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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/09/23 through 05/10/23.	{D 000}	10A NCAC 13F .0904 (e)(4) (e) An updated diet list and copies of diet orders have been placed in the kitchen for dietary aides to follow. This list will be assessed and updated monthly with documentation of any changes made. This will be completed on 6/7/2023. (4) Shakes will be removed from the freezer and placed in refridgerator by dietary aides. MAs will document in MAR as well as a inventory list kept on the refrigerator when given. It is the responsibility of the MAs to ensure shakes are given regardless of dietary aides removing them from the freezer.	
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve therapeutic diets as ordered for 1 of 3 sampled residents with an order for a nutritional supplement (Resident #2). The findings are: Review of Resident #2's current FL2 dated 03/24/23 revealed: -Diagnoses included major vascular neurocognitive disorder and essential hypertension. -Resident #2's diet order was documented as regular. Review of Resident #2's physician's orders dated 04/14/23 revealed an order or nutritional supplements 3 times a day with meals. Review of a list of residents receiving nutritional	{D 310}		

Reviewed and Acknowledged Keisha Banks 06/30/2023

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{D 310}	Continued From page 1 supplements, provided by the facility Director, on 05/09/23 revealed Resident #2 was to receive a nutritional supplement 3 times a day with meals. Review of the undated therapeutic diet list posted in the kitchen for staff guidance on 05/10/23 revealed Resident #2 was not listed to receive a nutritional supplement. Observation of the lunch meal service on 05/09/22 between 12:40pm and 1:35pm revealed: -Resident #2 was served cubed pork, mashed potatoes, peas, a roll, pineapple chunks, water, and juice. -Resident #2 ate about 50% of her meal. -Resident #2 was not offered or served a nutritional supplement. Observation of the breakfast meal service on 05/10/23 between 7:57am and 8:20am revealed: -Resident #2 was served biscuits with gravy, eggs, cereal, milk, juice, and water. -Resident #2 at about 10% of her meal. -Resident #2 was not offered or served a nutritional supplement. Observation of the kitchen on 05/10/23 at 11:04am revealed: -There were 3 cartons of nutritional supplements in the refrigerator. -The 3 cartons of nutritional supplements had been frozen, but they were thawing. -The nutritional supplement container did not feel as if It was thawed enough to pour and serve. -There was a box of nutritional supplements in the freezer. -There was documentation on each individual container of nutritional supplements to store frozen.	{D 310}		

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{D 310}	Continued From page 2	{D 310}		

Interview with Resident #2 on 05/09/13 at 1:04pm revealed she was not served a nutritional supplement with her lunch meal and she was usually not served a nutritional supplement with meals at any time.

Telephone interview with Resident #2's primary care provider (PCP) on 05/10/23 at 10:34am revealed:
-Nutritional supplements were ordered in April 2023 for Resident #2 with each meal because Resident #2 was not eating a full meal and was not going into the dining hall for meals like she normally did.
-The facility's standing orders included monthly weights for all residents.
-Resident #2's weight in April 2023 was 156 and she may have lost a few pounds since the beginning of the year, but she did not have any concerns.
-There were no major outcomes of Resident #2 not being served a nutritional supplement other than she could lose a little more weight.
-She would have expected the facility staff to serve Resident #2 nutritional supplements as ordered.

Interview with a cook on 05/10/23 at 11:14am revealed:
-She cooked the breakfast meal on 05/10/23 and made the residents' plates.
-There were no nutritional supplements taken out of the freezer to thaw the evening of 05/09/23, so she took 3 nutritional supplements out of the freezer to thaw when she realized it on the morning of 05/10/23.
-The cooks usually took the nutritional supplement out of the freezer and placed them in the refrigerator to thaw and the medication aides (MA) usually got the nutritional supplement out of

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{D 310}	Continued From page 3	{D 310}		

the refrigerator and served it.
-She was only aware of 1 resident who was to be served nutritional supplements and it was not Resident #2.
-She did not know Resident #2 was to be served nutritional supplements because her name was not on the therapeutic diet list and nutritional supplements was not a part of Resident #2's diet order dated 02/17/23 which was kept in the diet order notebook in the kitchen.

Interview with a second cook on 05/10/23 at 11:24am revealed:
-He cooked and plated the meals for the lunch meal service on 05/09/23.
-The facility Director told him Resident #2 was to be served a nutritional supplement, but he thought she was only served the supplement with her night time medication pass and she could have one with her meals if she wanted it.
-He did not take out a nutritional supplement from the freezer to thaw in the refrigerator for Resident #2 for the lunch meal on 05/09/23 because he did not know she was supposed to have the supplement 3 times a day with meals.

Interview with a MA on 05/10/23 at 11:35am revealed:
-There were 3 residents who were to be served a nutritional supplement including Resident #2.
-The MAs were responsible for ensuring residents who had orders for nutritional supplements with meals, received them with their meals.
-If the cook did not take the nutritional supplements out of the freezer to thaw in the refrigerator, the residents did not receive a nutritional supplement with their meal.
-Sometimes during her shift, she took out nutritional supplements from the freezer for

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{D 310}	Continued From page 4	{D 310}		

Resident #2 and other residents prior to meals being served.
-She had not told the facility Director that nutritional supplements were thawed and available to serve 3 times daily with each meal.
-Resident #2 usually ate about 50 percent of each meal.

Interview with a second MA on 05/10/23 at 11:53am revealed:
-She did not serve a nutritional supplement to Resident #2 for the lunch meal on 05/09/23 because no nutritional supplements had been taken out of the freezer and they were frozen solid.
-The cooks were responsible for taking the nutritional supplements out of the freezer, and the MAs and personal care aides (PCAs) usually got the nutritional supplements out of the freezer for residents who had orders for them and put them on the meal trays.
-There were 3 residents who were to receive nutritional supplements and Resident #2 was one of them.
-Resident #2 did not receive her nutritional supplements 3 times daily with meals as ordered and se usually receive them with a few meals weekly.
-She had not let the facility Director know until yesterday that the nutritional supplements were not being taken out of the freezer in time enough to thaw so that Resident #2 could receive her nutritional supplement with her meals.
-Resident #2 usually ate less than half her meal.

Interview with the facility Director on 05/10/23 at 1:04pm revealed:
-She was responsible for updating the therapeutic diet list in the kitchen to include residents who received nutritional supplements, but she had not

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{D 310}	Continued From page 5 updated the list for the kitchen staff in a few months. -She told the cooks which residents were to received nutritional supplements and how often. -The cooks were responsible for taking the nutritional supplements out of the freezer to thaw and the MAs and PCAs were responsible for serving nutritional supplements. -She did not know nutritional shakes were not being served. -She expected the cooks to thaw nutritional supplements to have them available prior to meals being served. Interview with the Administrator on 05/10/23 at 1:51pm revealed: -He was not aware nutritional supplements were not being served as ordered for Resident #2. -There were supplements available in the facility and they should have been served as ordered. -He expected staff to thaw the nutritional supplements prior to the meals to ensure they were served as ordered for Resident #2.	{D 310}	10 NCAC 13F .1004(a)	
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	{D 358}	(a) All refill requests for any physician will be requested by the facility director or staff trained to do audits. The pharmacy also sends refill requests to all physician. Two MAs have been trained to do cart audits. Training completed on 6/2/2023 Cart audits will be done weekly and documented by either the director or a trained MA to ensure all medication is in the facility. This began on 6/2/2023	

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{D 358}	Continued From page 6 TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 2 residents (#4) observed during the medication pass with an error related to a diuretic medication, and for 2 of 3 sampled residents for record review (#3 and #1) including not administering two pain medications, a stool softener, and a laxative as ordered (#1) and errors related to an antidepressant medication and insulin (#3) The findings are: 1. Review of Resident #1's current FL2 dated 02/21/23 revealed diagnoses included constipation, gastroesophageal reflux disease, anxiety disorder, trigeminal neuralgia (a chronic pain condition affecting the largest cranial nerve in the face) and intervertebral disc degeneration of the lumbar region. a. Review of Resident #1's current FL2 dated 02/21/23 revealed an order for pregabalin (used to treat nerve pain) 50mg 1 tablet 3 times daily. Review of Resident #1's electronic medication administration records (eMAR) for 03/04/23 through 03/31/23 revealed: -There was an entry for pregabalin 50mg 1 capsule 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was documentation pregabalin was not administered for 7 of 27 opportunities at 8:00am, 6 of 27 opportunities at 2:00pm, and 7 of 27 opportunities at 8:00pm for a total of 20 consecutive missed doses between 03/04/23 and 03/31/23. -There was documentation the 20 doses of	{D 358}	Change of Direction Stickers have been ordered from the pharmacy. Completed on 6/6/2023. Stickers will be applied to any med that has had direction changes. A list of any medication changes will be put on the cart for all MAs to review and sign. This will be completed by the Director or staff trained to do audits. This will start on 6/9/2023. A staff meeting will be held by Director on 6/7/2023 with all MAs to discuss mighty shakes and new documentation, go over previous meeting, reprimands and termination.	

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{D 358}	Continued From page 7 pregabalin were not administered due to the medication was not in the facility. Review of Resident #1's March 2023 eMAR for April 2023 revealed: -There was an entry for pregabalin 50mg 1 capsule 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was documentation pregabalin was not administered for 7 of 27 opportunities at 8:00am, 6 of 27 opportunities at 2:00pm, and 7 of 27 opportunities at 8:00pm for a total of 20 consecutive missed doses between 04/01/23 and 04/30/23. -There was documentation the 20 doses of pregabalin were not administered due to the medication was not in the facility. Observation of medications available for Resident #1 on 05/09/23 at 3:42pm revealed pregabalin 50mg 1 capsule 3 times daily was dispensed from the pharmacy on 04/20/23 with a quantity of 90 tablets and there were 26 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at 9:10am revealed pregabalin 50mg 1 tablet 3 times daily was dispensed to the facility on 04/20/23 with a quantity of 90 tablets. Telephone interview with a representative from the facility's previous contracted pharmacy on 05/10/23 at 9:20am revealed pregabalin 50mg 1 tablet 3 times daily was dispensed to the facility on 03/21/23/23 with a quantity of 73 tablets. Interview with Resident #1 on 05/09/23 at 12:21pm revealed: -She was always in severe pain, but it was usually controlled with pain medication.	{D 358}		

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{D 358}	Continued From page 8 -She was administered pregabalin for nerve pain. -She had nerve damage in her face and the pain extended from her face to the back of her head and behind her ears. -She also had nerve damage in her neck, lower back, and hips. -She did not remember if the facility ran out of pregabalin, but she did remember several times in March and April 2023 when she felt like she was "climbing the walls." -When she was out of her pain medication, she experienced increased pain. Interview with a medication aide (MA) on 05/09/23 at 2:01pm revealed: -MAs did not reorder medications. -The facility Director told the MAs to write medications that needed to be reordered in a red notebook; the red notebook had been in place for a few weeks. -There was documentation on the cover of the red notebook to write down medications in the notebook that were not in the facility. -She did not know if the facility Director looked at the red notebook daily to reorder medications. -Prior to using the red notebook, MAs verbally told the facility Director which medications needed to be reordered. -There was once a time when Resident #1 was going without some of her medications often because they were not being reordered. -She did not remember if Resident #1 was out of her pregabalin in March and April 2023, but she was always putting residents' name in the red notebook because residents were out of medications a lot. -Resident #1 got upset about the facility running out of her medication and Resident #1 stated she did not understand why her medications were not being refilled before they ran out.	{D 358}		

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{D 358}	Continued From page 9 -She did not know if Resident #1 complained about increased pain in March and April 2023. Interview with a second MA on 05/09/23 at 2:21pm revealed: -MAs did not reorder medication. -The MAs were responsible to let the facility Director know when a resident's medication was down to about 10 days of medication remaining. -There was a red notebook where MAs were to write down medications when there were no more doses remaining. -She remembered Resident #1 was out of her pregabalin and she let the facility Director and other MAs know. -Resident #1 complained of pain and said, "I don't know what I'm going to do." -She told Resident #1 to contact her family member to see if he could get her refills. Interview with Resident #1's family member on 05/09/23 at 2:48pm revealed: -He visited Resident #1 twice a week. -When Resident #1 was first admitted to the facility in February 2023, there was a lot of confusion regarding her mediations because the current facility and the facility she came from used different pharmacies. -The previous facility sent Resident #1's medication to the current facility and he assumed there was enough to last until her next scheduled doctor's appointment. -There was a lot of miscommunication between the MAs and the facility Director about who reordered medications, so Resident #1 told him when she ran out of medication and he contacted her doctor's office for refills. -For a long time, the facility Director was calling him and asking him to contact Resident #1's doctors to reorder medications.	{D 358}		

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{D 358}	Continued From page 10 -Resident #1 complained of pain from day to day, but she complained of more pain when she was out of her pain medication. -He noticed Resident #1 had withdrawal symptoms of increased anxiety and pain when she was out of pain medication. Telephone interview with a nurse from Resident #1's pain management clinic on 05/10/23 at 10:13am revealed: -Resident #1 had orders for pregabalin due to pain from neuropathy. -The pain management clinic did not know Resident #1 was not administered her pregabalin as ordered. -Resident #1's family member usually reached out to her to tell her the facility needed a refill of medication. -She had not received any medication refill requests from the facility staff or had been notified by the facility that they were out of Resident #1's pregabalin. -The pain management provider expected the facility to administer Resident #1's medications as ordered. -Pregabalin was a medication that Resident #1 should have been weaned off of and if she was not weaned from pregabalin, she could experience withdrawal symptoms including flu like symptoms, fever, nausea, anxiety, and increased pain. Interview with the facility Director on 05/09/23 at 3:25pm revealed: -She was responsible for reordering medications and they should have placed medications in the red notebook to be reordered within 8 to 10 days of the medication running out. -She checked the red notebook daily and reordered medications daily.	{D 358}		

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{D 358}	Continued From page 11 -She did not check the red notebook or reorder medications on 05/08/23. -The MAs knew to write medications in the red notebook that were running low so they could be reordered before they ran out. -When Resident #1 was first admitted to the facility in February 2023, her family member was contacting her doctors to get medication refills, but that got confusing. -She and MAs would let Resident #1's family member know when a medication was running low or had ran out and she would write the medication on a sheet of paper so that the family member could get the medication refilled. -She was aware Resident #1 had been out of pregabalin and she let her family member know prior to running out of the medication and when she was out of the medication. -She did not follow up with Resident #1's pain management clinic because Resident #1's family member had requested the refill of pregabalin. -She got Resident #1's primary care provider's (PCP) and her pain management clinic's phone number from Resident #1's family member about a week ago, but she had not needed to contact Resident #1's pain management clinic yet. Telephone interview with the Administrator on 05/10/23 at 1:51pm revealed: -The MAs were responsible for letting the facility Director know when medications were down to the last 7 doses and the facility Director was responsible for ensuring medications were reordered. -He expected Resident #1's medications to be reordered prior to the medication running out and to be administered as ordered. -He did not know Resident #1 ran out of medication and was not administered medication as ordered in March and April 2023.	{D 358}		

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-Resident #1 should not have run out of medication.
-The facility Director should have contacted Resident #1's providers to get orders for medication refills and should have had Resident #1's medications available in the facility no matter what.

b. Review of Resident #1's current FL2 dated 02/21/23 revealed an order for belbuca (used to treat chronic pain) 600mcg film place 1 film inside the cheek twice daily.

Review of Resident #1's electronic medication administration records (MAR) for April 2023 revealed:
-There was an entry for belbuca 600mcg film place 1 film inside the cheek twice daily for trigeminal neuralgia scheduled for administration at 8:00am and 8:00pm.
-There was documentation belbuca was not administered for 3 of 30 opportunities and 8:00am and 4 of 30 opportunities at 8:00pm a total of 7 consecutive missed doses between 04/01/23 and 04/30/23.
-There was documentation the 7 doses of belbuca were not administered due to the medication was not in the facility.

Observation of medications available for Resident #1 on 05/09/23 at 3:42pm revealed belbuca 600mcg film place 1 film inside cheek twice daily was dispensed from the pharmacy on 04/20/23 with a quantity of 60 films and there were 35 films remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at 9:10am revealed belbuca 600mcg film 1 film twice daily was dispensed to the facility on

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{D 358}	Continued From page 13 04/20/23 with a quantity of 60 films for a 30-day supply. Telephone interview with a representative from the facility's previous contracted pharmacy on 05/10/23 at 9:20am revealed belbuca 600mcg film 1 film twice daily was dispensed to the facility on 03/21/23 with a quantity of 60 films for a 30-day supply. Interview with Resident #1 on 05/09/23 at 12:21pm revealed: -She was always in severe pain, but it was usually controlled with pain medication. -She was administered belbuca for pain; she placed the film of belbuca in her cheek twice a daily. -She had nerve damage in her face and the pain extended from her face to the back of her head and behind her ears. -She also had nerve damage in her neck, lower back and hips, and she had migraine headaches frequently; she had arthritis all over her body. -She did not get her belbuca for about a week in April 2023 and she experienced withdrawal symptoms. -She had increased pain and increased anxiety as she felt like she was "climbing the walls" when she was out of belbuca in April 2023. -The facility staff told her they did not have her medication available because they were waiting on her pain management clinic to write an order to refill the medication. Interview with a medication aide (MA) on 05/09/23 at 2:01pm revealed: -MAs did not reorder medications. -The facility Director told the MAs to write medications that needed to be reordered in a red notebook; the red notebook had been in place for	{D 358}		

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a few weeks.
-There was documentation on the cover of the red notebook to write down medications in the notebook that were not in the facility.
-She did not know if the facility Director looked at the red notebook daily to reorder medications.
-Prior to using the red notebook, MAs verbally told the facility Director which medications needed to be reordered.
-There was once a time when Resident #2 was going without some of her medications often because they were not being reordered.
-Resident #1 was out of belbuca in April 2023, but she did not remember for how long.
-She did not remember writing belbuca in the red notebook for the facility Director to reorder or if she verbally told the facility Director belbuca needed to be reordered.
-Resident #1 got upset about the facility running out of her medication and Resident #1 stated she did not understand why her medications were not being refilled before they ran out.
-She did not know if Resident #1 complained about increased pain in March and April 2023.

Interview with a second MA on 05/09/23 at 2:21pm revealed:
-MAs did not reorder medication.
-The MAs were responsible to let the facility Director know when a resident's medication was down to about 10 days of medication remaining.
-Resident #1 was out of belbuca in April 2023 and she told the facility Director.
-The facility Director told her that Resident #1 had a primary care provider (PCP) who was different than the facility's contracted PCP and that she would contact Resident #1's family member to let him know so he could contact Resident #1's PCP.
-Resident #1's family member had requested, after finding out that Resident #1 was out of

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medications, to let him know if she was out and he would contact her PCP to advise.

Interview with Resident #1's family member on 05/09/23 at 2:48pm revealed:
-He visited Resident #1 twice a week.
-When Resident #1 was first admitted to the facility in February 2023, there was a lot of confusion regarding her medications because the current facility and the facility she came from used different pharmacies.
-The previous facility sent Resident #1's medication to the current facility and he assumed there was enough to last until her next scheduled doctor's appointment.
-There was a lot of miscommunication between the MAs and the facility Director about who reordered medications, so Resident #1 told him when she ran out of medication and he contacted her doctor's office for refills.
-For a long time, the facility Director was calling him and asking him to contact Resident #1's doctors to reorder medications.
-Resident #1 complained of pain from day to day, but she complained of more pain when she was out of her pain medication.
-He noticed Resident #1 had withdrawal symptoms of increased anxiety and pain when she was out of pain medication.

Telephone interview with a nurse from Resident #1's pain management clinic on 05/10/23 at 10:13am revealed:
-Resident #1 had orders for belbuca due to chronic pain.
-The pain management clinic did not know Resident #1 was not administered belbuca as ordered.
-Resident #1's family member usually reached out to her to tell her the facility needed a refill of

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{D 358}	Continued From page 16 medication. -She had not received any medication refill requests from the facility staff or had been notified by the facility that they were out of Resident #1's belbuca. -The pain management provider expected the facility to administer Resident #1's medications as ordered. -Belbuca was a medication that Resident #1 should have been weaned off and if she was not weaned from belbuca, she could experience withdrawal symptoms including flu like symptoms, fever, nausea, anxiety, and increased pain. Interview with the facility Director on 05/09/23 at 3:25pm revealed: -She was responsible for reordering medications and they should have placed medications in the red notebook to be reordered within 8 to 10 days of the medication running out. -She checked the red notebook daily and reordered medications daily. -She did not check the red notebook or reorder medications on 05/08/23. -The MAs knew to write medications in the red notebook that were running low so they could be reordered before they ran out. -When Resident #1 was first admitted to the facility in February 2023, her family member was contacting her doctors to get medication refills, but that got confusing. -She and MAs would let Resident #1's family member know when a medication was running low or had ran out and she would write the medication on a sheet of paper so that the family member could get the medication refilled. -She was aware Resident #1 had been out of belbuca and she let her family member know prior to running out of the medication and when she was out of the medication.	{D 358}		

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{D 358}	Continued From page 17 -She did not follow up with Resident #1's pain management clinic because Resident #1's family member had requested the refill of belbuca. -She got Resident #1's primary care provider's (PCP) and her pain management clinic's phone number from Resident #1's family member about a week ago, but she had not not needed to contact Resident #1's pain management clinic yet. Telephone interview with the Administrator on 05/10/23 at 1:51pm revealed: -The MAs were responsible for letting the facility Director know when medications were down to the last 7 doses and the facility Director was responsible for ensuring medications were reordered. -He expected Resident #1's medications to be reordered prior to the medication running out and to be administered as ordered. -He did not know Resident #1 ran out of medication and was not administered medication as ordered in March and April 2023. -Resident #1 should not have run out of medication. -The facility Director should have contacted Resident #1's providers to get orders for medication refills and should have had Resident #1's medications available in the facility no matter what. c. Review of Resident #1's current FL2 dated 02/21/23 revealed an order for docusate (a stool softener used to treat constipation) 100mg 1 capsule at bedtime. Review of Resident #1's electronic medication administration records (MAR) for April 2023 revealed: -There was an entry for docusate 100mg 1	{D 358}		

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capsule at bedtime scheduled for administration at 8:00pm.
-There was documentation docusate was not administered for 13 of 30 opportunities between 04/01/23 through 04/30/23.
-There was documentation the doses of docusate were not administered due to the medication was not in the facility.

Observation of medications available for Resident #1 on 05/09/23 at 3:42pm revealed docusate 100mg 1 capsule daily at bedtime dispensed by the pharmacy on 04/25/23 with a quantity of 20 capsules and there were 6 capsules remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at 9:10am revealed docusate 100mg 1 capsule at bedtime was dispensed to the facility on 04/25/23 with a quantity of 20 tablets.

Telephone interview with a representative from the facility's previous contracted pharmacy on 05/10/23 at 9:20am revealed docusate 100mg 1 capsule at bedtime was dispensed to the facility on 03/06/23 with a quantity of 30 capsules and on 04/12/23 with a quantity of 8 capsules.

Interview with Resident #1 on 05/09/23 at 12:21pm revealed:
-She went for a long time without being administered her stool softener, but she could not remember how long.
-When the facility did not administer her stool softener, she experienced cramping in her abdomen, and she was not able to go the bathroom for days at a time.

Telephone interview with nurse from Resident #1's primary care provider's (PCP) office on

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{D 358}	Continued From page 19 05/09/23 at 12:33pm revealed: -Resident #1 had an order for docusate stool softener 1 capsule at bedtime. -There were no notes in Resident #1's medical record to hold or discontinue the stool softener. -The facility had not contacted the PCP's office to advise that Resident #1 was out of docusate or to request a refill. -Resident #1's family member had made requests for medications. -Possible outcomes of not being administered docusate as ordered were constipation and abdominal pain. Interview with a medication aide (MA) on 05/09/23 at 2:01pm revealed: -MAs did not reorder medications. -The facility Director told the MAs to write medications that needed to be reordered in a red notebook; the red notebook had been in place for a few weeks. -Prior to using the red notebook, MAs verbally told the facility Director which medications needed to be reordered. -There was once a time when Resident #1 was going without some of her medications often because they were not being reordered. -She did not remember if Resident #1 was out of her docusate in April 2023. -Resident #1 got upset about the facility running out of her medication and Resident #1 stated she did not understand why her medications were not being refilled before they ran out. -She did not know of Resident #1 complaining about constipation in April 2023. Interview with a second MA on 05/09/23 at 2:21pm revealed: -MAs did not reorder medication. -The MAs were responsible to let the facility	{D 358}		

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{D 358}	Continued From page 20 Director know when a resident's medication was down to about 10 days of medication remaining. -She did not know if Resident #1 was out of docusate because it was not administered during her shift. Interview with Resident #1's family member on 05/09/23 at 2:48pm revealed: -He visited Resident #1 twice a week. -When Resident #1 was first admitted to the facility in February 2023, there was a lot of confusion regarding her mediations because the current facility and the facility she came from used different pharmacies. -The previous facility sent Resident #1's medication to the current facility and he assumed there was enough to last until her next scheduled doctor's appointment. -There was a lot of miscommunication between the MAs and the facility facility Director about who reordered medications, so Resident #1 told him when she ran out of medication and he contacted her doctor's office for refills. -For a long time, the facility Director was calling him and asking him to contact Resident #1's doctors to reorder medications. -Resident #1 complained about being constipated in April 2023. -Even when she was getting stool softener regularly, she still had a little trouble with constipation. Interview with the facility Director on 05/09/23 at 3:25pm revealed: -She was responsible for reordering medications and they should have placed medications in the red notebook to be reordered within 8 to 10 days of the medication running out. -She checked the red notebook daily and reordered medications daily.	{D 358}		

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{D 358}	Continued From page 21 -She did not check the red notebook or reorder medications on 05/08/23. -When Resident #1 was first admitted to the facility in February 2023, her family member was contacting her doctors to get medication refills, but that got confusing. -She and MAs would let Resident #1's family member know when a medication was running low or had ran out and she would write the medication on a sheet of paper so that the family member could get the medication refilled. -She was aware Resident #1 had been out of docusate and she let her family member know prior to running out of the medication and when she was out of the medication. -She did not follow up with Resident #1's PCP because Resident #1's family member had requested the refill of docusate. -She got Resident #1's PCP's phone number from Resident #1's family member about a week ago and followed up with the PCP after Resident #1's family member requested a refill of docusate and did not get the refill. Telephone interview with the Administrator on 05/10/23 at 1:51pm revealed: -The MAs were responsible for letting the facility Director know when medications were down to the last 7 doses and the facility Director was responsible for ensuring medications were reordered. -He expected Resident #1's medications to be reordered prior to the medication running out and to be administered as ordered. -He did not know Resident #1 ran out of medication and was not administered medication as ordered in March and April 2023. -Resident #1 should not have run out of medication. -The facility Director should have contacted	{D 358}		

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{D 358}	Continued From page 22 Resident #1's providers to get orders for medication refills and should have had Resident #1's medications available in the facility no matter what. d. Review of Resident #1's current FL2 dated 02/21/23 revealed an order for senexon-s (used to treat constipation) 2 tablets at bedtime. Review of Resident #1's physician's orders dated 02/21/23 revealed an order for senexon-s 8.6mg-50mg 2 tablets at bedtime. Review of Resident #1's electronic medication administration records (MAR) for April 2023 revealed: -There was an entry for senexon-s 8.6mg-50mg tablets at bedtime scheduled for administration at 8:00pm. -There was documentation docusate was not administered for 14 of 30 opportunities between 04/01/23 through 04/30/23 with 12 doses being consecutive. -There was documentation the doses of senexon-s were not administered due to the medication was not in the facility. Observation of medications available for Resident #1 on 05/09/23 at 3:42pm revealed senexon -s 8.6mg-50mg 2 tablets daily at bedtime was dispensed by the pharmacy on 04/20/23 with a quantity of 60 tablets and there were 26 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at 9:10am revealed senexon-s 8.6mg-50mg 2 tablets at bedtime was dispensed to the facility on 04/20/23 with a quantity of 60 tablets.	{D 358}		

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{D 358}	Continued From page 23 Telephone interview with a representative from the facility's previous contracted pharmacy on 05/10/23 at 9:20am revealed senexon-s 8.6mg-50mg 2 tablets at bedtime was dispensed to the facility on 03/16/23 with a quantity of 60 tablets. Interview with Resident #1 on 05/09/23 at 12:21pm revealed: -She was administered senexon-s for constipation. -She went for a long time without being administered her laxative, but she could not remember how long. -When the facility did not administer her laxative, she experienced cramping in her abdomen, and she was not able to go the bathroom for days at a time. Telephone interview with a nurse from Resident #1's primary care provider's (PCP) office on 05/09/23 at 12:33pm revealed: -Resident #1 had an order for senexon-s 8.6mg-50mg laxative 2 tablets at bedtime. -There were no notes in Resident #1's medical record to hold or discontinue the laxative. -The facility had not contacted the PCP's office to advise that Resident #1 was out of senexon-s or to request a refill. -Resident #1's family member had made requests for medications. -Possible outcomes of not being administered senexon-s as ordered were constipation and abdominal pain. Interview with a medication aide (MA) on 05/09/23 at 2:01pm revealed: -MAs did not reorder medications. -The facility Director told the MAs to write medications that needed to be reordered in a red	{D 358}		

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notebook; the red notebook had been in place for a few weeks.
-There was documentation on the cover of the red notebook to write down medications in the notebook that were not in the facility.
-She did not know if the facility Director looked at the red notebook daily to reorder medications.
-Prior to using the red notebook, MAs verbally told the facility Director which medications needed to be reordered.
-There was once a time when Resident #1 was going without some of her medications often because they were not being reordered.
-She did not remember if Resident #1 was out of her senexon-s in April 2023, but she was always putting residents' name in the red notebook because residents were out of medications a lot.
-Resident #1 got upset about the facility running out of her medication and Resident #1 stated she did not understand why her medications were not being refilled before they ran out.
-She did not know of Resident #1 to complain about constipation in April 2023.

Interview with a second MA on 05/09/23 at 2:21pm revealed:
-MAs did not reorder medication.
-The MAs were responsible to let the facility Director know when a resident's medication was down to about 10 days of medication remaining.
-There was a red notebook where MAs were to write down medications when there were no more doses remaining.
-She did not know if Resident #1 was out of senexon-s because it was not administered during her shift.

Interview with Resident #1's family member on 05/09/23 at 2:48pm revealed:
-He visited Resident #1 twice a week.

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{D 358}	Continued From page 25 -When Resident #1 was first admitted to the facility in February 2023, there was a lot of confusion regarding her mediations because the current facility and the facility she came from used different pharmacies. -The previous facility sent Resident #1's medication to the current facility and he assumed there was enough to last until her next scheduled doctor's appointment. -There was a lot of miscommunication between the MAs and the facility Director about who reordered medications, so Resident #1 told him when she ran out of medication and he contacted her doctor's office for refills. -For a long time, the facility Director was calling him and asking him to contact Resident #1's doctors to reorder medications. -Resident #1 complained about being constipated in April 2023. -Even when she was getting her laxative regularly, she still had a little trouble with constipation. Interview with the facility Director on 05/09/23 at 3:25pm revealed: -She was responsible for reordering medications and MAs should have placed medications in the red notebook to be reordered within 8 to 10 days of the medication running out. -She checked the red notebook daily and reordered medications daily. -She did not check the red notebook or reorder medications on 05/08/23. -The MAs knew to write medications in the red notebook that were running low so they could be reordered before they ran out. -When Resident #1 was first admitted to the facility in February 2023, her family member was contacting her doctors to get medication refills, but that got confusing.	{D 358}		

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{D 358}	Continued From page 26 -She and MAs would let Resident #1's family member know when a medication was running low or had ran out and she would write the medication on a sheet of paper so that the family member could get the medication refilled. -She was aware Resident #1 had been out of senexon-s and she let her family member know prior to running out of the medication and when she was out of the medication. -She did not follow up with Resident #1's PCP because Resident #1's family member had requested the refill of senexon-s. -She got Resident #1's PCP's phone number from Resident #1's family member about a week ago. Telephone interview with the Administrator on 05/10/23 at 1:51pm revealed: -The MAs were responsible for letting the facility Director know when medications were down to the last 7 doses and the facility Director was responsible for ensuring medications were reordered. -He expected Resident #1's medications to be reordered prior to the medication running out and to be administered as ordered. -He did not know Resident #1 ran out of medication and was not administered medication as ordered. -Resident #1 should not have run out of medication. -The facility Director should have contacted Resident #1's providers to get orders for medication refills and should have had Resident #1's medications available in the facility no matter what. 2. Review of Resident #4's current FL2 dated 03/30/23 revealed: -Diagnoses included bipolar disorder,	{D 358}		

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hyperlipidemia, long-term use of anticoagulants, glaucoma, and anxiety disorder.
-There was an order for torsemide (a diuretic medication used to treat fluid retention) 20mg daily.

Review of Resident #4's primary care provider (PCP) visit note dated 03/24/23 revealed:
-The PCP appointment with Resident #4 was because he was a new resident at the facility.
-Resident #4 had a diagnosis of chronic congestive heart failure and the PCP documented that the resident had lower extremity edema.
-She planned to check laboratory work and adjust Resident #4's medications.

Review of Resident #4's physician's order dated 04/14/23 revealed:
-There was an order to increase torsemide from 20mg daily to 40mg daily.
-There was an order to start potassium chloride (a potassium supplement used to treat low potassium levels in the blood) 20 mEq daily.

Observation of the 8:00am medication pass on 05/10/23 revealed:
-At 7:35am, the medication aide (MA) pulled 13 medication cards from the medication cart for Resident #4.
-She popped 1 tablet of torsemide 20mg (2 tablets=40mg) and 1 tablet of potassium chloride 20 mEq from the medication cards into a plastic souffle cup with the rest of his morning medications.
-There were 16 tablets and capsules counted in the medication cup and should have been 17 tablets.
-The MA handed Resident #4 his cup of morning medications along with a small cup of water, and Resident #4 took all his medications.

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{D 358}	Continued From page 28 Observation of Resident #4's medications on hand on 05/10/23 at 8:40am revealed: -There was one medication card for torsemide 20mg, take 1 tablet daily with a dispensed date of 04/20/23 and a dispensed quantity of 30 tablets. -There were 8 out of 30 tablets remaining in the medication card. -There were initials next to each pill bubble on the medication card indicating which MA administered each dose. -The first tablet administered from the medication card was dated 04/19/23 and the subsequent dates and initials, when compared to the electronic medication administration record (eMAR) indicated that one 20mg tablet had been administered to Resident #4 each day instead of two tablets as ordered from 04/19/23 through 05/10/23. -There was one medication card for potassium chloride 20 mEq take 1 tablet daily with a dispensed date of 04/21/23 and a dispensed quantity of 28 tablets. -There were 10 out of 28 tablets remaining in the medication card. -There were initials next to each pill bubble indicating which MA administered each dose. -The first tablet administered from the medication card was dated 04/23/23 and the subsequent dates and initials, when compared to the eMAR, indicated that 1 tablet of potassium chloride had been administered to Resident #4 each day from 04/23/23 through 05/10/23. Observation of Resident #4 on 05/10/23 at 11:25am revealed: -He was sitting in his wheelchair in his room. -His lower legs were swollen and the skin was dry, slightly reddened, and scaly on both legs. -He had one dressing to his left medial ankle and	{D 358}		

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one dressing to his left lateral calf; both dressings were clean, dry and intact.
-There were no blisters observed but some areas of the skin on his lower legs were bumpy.

Review of Resident #4's April 2023 eMAR revealed:
-There was an entry for potassium chloride 20 mEq take 1 tablet daily scheduled at 8:00am.
-There was documentation potassium chloride was administered once daily from 04/18/23 through 04/30/23.
-There was an entry for torsemide 20mg,take 1 tablet daily scheduled at 8:00am with a stop date of 04/17/23.
-There was an entry for torsemide 20mg take 2 tablets (40mg total) daily scheduled at 8:00am with a start date of 04/17/23.
-There was documentation torsemide 20mg was administered daily from 04/01/23 through 04/17/23, and torsemide 40mg was administered daily from 04/19/23 through 04/30/23.

Review of Resident #4's May 2023 eMAR from 05/01/23 through 05/10/23 revealed:
-There was an entry for potassium chloride 20 mEq take 1 tablet daily scheduled at 8:00am.
-There was documentation potassium chloride was administered daily from 05/01/23 through 05/10/23.
-There was an entry for torsemide 20mg take 2 tablets (40mg total) daily scheduled at 8:00am.
-There was documentation that torsemide 40mg was administered daily from 05/01/23 through 05/10/23.

Interview with a MA on 05/10/23 at 8:35am revealed:
-During the medication pass that morning she had only administered one torsemide 20mg tablet

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to Resident #4.
-The medication entry in the eMAR included instructions to administer 2 tablets, but since the medication card instructed to administer only 1 tablet daily she went with those instructions.
-She had never administered two torsemide 20mg tablets to Resident #4.
-She was not aware that Resident #4's order for torsemide had increased from 20mg to 40mg.
-The Director of the facility had not told her that Resident #4's torsemide dose had been increased, and there was not a sticker on the medication card indicating that the order had changed.
-Resident #4 had swelling to his legs since he was admitted to the facility in March 2023 and the swelling had not improved or worsened since his admission.
-Resident #4 never appeared or sounded short of breath.
-Resident #4 never complained about chest pain, irregular heart rate or rhythm to her.

Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at 9:00am revealed:
-Resident #4's torsemide order dated 04/18/23 was to take two 20mg tablets for a total of 40mg daily.
-Resident #4's potassium chloride order dated 04/18/23 was to take one 20 mEq tablet daily.
-Their pharmacy took over dispensing medications to the facility on 04/19/23 and had not yet dispensed torsemide to the facility for Resident #4.
-The pharmacy dispensed potassium chloride 20 mEq tablets to the facility for Resident #4 on 04/21/23 for a quantity of 28 tablets.
-Pharmacy staff entered medication orders into the eMAR system, and someone at the facility

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{D 358}	Continued From page 31 was responsible for checking the order and approving it to make the order active on the eMAR. Telephone interview with a representative from the facility's former contracted pharmacy on 05/10/23 at 9:15am revealed: -Resident #4 had an order on file for torsemide 20mg daily dated 03/24/23. -The pharmacy dispensed torsemide 20mg take 1 tablet daily on 04/15/23 for a quantity of 30 tablets. -They did not have an order on file for Resident #4 to take torsemide 40mg daily. Telephone interview with Resident #4's PCP on 05/10/23 at 10:20am revealed: -She had increased Resident #4's dose of torsemide from 20mg daily to 40mg daily to try to reduce the amount of swelling in his legs because he was starting to form blisters due to the excess fluid. -She had prescribed the potassium supplement to go along with the increased dose of torsemide, because torsemide could deplete blood potassium levels. -Resident #4's laboratory work collected on 04/03/23 showed that Resident #4's potassium level prior to the torsemide dose being increased was normal at 4.1 mmol/L (normal reference range was 3.5 - 5.1 mmol/L). -She had not seen Resident #4 since she increased his torsemide dose and added the potassium supplement. -She was not aware that Resident #4 had been receiving potassium chloride as ordered, but that the MAs were still only administering 20mg of torsemide daily instead of 40mg. -Possible adverse effects from not receiving the increased dose of torsemide included worsening,	{D 358}		

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or no improvement to the swelling in Resident #4's legs or delayed healing to the blisters on his legs.
-The home health nurse (HHN) had been treating a wound to Resident #4's ankle that he had been admitted to the facility with, and the HHN had not reported any worsening condition to Resident #4's legs to her.
-Possible adverse effects from receiving the potassium supplement without also taking the increased dose of torsemide included hyperkalemia (high blood potassium levels) which could eventually cause irregular heart rhythms or a heart attack if the potassium level got too high.
-She had not received any notification about Resident #4 reporting cardiac symptoms to the facility staff.
-She expected the facility staff to administer medications how she ordered them.

Telephone interview with a representative from Resident #4's home health provider on 05/10/23 at 10:45am revealed:
-The HHN had been treating a wound on Resident #4's ankle since 04/01/23.
-There was no documentation about the swelling in Resident #4's legs, but there was documentation indicating a slight decrease in the size of his ankle wound.
-The HHN was at the facility to see Resident #4 the day prior on 05/09/23, and had not documented any abnormal findings or new skin concerns during her visit.

Interview with a second MA on 05/10/23 at 11:00am revealed:
-She had always only administered one torsemide 20mg tablet to Resident #4.
-The eMAR sometimes gave different instructions for medication administration than the medication

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cards instructions, and since they had just changed pharmacies at the time Resident #4's torsemide order changed from 1 tablet to 2 tablets daily in the eMAR, she figured they had made a mistake.
-She told the Director about the discrepancy between Resident #4's torsemide medication card, and the torsemide entry in the eMAR and the Director told her she would follow up with the pharmacy.
-The Director never notified the MAs if a resident's medication orders changed.
-She never pulled a resident' record to look at a medication order if she had a question about it.
-Resident #4's legs had not become more swollen in the last month and he never complained about being short of breath or having chest pains.

Interview with Resident #4 on 05/10/23 at 11:20am revealed:
-He was prescribed a diuretic medication because his legs were swollen.
-The swelling in his legs had been the same for the last month.
-He had some blisters on his legs a month or two ago, but they had already dried up and healed.
-He did not have any chest pain or irregular heart beats in the last month.
-He had mild shortness of breath, but nothing worse than his baseline in the last month.
-He was blind so he did not know what pills he was taking each day because he could not see them.
-His PCP had not mentioned starting him on a higher dose of the diuretic or a potassium supplement, so he had not asked the staff how he was receiving them.

Interview with the facility Director on 05/10/23 at

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{D 358}	Continued From page 34 1:10pm revealed: -One month prior, she started doing audits of the eMARs once weekly. -She had not checked Resident #4's medication cards to see if he was receiving two tablets of torsemide daily instead of one as previously ordered. -She was not aware the MAs had only been administering 20mg of torsemide daily instead of 40mg to Resident #4. -None of the MAs had asked her about the discrepancy between the instructions for Resident #4's torsemide on the medication card versus on the eMAR. -She could not find her stickers for the medication cards to indicate there had been a change in the order, so she had not put a change of order sticker on Resident #4's torsemide medication card. -The MAs were trained to, and expected to, compare the medication card to the order in the eMAR and not to administer a medication if they were not sure what the correct dose was. -If there was a dose discrepancy between what the medication card instruction were versus what the eMAR instructions were, the MAs were supposed to let her know so that she could clarify the order with them. -All of the MAs had access to the resident records and knew to check the resident record if they had a question about a medication order. -Resident #4 had not complained of having chest pain or an irregular heart beat since he started receiving the potassium supplement. -The swelling to Resident #4's legs was the same as it had been since his admission to the facility; it had not worsened and the skin to his legs had improved with the care of the HHN. -Resident #4 never seemed to be short of breath.	{D 358}		

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Telephone interview with the Administrator on 05/10/23 at 1:50pm revealed:
-He was not aware that Resident #4 had been receiving the incorrect dose of torsemide.
-The facility Director and the previous Resident Care Coordinator (RCC) had been doing weekly audits of the eMARs and medication cart, and if they had noticed a discrepancy between a medication card and the current order it should have been corrected by placing a change of order sticker on the medication card.
-He expected the staff to compare the medication card to the order in the eMAR and ensure they knew the current and correct dose prior to administering the medication.

3. Review of Resident #3's current FL2 dated 01/13/23 revealed diagnoses included stage 3 chronic kidney disease, type 2 diabetes, peripheral artery disease and dementia.

a. Review of Resident #3's primary care provider's (PCP) appointment note dated 02/17/23 revealed:
-Resident #3 had complained of being depressed during her visit.
-The PCP had adjusted Resident #3's medication due to her report of feeling depressed.

Review of Resident #3's physician's order dated 02/17/23 revealed an order to start sertraline (used to treat depression) 50mg daily.

Review of Resident #3's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for sertraline 50mg daily scheduled at 8:00am.
-There was documentation sertraline was not administered from 03/01/23 through 03/17/23.

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{D 358}	Continued From page 36 -The documented reason sertraline was not administered was that the medication was not in the facility. Observation of medication on hand for Resident #3 on 05/09/23 at 11:45am revealed there was one medication card for sertraline 50mg with a dispensed date of 04/20/23 and there were 9 out of 30 dispensed tablets remaining. Review of Resident #3's PCP appointment note dated 03/24/23 revealed: -During the visit Resident #3 was laying in bed watching television. -The facility Director reported to her that Resident #3 had been getting up out of bed and around the facility more. -The PCP reviewed Resident #3's medications. -There was no documentation about Resident #3 not receiving sertraline from 03/01/23 through 03/17/23. Review of Resident #3's progress notes revealed: -On 03/05/23, 03/08/23, 03/09/23, 03/14/23, and 03/15/23, there was documentation from the medication aides (MA) that Resident #3 stayed in her bed all day. -There was no documentation that Resident #3 reported feeling depressed to the staff. Interview with a medication aide (MA) on 05/09/23 at 11:55am revealed: -The facility Director was the only staff in the facility who could reorder medication, call the pharmacy, or contact the PCP. -In the previous couple of weeks, the facility Director had initiated a system for refilling medications by placing a red notebook on the medication cart. -The MAs were supposed to write which	{D 358}		

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medications had run out in the red notebook.
-The facility Director told the MAs she would check the red notebook every day and refill whichever medications were listed in the notebook.
-She did not know if the facility Director checked the red notebook every day.
-The MAs were supposed to let the facility Director know verbally if a medication needed to be refilled.
-She could not remember if she had verbally told the facility Director that Resident #3 did not have sertraline available on the medication cart.
-She had administered sertraline to Resident #3 on 03/18/23, but did not remember if the pharmacy delivered a new medication card, or if the medication card had been found in the medication cart.
-She did not remember Resident #3 having increased symptoms of depression when she was not taking sertraline.
-Since Resident #3 was admitted to the facility in January 2023, she mostly stayed in her room all day.
-Resident #3 never expressed suicidal ideations.
-She did not know if any staff were responsible for auditing the eMARs for medications not administered.
-The facility Director sometimes audited the medication cart and she saw another MA do a medication cart within the past few weeks as well.
-She did not know what the MA or the facility Director looked at during the medication cart audit.

Interview with a second MA on 05/09/23 at 2:20pm revealed:
-The MAs did not reorder medication refills from the pharmacy; only the facility Director could refill medication.

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PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 38 -The MAs were expected to let the facility Director know if a medication was down to the last row on the medication card which was usually 10 doses before the medication ran out. -The MAs notified the facility Director of needed medication refills by telling her in person. -Resident #3 received two or three tablets of sertraline from the pharmacy in February 2023, but that was all the pharmacy sent. -She verbally let the facility Director know that Resident #3 ran out of sertraline in February 2023. -Resident #3 never expressed thoughts of depression or suicide. -There were some days where Resident #3 just laid in bed all day and other days where she got up and moved around the facility. -When Resident #3 first moved into the facility in January 2023, she left her room more and ate more meals in the dining room but after she had been at the facility for a couple weeks, she started eating more meals in her room. -Resident #3 sometimes participated in activities. Telephone interview with Resident #3's power of attorney (POA) on 05/09/23 at 3:05pm revealed: -Resident #3 had been depressed since she moved to the facility in January 2023, because she was upset about having to move. -Resident #3 did not have thoughts of suicide that he was aware of. -Resident #3 seemed to be more depressed after first moving into the facility, but she seemed to be doing better when he visited her two or three weeks ago. -Resident #3 was not aware of which medications she was taking. Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at	{D 358}		

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{D 358}	Continued From page 39 9:00am revealed: -The pharmacy took over dispensing medications to the facility on 04/19/23. -There was an order on file for Resident #3 for sertraline 50mg daily. -The pharmacy had not yet dispensed sertraline for Resident #3 because the cycle-fill from the previous pharmacy had not ran out yet. Telephone interview with a representative from the facility's former contracted pharmacy on 05/10/23 at 9:15am revealed: -Resident #3 had an order dated 02/17/23 for sertraline 50mg daily. -On 02/17/23, they dispensed sertraline 50mg to the facility for Resident #3 for a quantity of 2 tablets to get to the next cycle-fill dispense date of 02/20/23. -On 02/20/23, they dispensed sertraline 50mg to the facility for Resident #3 for a quantity of 28 tablets. -On 03/20/23, they dispensed sertraline 50mg to the facility for Resident #3 for a quantity of 26 tablets. -They had received a refill request for Resident #3's sertraline 50mg tablets on 03/07/23 but had not dispensed any additional sertraline because it was too early for a refill. Telephone interview with Resident #3's PCP on 05/10/23 at 10:20am revealed: -She had prescribed sertraline to Resident #3 on 02/17/23 due to the resident reporting feeling depressed. -She was not aware that Resident #3 had not been administered sertraline from 03/01/23 through 03/17/23. -Possible adverse effects from not receiving sertraline as ordered included ongoing mild depressive symptoms and prolonged	{D 358}		

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{D 358}	Continued From page 40	{D 358}		

improvement of symptoms.
-Resident #3 had never reported suicidal ideations to her.
-Resident #3 had been in good spirits last month during her visit.
-She expected the facility to reorder medications prior to them running out and to administer medications how she ordered them.

Interview with the facility Director on 05/10/23 at 1:10pm revealed:
-One month prior, she started doing audits of the eMARs once weekly.
-In the last month, she had tried to look at the exceptions report on the eMARs daily.
-In February and March 2023, she had not been auditing medication administration on a regular basis.
-The former RCC had been responsible for completing audits of the medication cart to ensure all ordered medications were available for administration, but there was no documentation required for proof of the audit.
-She was not aware that sertraline was not documented as administered to Resident #3 from 03/01/23 through 03/17/23.
-She had a packing slip from the delivery of Resident #3's sertraline 50mg tablets to cover the cycle-fill dates of 02/17/23 through 03/17/23, so she did not know why the sertraline was not documented as administered due to the medication not being in the facility.
-She had looked at Resident #3's February 2023 eMAR on her computer, and sertraline 50mg was documented as administered on 02/18/23 and 02/19/23, but not documented as administered from 02/20/23 through 02/28/23.
-The MAs were expected to let her know once a medication quantity was down to the last row on the medication card so that she could request the

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refill.
-The MAs were supposed to let her know verbally about medication refills needed.
-Resident #3 had never reported feeling sad or depressed to her.
-Since Resident #3 was admitted to the facility in January 2023, there had been no change to her character or demeanor; she had stayed in her room a lot since moving to the facility.

Telephone interview with the Administrator on 05/10/23 at 1:50pm revealed:
-The facility Director was responsible for ensuring all the residents' medications were ordered and available for administration unless she had an RCC she could delegate that task to.
-He was not aware that Resident #3 had not been administered sertraline from 02/20/23 through 03/17/23.
-He expected all medications to be administered as ordered and for staff to expedite a refill of a medication that same day if it was not available on the medication cart.

Based on observation, record review and interview, it was determined Resident #3 was not interviewable.

b. Review of Resident #3's current FL2 dated 01/13/23 revealed:
-An order for lantus insulin (a long-acting insulin used to control blood sugar levels) 10 units at bedtime.
-An order to check fingerstick blood sugar (FSBS) twice daily before breakfast and at bedtime.

Review of Resident #3's physician's order dated 01/13/23 revealed an order to change lantus from 10 units at bedtime to 8 units in the morning and 8 units in the evening.

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{D 358}	Continued From page 42 Review of Resident #3's physician's order dated 02/03/23 revealed an order to change lantus insulin to Levemir insulin (a long-acting insulin used to control blood sugar levels) 8 units every morning and evening. Review of Resident #3's physician's order dated 02/17/23 revealed an order to increase Levemir to 10 units twice daily. Review of Resident #3's physician's order dated 04/14/23 revealed an order to increase Levemir to 10 units in the morning and 14 units in the evening. Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Levemir insulin, inject 10 units every morning scheduled at 8:00am. -Levemir was not documented as administered at 8:00am on 4/27/23, 04/28/23, 04/29/23, or 04/30/23. -There was an entry for Levemir insulin, inject 10 units every evening scheduled at 8:00pm, with a stop date of 04/14/23. -There was an entry for Levemir insulin, inject 14 units every evening scheduled at 8:00pm, with a start date of 04/14/23. -Levemir was not documented as administered at 8:00pm on 4/27/23, 04/28/23, 04/29/23, or 04/30/23. -The documented reason Levemir was not administered was that the medication was not in the facility. -There was an entry to check FSBS twice daily scheduled at 6:30am and 8:00pm. -Resident #3's FSBS values from 04/01/23 through 04/26/23 ranged from 111 to 519.	{D 358}		

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{D 358}	Continued From page 43 -Resident #3's FSBS values from 04/27/23 through 04/30/23 when she did not receive Levemir ranged from 139 to 357. Review of Resident #3's May 2023 eMAR from 05/01/23 through 05/09/23 revealed: -There was an entry for Levemir insulin, inject 10 units every morning scheduled at 8:00am. -Levemir was not documented as administered at 8:00am on 05/01/23 or 05/02/23. -There was an entry for Levemir insulin, inject 14 units every evening scheduled at 8:00pm. -Levemir was not documented as administered at 8:00pm on 05/01/23. -The documented reason Levemir was not administered was that the medication was not in the facility. -There was an entry to check FSBS twice daily scheduled at 6:30am and 8:00pm. -Resident #3's FSBS values from 05/01/23 through 05/09/23 ranged from 141 to 412. -Resident #3's FSBS values from 8:00am on 05/01/23 to 8:00am on 05/02/23 when she did not receive Levemir ranged from 207 to 348. Observation of medication on hand for Resident #3 on 05/09/23 at 11:45am revealed there was one vial of Levemir insulin that was 2/3 full with a dispensed date of 04/30/23 and an opened date of 05/02/23. Review of Resident #3's progress notes revealed there was no documentation about Resident #3 being out of Levemir or experiencing symptoms of high blood sugar. Interview with a medication aide (MA) on 05/09/23 at 11:55am revealed: -The facility Director was the only staff in the facility who could reorder medication, call the	{D 358}		

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pharmacy, or contact the primary care provider (PCP).
-The MAs were supposed to let the facility Director know verbally if a medication needed to be refilled.
-She had not notified the facility Director that Resident #3 was out of Levemir insulin, because she had assumed that another MA had already contacted the facility Director.
-She did not know if any of the other MAs notified the facility Director that Resident #3 was out of Levemir.
-Resident #3 never displayed symptoms of experiencing hyper- or hypoglycemia.

Interview with a second MA on 05/09/23 at 2:20pm revealed:
-The MAs did not reorder medication refills from the pharmacy; only the facility Director could refill medication.
-The MAs were expected to let the facility Director know if a medication was low or down to the last weeks' worth of medication.
-The MAs notified the facility Director of needed medication refills by telling her in person.
-She had verbally told the facility Director that Resident #3 was out of Levemir insulin on 04/27/23 when she did not have Levemir available on the medication cart to administer to Resident #3.
-Once a medication was ordered from the pharmacy, it could sometimes take a week or two to be delivered to the facility because they had been having issues with their pharmacy which was why they recently changed pharmacies.
-When Resident #3 was out of Levemir insulin she did not have any high or low FSBS values outside of her baseline values.
-Resident #3 had not displayed symptoms of having really high or low blood sugar levels.

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{D 358}	Continued From page 45 Telephone interview with a representative from the facility's contracted pharmacy on 05/10/23 at 9:00am revealed: -The pharmacy took over dispensing medications to the facility on 04/19/23. -There was an order on file for Resident #3 for Levemir 10 units in the morning and 14 units in the evening. -They had received a refill request for Resident #3's Levemir on 04/30/23, so they dispensed 1 vial of Levemir insulin on 04/30/23 and the facility should have received it that same evening. Telephone interview with a representative from the facility's former contracted pharmacy on 05/10/23 at 9:15am revealed: -The pharmacy had an order on file for Resident #3 for Levemir 10 units twice daily dated 02/17/23. -They recently dispensed one Levemir insulin pen for Resident #3 on 03/06/23, 03/25/23 and 04/10/23. -Each Levemir insulin pen contained 300 units of insulin which was a 15-day supply. -The pharmacy received the order to increase Resident #3's evening dose of Levemir to 14 units, but had not dispensed any additional Levemir insulin after receiving the order because the facility changed pharmacy services a few days after. Telephone interview with Resident #3's PCP on 05/10/23 at 10:20am revealed: -Resident #3 had a history of high blood sugar levels in the evening, so she had increased her dose of Levemir in the evening from 10 units to 14 units. -She was not aware that Resident #3 did not receive Levemir insulin from the 8:00am dose on	{D 358}		

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04/27/23 through the 8:00am dose on 05/02/23.
-Possible adverse effects from not receiving the Levemir insulin included high blood sugar levels which could cause tiredness, blurred vision, thirst and dry mouth, or weight loss.
-She was not aware of Resident #3 experiencing symptoms of high blood sugar.
-The facility provided Resident #3's FSBS values for her to review, and she had last reviewed them on 04/14/23.
-She expected medications to be refilled prior to them running out or to notify her if a new prescription needed to be sent to the pharmacy.
-She expected the facility staff to administer medication as ordered or notify her when 2 to 3 doses had been missed.

Interview with the facility Director on 05/10/23 at 1:10pm revealed:
-About one month prior, she started doing audits of the eMARs once weekly.
-In the last month she had tried to look at the exceptions report on the eMARs daily.
-The former RCC had been responsible for completing audits of the medication cart to ensure all ordered medications were available on the medication cart, but there was no documentation required for proof of the audit.
-One of the MAs had called her on the evening of 04/27/23 regarding Resident #3 being out of Levemir insulin so she reordered it the following day, on 04/28/23.
-She was not aware Resident #3's Levemir insulin was not documented as administered from 04/27/23 through 05/02/23.
-When a medication refill was requested from the pharmacy, it usually arrived the following day.
-If a medication that she requested a refill for was not delivered from the pharmacy within a day or two she expected the MAs to let her know so that

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{D 358}	Continued From page 47 she could follow up with the pharmacy or PCP. -Resident #3 had not displayed symptoms of high blood sugar on the days she did not receive Levemir insulin. Telephone interview with the Administrator on 05/10/23 at 1:50pm revealed: -The facility Director was responsible for ensuring all the residents' medications were ordered and available for administration unless she had an RCC she could delegate that task to. -He was not aware that Resident #3 had not been administered Levemir insulin from 04/27/23 through 05/02/23. -He expected all medications to be administered as ordered and for staff to expedite a refill of a medication that same day if it was not available on the medication cart. Based on observation, record review and interview, it was determined Resident #3 was not interviewable. The facility failed to ensure medications were administered as ordered for 3 residents including a resident who had lower extremity edema causing the formation of blisters to his legs, and an order to increase the dosage of a diuretic medication, which resulted in no improvement to the swelling in his legs and placed him at risk for heart arrhythmia or heart attack due to taking a daily potassium supplement in conjunction with the diuretic dose increase (Resident #4); a resident who had a one month delay in starting an antidepressant medication who had reported feelings of depression and subsequently had no reported improvement was not administered insulin for 11 consecutive doses from April to May 2023 resulting in blood sugar values up to the 300's and placing her at risk for further	{D 358}		

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{D 358}	Continued From page 48 hyperglycemia (Resident #3); and a resident who had nerve damage and not administered 20 consecutive doses of a medication for nerve pain resulting in the resident experiencing withdrawal symptoms including increased pain and anxiety, and not administered 7 consecutive doses of a medication for chronic pain resulting in the resident experiencing withdrawal symptoms including increased pain and anxiety, and the resident was not administered 13 daily doses of a stool softener in a month and 14 daily doses of a laxative in a month resulting in the resident experienced constipation and abdominal pain. (Resident #1) This failure placed residents at substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, JUNE 9, 2023.	{D 358}		