for 30 tablets dispensed on 12/28/22.
-On 01/06/23 at 8:00pm, clonazepam 2mg was not signed out on the CSCS.
-On 01/12/23 at 8:00pm, clonazepam 2mg, one dose was signed out on the CSCS when the resident was out of the facility.
-On 01/14/23 at 8:00pm, clonazepam 2mg, one dose was signed out on the CSCS when the resident refused (no documentation the tablet was wasted).
-On 01/15/23 at 8:00am, clonazepam 2mg was not signed out on the CSCS.
-On 01/17/23 at 8:00am, clonazepam 2mg, one dose was signed out on the CSCS which completed the CSCS sheet for 30 tablets dispensed on 12/28/22.

Review of Resident #3's February 2023 eMAR and revealed:
-There was an entry for clonazepam 2mg twice a day for anxiety and sleep scheduled for administration at 8:00am and 8:00pm.
-On 02/05/23 at 8:00am, clonazepam 2mg was documented as administered.
-On 02/05/23 at 8:00pm, clonazepam 2mg was not documented as administered.
-On 02/06/23 at 8:00pm, clonazepam 2mg was documented as administered.
-On 02/11/23 at 8:00am, clonazepam 2mg was documented as administered.
-On 02/11/23 at 8:00pm, clonazepam 2mg was documented as administered.

Review of Resident #3's CSCS for clonazepam 2mg dispensed on 01/05/23 for 60 tablets revealed:
-Clonazepam 2mg was signed out on the CSCS beginning 01/17/23 to 02/17/23 (9 tablets remaining matching the count on the bubble

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D 392	Continued From page 130 pack). -On 02/05/23 at 8:00am, clonazepam 2mg was not signed out on the CSCS. -On 02/05/23 at 8:00pm, clonazepam 2mg was documented as signed out on the CSCS. -On 02/06/23 at 8:00pm, clonazepam 2mg was documented as signed out on the CSCS. -On 02/11/23 at 8:00am, clonazepam 2mg was not signed out on the CSCS. -On 02/11/23 at 8:00pm, clonazepam 2mg was not signed out on the CSCS. Observation of Resident #3's medications on hand on 02/17/23 at 9:00am revealed: -There were no clonazepam 2mg tablets on hand for 30 tablets dispensed on 11/22/22. -There were no clonazepam 2mg tablets on hand for the 6 tablets dispensed on 12/06/22. -There was one bubble pack of clonazepam 2mg labeled one tablet twice a day dispensed on 01/05/23. -The bubble pack was labeled for quantity dispensed on 01/05/23 as 60 tablets with 9 tablets remaining. Based on observations, interviews and record reviews, there were 126 clonazepam 2 mg dispensed from 11/22/22 to 01/05/23 with 39 clonazepam 2mg tablets missing and not accounted for according to the CSCS documentation and clonazepam 2mg tablets available for administration. There were 11 doses of clonazepam 2mg incorrectly accounted for compared to the eMAR documentation and doses signed out on the corresponding CSCS. Interview with the Resident Care Director (RCD) on 02/16/23 at 4:50pm revealed: -She had been back at the facility since December 2022 after being away for a while.	D 392		

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D 392	Continued From page 131 -There was currently no system for routinely auditing the residents' controlled drugs on hand inventory compared to the eMAR and the controlled substances sent from the contracted pharmacy. -She had started auditing eMARs, and CSCS, including Resident #3's controlled medications and CSCS documentation last week (02/06/23) and observed errors. -The facility previously had kept all completed CSCS in the residents' record for easy access. -The facility had experienced change of Administrators 2 times in the last 6 months. -The previous Administrator had assumed responsibility for processing physicians' orders, faxing the orders to the contracted pharmacy, reviewing all CSCS logs and packing slips. -The previous Administrator removed all the CSCS sheets except the current one from the records and overstock from the medication carts and facility medication storage areas. -The previous Administrator left abruptly, around 02/06/23, and had not completed organizing the paperwork from the facility; leaving multiple boxes of unlabeled and randomly pulled paperwork. -She had started trying to find information and sort through all the boxes to implement a retrievable information system, but was left with "a mess". -She found some CSCS documentation in desk drawers and some in stacked papers in the Administration's office on the facility's campus. -She was unable to locate additional missing CSCS or pharmacy return credits for controlled substances. Telephone interview with Resident #3's mental health provider (MHP) on 03/17/23 at 3:10pm revealed: -The facility staff had not told her about any	D 392		

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missing clonazepam for Resident #3.
-She looked at the eMARs when she had a routine visit with the residents related to administration refusals or frequency of administration of as needed (prn) medications.
-She used the eMAR documentation to help monitor medication effectiveness and help determine if an adjustment to doses was needed for best results.
-Resident #3 had not complained of increased anxiety.

Interview with Resident #3 on 02/17/23 at 3:20pm revealed:
-He refused his clonazepam sometimes.
-He asked for as needed clonazepam sometimes to help him with sleeping at night if his MS was acting up to help with the anxiety.
-He had no idea of the times he may have requested as needed clonazepam to help determine if he received it on days it was signed out on the CSCS but not documented on the eMAR.

Refer to interview with the Executive Director (ED) on 02/17/23 at 2:55pm.

b. Review of Resident #3's physician's orders from encounters with the residents' psychiatric provider revealed:
-There was an order dated 12/21/22 for clonazepam (a Scheduled IV controlled substance used to treat anxiety and panic disorders) 1mg two times a day as needed (prn).
-There was an order dated 01/04/23 to stop clonazepam 1mg and start clonazepam 1mg three times a day, as needed.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/17/22 at

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9:15am for dispensing of clonazepam 1mg for Resident #3 revealed:
-There were 30 tablets of clonazepam 1mg dispensed on 12/22/22 labeled one tablet two times a day prn.
-There were 90 tablets of clonazepam 1mg dispensed on 01/04/23 labeled one tablet three a day prn.
-There were 90 tablets of clonazepam 1mg dispensed on 01/30/23 labeled one tablet three a day prn.
-The pharmacy routinely sent controlled substance count sheets (CSCS) with each controlled substance medication bubble pack to assist the facility in tracking medication administration.

Review of Resident #3's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1mg one tablet twice a day prn.
-Clonazepam 1mg was documented as administered for 6 doses from 12/01/22 to 12/28/22.
-Clonazepam 1mg was documented as administered twice on 12/22/22 at 5:36pm and 7:37pm, on 12/23/22 administered 3 times (at 8:27am, 4:40pm and 8:00pm), and on 12/28/22 at 5:03pm.

Review of Resident #3's Controlled Substance Count Sheet (CSCS) for clonazepam 1mg revealed there was no CSCS available for review for clonazepam 1mg dispensed on 12/22/22 for 30 tablets.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for clonazepam 1mg one

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tablet three a day prn for anxiety.
-Clonazepam 1mg was documented as administered for 6 doses from 01/01/23 to 01/31/23.
-Clonazepam 1mg was documented as administered on 01/06/23 at 8:28am, on 01/10/23 at 1:21pm, on 01/14/23 at 12:36pm, on 01/29/23 at 8:27pm and on 01/30/23 at 7:39pm.

Review of Resident #3's CSCS for clonazepam 1mg revealed:
-There was no CSCS available for review for clonazepam 1mg dispensed on 01/04/23 for 90 tablets.
-There were 54 clonazepam 1mg from 90 dispensed 01/04/23 without an accurate accounting and no medication on hand for administration on 02/17/23.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet three a day prn for anxiety.
-Clonazepam 1mg was not documented as administered from 02/01/23 to 02/16/23.

Review of Resident #3's CSCS for clonazepam 1mg revealed clonazepam 1mg was signed out on a CSCS dated 01/30/23 with no corresponding clonazepam 1mg bingo card as follows: on 02/09/23 at 8:28pm, on 02/10/23 at 8:00pm, on 02/12/23 at 8:00am, and on 02/13/23 at 8:00am.

Observation of Resident #3's clonazepam 1mg on hand for administration on 02/17/23 revealed:
-There was a bingo card of clonazepam 1mg dispensed on 12/22/22 for 30 tablets with 25 tablets remaining located on the medication cart with no corresponding CSCS for sign out.
-There was a bingo card of clonazepam 1mg

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dispensed on 01/04/23 for 30 of 90 tablets with 30 tablets remaining located in a locked box in the facility's Administrator's office with no CSCS attached.
-There were 3 cards of 30 each for a total of 90 clonazepam 1mg dispensed on 01/30/23 in overstock that had 2 pharmacy printed CSCS for 30 each and one handwritten CSCS for 30 tablets attached to the medication.

Based on observations and record reviews and interviews, there were 210 clonazepam 1mg tablets dispensed for Resident # 3 from 12/22/22 to 01/30/23 with 145 tablets on hand and available for administration on 02/17/23; there were 65 tablets of clonazepam 1mg not accounted for with no CSCS, no documentation for disposition, and no clonazepam 1mg on hand.

Interview with Resident #3 on 02/17/23 at 3:20pm revealed:
-He refused his clonazepam sometimes.
-He asked for as needed clonazepam sometimes to help him with sleeping at night of if his MS was acting up to help with the anxiety.
-He had no idea of the times he made have requested as needed clonazepam to help determine if he received it on days it was signed out on the CSCS but not documented on the eMAR.

Interview with the Resident Care Director (RCD) on 02/16/23 at 4:50pm revealed:
-She had been back at the facility since December 2022 after being away for a while.
-The facility had experienced staffing shortages as several staff had been dismissed for various reasons including missing medication documentation, including controlled substances.
-There was currently no system for routinely

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auditing the residents' controlled drugs on hand inventory compared to the eMAR and the controlled substances sent from the contracted pharmacy.
-She had started auditing residents' including Resident #3's, controlled medications and CSCS documentation last week (02/06/23) and observed errors.
-The facility previously had kept all completed CSCS in the residents' record for easy access.
-The facility had experienced change of Administrators 2 times in the last 6 months.
-The previous Administrator had assumed responsibility for processing physicians' orders, faxing the orders to the contracted pharmacy, reviewing all CSCS logs and packing slips.
-The previous Administrator removed all the CSCS sheets except the current one from the records and overstock from the medication carts and facility medication storage areas.
-The previous Administrator left abruptly, around 02/06/23, and had not completed organizing the paperwork from the facility; leaving multiple boxes of unlabeled and randomly pulled paperwork.
-She had started trying to find information and sort through all the boxes to implement a retrievable information system but was left with "a mess".
-She found some CSCS documentation in desk drawers and some in stacked papers in the Administration office on the facility's campus.
-She was unable to locate additional missing CSCS or pharmacy return credits for controlled substances.

Telephone interview with Resident #3's mental health provider (MHP) on 03/17/23 at 3:10pm revealed:
-The facility staff had not told her about any missing clonazepam for Resident #3.

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-She looked at the eMARs when she had a routine visit with the residents related to administration refusals or frequency of administration of as needed (prn) medications.
-She used the eMAR documentation to help monitor medication effectiveness and help determine if an adjustment to doses was needed for best results.

Refer to interview with the Executive Director (ED) on 02/17/23 at 2:55pm.

3. Review of Resident #5's current FL2 dated 05/25/22 revealed:
-Diagnoses included schizoaffective disorder.
-There was an order for lorazepam 0.5mg ½ tablet (0.25mg) twice daily at 8:00am and 3:00pm (a Scheduled IV controlled substance used to treat anxiety).
-There was an order for lorazepam 0.5mg 1 tablet as needed (prn).
-There was an order for lorazepam 1mg 1 tablet at bedtime.

Review of Resident #5's physician's order revealed an order dated 10/31/22 that changed lorazepam 0.5mg, ½ tablet (0.25mg) from twice daily to once daily at 8:00am.

Review of Resident #5's physician's order sheet dated 02/08/23 revealed:
-There was an order for lorazepam 0.5mg ½ tablet (0.25mg) once daily at 8:00am.
-There was an order for lorazepam 0.5mg 1 tablet prn.
-There was an order for lorazepam 1mg 1 tablet at bedtime.

Interview with a pharmacist at the facility's contracted pharmacy on 02/17/23 at 10:03am

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D 392	Continued From page 138 revealed: -The pharmacy last received an order for lorazepam 0.5mg ½ tablet (0.25mg) once daily at 8:00am dated 01/20/23. -The pharmacy filled and dispensed Resident #5's lorazepam 0.5mg ½ tablet (0.25mg) at 8:00am on the following dates: -On 01/20/23, for a quantity of 15 tablets (30-day supply). -On 12/19/22, for a quantity of 15 tablets (30-day supply). -On 12/15/22, for a quantity 2 tablets (4-day supply). -On 12/05/22, for a quantity of 3 tablets for a (6-day supply). -There was no 0.5mg ½ tablet (0.25mg) lorazepam once daily at 8:00am dispensed in November 2022. -The pharmacy last received an order for Resident #5's lorazepam 1mg at bedtime dated 02/03/23. -The pharmacy dispensed Resident #5's lorazepam 1mg at bedtime as follows: -On 02/03/23, a 30-day supply of lorazepam 1mg was dispensed. -On 12/31/23, a 30-day supply of lorazepam 1mg was dispensed. -On 11/30/22, at 30-day supply of lorazepam 1mg was dispensed. -The pharmacy last received an order for Resident #5's lorazepam 0.5mg 1 tablet every day prn for anxiety on 07/11/22. -The pharmacy filled and dispensed Resident #5's lorazepam 0.5mg every day prn as follows: -On 12/29/22, the pharmacy filled and dispensed 30 tablets of lorazepam 0.5mg as needed. -On 12/06/22, the pharmacy filled and dispensed 30 tablets of lorazepam 0.5mg as needed. -There was no lorazepam 0.5mg once daily prn dispensed in November 2022.	D 392		

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Observation of Resident #5's medications on hand on 02/17/23 at 10:14am revealed:
-There was one bubble packaged medication card of lorazepam 0.5mg ½ tablet (0.25mg) on hand.
-There were 15 tablets (30 half tablets) dispensed on 01/20/23, and there were 4 tablets remaining.
-There was one bubble packed medication card of lorazepam 1mg tablet with 30 tablets dispensed on 02/03/23, and there were 21 tablets remaining.
-There was one bubble packaged medication card of lorazepam 0.5mg 1 tablet prn with 30 tablets dispensed on 12/27/22, and there were 29 tablets remaining.
-There were no more lorazepam tablets available for administration in the overstock storage or in the medication cart for lorazepam 0.5mg ½ tablet (0.25mg).

Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am.
-Lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am was documented as administered from 12/01/22 to 12/31/22 except for 1 date.
-On 12/06/23 at 8:00am, lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am was documented as the medication was out of stock.

Review of Resident #5's Controlled Substance Count Sheet (CSCS) for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am quantity of 3 tablets/6 doses dispensed on 12/05/22 revealed there no lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am signed out on

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the CSCS on 12/05/22, 12/06/22, and 12/07/22.

Review of Resident #5's CSCS for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am 2 tablets/4 doses dispensed on 12/15/22 revealed there was no CSCS documentation available for review to reference for the 2 tablets/4 doses dispensed.

Review of Resident #5's CSCS for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am quantity of 30 tablets dispensed on 12/19/22 revealed there was no lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am signed out on the CSCS on 12/19/22, 12/20/22, 12/21/22, 12/22/22, 12/23/22, and 12/28/22.

Review of Resident #5's January 2023 eMAR revealed:
-There was an entry for lorazepam 0.5mg ½ tablet (0.25mg) at 8:00am.
-There was documentation lorazepam 0.5mg ½ tablet (0.25mg) at 8:00am was administered from 01/01/23 through 01/31/23, except on 01/09/23 and 01/15/23 when Resident #5 was documented as out of the facility.

Review of Resident #5's CSCS for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am quantity of 30 tablets dispensed on 01/20/23 revealed there was no lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am signed out on the CSCS on 01/21/23, and on 01/22/23.

Review of Resident #3's February 2023 eMAR and revealed:
-There was an entry for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am.
-On 02/01/23, there was documentation Resident

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#5 was out of the facility.
-There was documentation lorazepam 0.5mg ½ tablet (0.25mg) daily at 8:00am was documented as administered from 02/02/23 through 02/16/23.

Review of Resident #5's CSCS for lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am quantity of 30 tablets dispensed on 01/20/23 revealed there was no lorazepam 0.5mg ½ tablet (0.25mg) in the morning at 8:00am signed out on the CSCS on 02/06/23.

Based on observation of medications on hand, interview with the contracted pharmacy, and review of eMARs and CSCS documentation, there were 16 tablets of lorazepam 0.5mg ½ tablet (0.25mg) daily at 8:00am missing and unaccounted for.

b. Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 1mg at bedtime scheduled at 8:00pm.
-There was documentation lorazepam 1mg at bedtime was administered daily at 8:00pm from 12/01/22 through 12/31/22 except for 3 dates as follows:
-On 12/06/22 and 12/27/22, there was no documentation of administration.
-On 12/17/22, there was staff circled initials with documentation the resident was out of the facility.

Review of Resident #5's Controlled Substance Count Sheet (CSCS) for lorazepam 1mg at bedtime to review and reference the quantity of 30 tablets dispensed on 11/30/22 revealed there was no lorazepam 1mg at bedtime signed out on the CSCS from 12/01/22 through 12/31/22.

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D 392	Continued From page 142 Review of Resident #5's January 2023 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime scheduled at 8:00pm. -There was an entry for lorazepam 1mg at bedtime scheduled at 8:00pm. -There was documentation lorazepam 1mg at bedtime was administered daily at 8:00pm from 01/01/23 through 01/31/23 except for 4 dates (01/08/23, 01/14/23, 01/30/23, and 01/31/23) with documentation the resident was out of the facility. Review of Resident #5's CSCS for lorazepam 1mg at bedtime quantity of 30 tablets dispensed on 12/31/22 revealed lorazepam 1mg at bedtime was not documented as signed out on the CSCS and there was no documentation for review that referenced and accounted for lorazepam 1mg at bedtime signed out on the CSCS log for 01/01/23, 01/02/23, 01/05/23, 01/06/23, 01/07/23, 01/13/23, 01/30/23, and 01/31/23. Review of Resident #3's February 2023 eMAR and revealed: -There was an entry for lorazepam 1mg at bedtime scheduled for administration at 8:00pm. -There was documentation lorazepam 1mg at bedtime was administered at 8:00pm from 02/02/23 through 02/16/23. -There was documentation lorazepam 1mg at bedtime was not administered on 02/01/23 and 02/12/23 with the reason documented as the resident was out of the facility. Review of Resident #5's CSCS for lorazepam 1mg at bedtime quantity of 30 tablets dispensed on 02/03/23 revealed lorazepam 1mg at bedtime was not documented as signed out on the CSCS on 02/07/23 and 02/11/23 and did not match the February 2023 eMAR.	D 392		

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-There was no CSCS documentation available for review that referenced and accounted for lorazepam 1mg tablets at bedtime dispensed on 02/03/23 and signed out on CSCS log on 02/07/23, 02/11/23, and 02/12/23.

Based on observation of medications on hand, interview with the contracted pharmacy, and review of eMARs and CSCS documentation, there were 41 tablets of lorazepam 1mg at bedtime missing and not accounted for.

c. Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg 1 tablet daily as needed (prn).
-There was no documentation 0.5mg 1 tablet daily prn was administered from 12/01/22 through 12/31/22.

Review of Resident #5's Controlled Substance Count Sheet (CSCS) for 30 tablets of lorazepam 0.5mg 1 tablet every day prn for 30 tablets dispensed on 12/06/22 revealed there was no CSCS documentation available to reference and account for the 30 tablets of lorazepam 0.5mg 1 tablet daily prn dispensed on 12/07/22.

Review of Resident #5's CSCS for 30 tablets of lorazepam 0.5mg 1 tablet every day prn dispensed on 12/27/22 revealed there was CSCS documentation available to account for 1 dose of lorazepam 0.5mg 1 tablet every day prn dispensed on 12/27/22. There were 29 tablets remaining.

Review of Resident #5's January 2023 eMAR revealed:
-There was an entry for lorazepam 0.5mg once

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daily prn.
-On 01/21/23, there was documentation lorazepam 0.5mg was administered.

There was no CSCS documentation available for review to reference and account for lorazepam 0.5mg from 01/01/23 through 01/31/23.

Review of Resident #5's February 2023 eMAR and revealed:
-There was an entry for lorazepam 0.5mg once daily prn.
-There was no documentation lorazepam 0.5mg once daily prn was administered from 02/01/23 through 02/17/23.

Review of Resident #5's CSCS for 30 tablets of lorazepam 0.5mg 1 tablet every day prn dispensed on 12/27/22 revealed there was no CSCS documentation available to account for or reference lorazepam 0.5mg 1 tablet every day prn from 02/01/23 to 02/15/23.

Based on observation of medications on hand, interview with the contracted pharmacy, and review of eMARs and CSCS documentation, there were 30 tablets of lorazepam 0.5mg 1 tablet daily prn missing and unaccounted for.

Interview with Resident #5 on 02/17/23 at 3:24pm revealed:
-He was administered lorazepam by facility staff when he was at the facility.
-When he was out of the facility, he administered his own medications.
-He was administered medications by the MA.
-He did not know the dosage of his lorazepam and how frequent it was ordered.

Telephone interview with Resident #5's mental

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D 392	Continued From page 145 health provider (MHP) on 03/17/23 at 3:05pm revealed: -The facility staff had not made her aware Resident #5 had any missing or unaccounted for lorazepam. -When she visited the facility, she looked at the eMARs, but did not ensure the controlled medications were accounted for. Interview with a medication aide (MA) on 02/16/23 at 9:19am revealed: -When she worked she did not count off the controlled drugs with the previous medication aide. -She checked the CSCS with the medications on the medication cart. -They did not review eMARs with CSCS to ensure both matched. Telephone interview with a previous MA on 02/17/23 at 1:40pm revealed: -She was not surprised that Resident #5 had missing controlled drugs. -When she worked at the facility, there was no system for counting controlled drugs with another staff person before starting her shift. -The facility did not have a system of ensuring the count of controlled drugs were accurate. -The previous Administrator was aware that some staff might be taking resident's controlled drugs but nothing was done. -She had not contacted the health care personnel registry, the local police or told anyone about her suspicions of the MA. Telephone interview with the previous Administrator on 02/17/23 at 10:57am revealed: -The MAs were supposed to count controlled drugs at the end of each shift. -If there was a discrepancy, she was to be	D 392		

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notified.
-No MAs had informed her of discrepancies with controlled drugs; however, she had suspected that some MAs were taking residents' controlled drugs.
-She did not get the opportunity to investigate her suspicions.
-She was unable to say if Resident #5's missing medications were taken by the MA.

Telephone interview with the previous Office Manager on 02/17/23 at 6:03pm revealed:
-It was no secret that controlled drugs were missing.
-The MAs were supposed to count off controlled drugs when changing shifts.
-There was no system that compared the CSCS with the eMAR to ensure controlled drugs were available for administration; matched the CSCS and was accurate.

Interview with the Resident Care Director (RCD) on 02/17/23 at 2:05pm revealed:
-She had noticed there were discrepancies with the controlled drugs compared to the eMAR.
-She had not done anything about discrepancy with controlled drugs.
-She suspected that some staff at the facility may have been taking the medication.
-On 02/01/22, a MA had to be taken from the facility due to passing out related to a drug overdose.
-The MA no longer worked at the facility.
-She was unable to say the MA was responsible for Resident #5's missing lorazepam, but she did not know what happened to the missing cards of Resident #5's lorazepam.
-There was currently no system for routinely auditing the residents' controlled drugs on hand inventory compared to the eMAR and the

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D 392	Continued From page 147 controlled substances sent from the contracted pharmacy. -She had started auditing eMARs, and CSCS, including Resident #5's controlled medications and CSCS documentation last week (02/06/23) and identified errors. -The facility previously had kept all completed CSCS in the residents' record, but she was unable to find Resident #5's CSCS for November and December 2022. -The previous Administrator removed all the CSCS; except the current ones from the resident records and placed them in her office. -She also moved the overstock controlled drugs from the medication carts and facility medication storage area to her office. -She was unable to locate additional missing CSCS or pharmacy return credits for controlled substances. Refer to interview with the Executive Director (ED) on 02/17/23 at 2:55pm. ________________ Interview with the facility's Executive Director (ED) on 02/17/23 at 2:55pm revealed: -The facility's policy had always been to file the completed CSCS in the residents' records and store the residents' overstock controlled medications locked in the facilty's medication room. -When she came back to the facility to work (a couple of weeks ago), she discovered the previous Administrator had removed all the CSCS documents from the residents' records. -The RCD and Office Manager had been finding residents' paperwork in desk drawers, unlabeled boxes and folders, and loosely stacked piles of papers. ________________________ The facility failed to ensure controlled substance	D 392		

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D 392	Continued From page 148 count sheets (CSCS) for 2 residents (#3 and #5) accurately reconciled the administration, receipt, and disposal of controlled substances resulting in missing documentation of as needed clonazepam 1mg resulting in the MHP's inability to properly assess medication effectiveness for anxiety control with 39 tablets unaccounted for (Resident #3);and missing documentation of a resident's lorazepam 0.5mg 1/2 (0.25mg) once daily, 1mg lorazepam at bedtime and 0.5mg as needed for anxiety with 87 tablets unaccounted for (Resident #5). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 17, 2023 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2023.	D 392		