STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL098036	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE HOME AT FOXCROFT	2413 FOXCROFT RD WILSON, NC 27893

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 5, 2023.	C 000	Clarification to policy and procedure has been implemented. All staff has received written and verbal instruction on policy and procedure regarding new orders. They have acknowledged receipt and understanding with their signature. Clarification is as follows: When orders are received by STAFF whether they are faxed, written or called staff will: 1) immediately notify manager AND administrator of new orders. 2) clarify orders by asking manager/ administrator or calling provider if needed. 3) fax the orders to pharmacy or appropriate recipient 4) put printed copy in resident's chart under "orders" 5)follow orders as written. 6)Once pharmacy inputs orders to eMAR, staff will verify that it matches the original order. If not, a call to pharmacy and re-fax order. If orders have not been entered by pharmacy or if staff is unable to complete orders as given due to other circumstances (i.e. lab has not picked up specimen), by end of shift, a call to pharmacy, provider, and the manager/admin is required. 7)MANAGER and ADMINISTRATOR will follow up on day two to ensure that orders have been correctly implemented. Manager/ administrator will then notate the written order that orders have been correctly implemented/completed.	11/12/23
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 residents (#1) related to weekly weights and a urinalysis. The findings are: Review of Resident #1's current FL-2 dated 09/08/23 revealed diagnosis included congestive heart failure (CHF). a. Review of Resident #1's current FL-2 dated 09/08/23 revealed there was an order for daily weight and report weight gain of 3 pounds or greater in 24 hours or 5 pounds or greater in 1 week to primary care provider (PCP). Review of Resident #1's physician order sheet dated 06/29/23 revealed: -There was an order to start daily weights and document in resident's chart. -There was an order to start Lasix (a medication	C 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Pridgen,RN | TITLE: Administrator | (X6) DATE: 11/12/23

Reviewed and Acknowledged 11/14/23

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C 249	Continued From page 1	C 249		

used to treat fluid retention) 40mg once a day for 4 days, then start as needed for weight gain of 3 pounds in 1 day or 5 pounds in 1 week.

Review of Resident #1's resident vital signs sheet revealed:
-Resident #1's weight was documented as 185 pounds on 06/06/23.
-Resident #1's weight was documented as 189 pounds on 07/06/23.
-Resident #1's weight was documented as 194 pounds on 07/28/23.
-Resident #1's weight was documented as 186.2 pounds on 08/06/23.
-Resident #1's weight was documented as 183.6 pounds on 09/06/23.
-There were no daily weights recorded.

Interview with a medication aide (MA) on 10/05/23 at 11:19am revealed she just weighed Resident #1 and his weight was 186 pounds.

Review of Resident #1's June 2023 electronic medication administration record (eMAR) revealed there was no entry for daily weights.

Review of Resident #1's July 2023 eMAR revealed there was no entry for daily weights.

Review of Resident #1's August 2023 eMAR revealed there was no entry for daily weights.

Review of Resident #1's September 2023 eMAR revealed there was no entry for daily weights.

Review of Resident #1's October 2023 eMAR revealed there was no entry for daily weights.

Second interview with a MA on 10/05/23 at 10:50am revealed:

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COMPASSIONATE CARE HOME AT FOXCROFT	2413 FOXCROFT RD WILSON, NC 27893

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C 249	Continued From page 2	C 249		

-She did not know Resident #1 had an order for daily weights.
-When a new order was received from the facility's primary care provider (PCP) it was printed out by the business office manager (BOM) and given to the staff that was on duty at the time.
-It was the responsibility of the staff who received the orders to fax the orders to the facility's contracted pharmacy so they could place the orders on the resident's eMAR.
-She never saw the orders for daily weights for Resident #1.

Interview with the Administrator on 10/05/23 at 10:52am revealed:
-The facility was not performing daily weights on Resident #1.
-The facility performed monthly weights on all residents in the facility.
-She did not know daily weights were ordered for Resident #1.
-She performed chart audits "every couple of months" to make sure no orders had gotten missed.
-She did not think she had done a chart audit for Resident #1 since 06/29/23.
-The facility's contracted pharmacy was who put orders on the eMAR.
-It was the responsibility of the staff member who received orders to fax the orders to the pharmacy.

Second interview with the Administrator on 10/05/23 at 3:39pm revealed:
-The facility's contracted PCP was supposed to send orders to the pharmacy.
-The order for Resident #1's daily weights on 06/29/23 was not faxed to the pharmacy by the facility because she thought the facility's contracted PCP had sent the order to the

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C 249	Continued From page 3 pharmacy already. -Since the orders for daily weights for Resident #1 were not sent to the pharmacy the order was never entered onto the eMAR so facility staff did not know to perform daily weights for the resident. -It was the facility's responsibility to make sure resident orders were followed. -It was important for Resident #1 to have his weight checked daily so facility staff would know whether to administer Lasix to him or not. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/23 at 12:10pm revealed: -When the pharmacy received an order from the facility or the PCP, they placed the orders on the eMAR. -The pharmacy did not receive an order for daily weights for Resident #1. -If the pharmacy had received an order for daily weights for Resident #1, they would have placed the order on the resident's eMAR. Telephone interview with Resident #1's PCP on 10/05/23 at 4:39pm revealed: -She ordered Lasix to be given to Resident #1 because the facility had called and reported to her that he was having swelling in his leg. -She also ordered daily weights for Resident #1. -She ordered Lasix to be given to Resident #1 if he had a weight gain of 3 pounds in 1 day or 5 pounds in one week. -She ordered daily weights for Resident #1 so the facility would know when to administer the Lasix to the resident. -If Resident #1 had a weight gain of 3 pounds in 1 day or 5 pounds in 1 week it meant the resident was retaining fluid and he needed Lasix to be administered to treat the fluid retention.	C 249	**See #3 and #6 Clarification to policy and procedure has been implemented. All staff has received written and verbal instruction on policy and procedure regarding new orders. They have acknowledged receipt and understanding with their signature. Clarification is as follows: When orders are received by STAFF whether they are faxed, written or called staff will: 1) immediately notify manager AND administrator of new orders. 2) clarify orders by asking manager/ administrator or calling provider if needed. 3) fax the orders to pharmacy or appropriate recipient 4) put printed copy in resident's chart under "orders" 5)follow orders as written. 6)Once pharmacy inputs orders to eMAR, staff will verify that it matches the original order. If not, a call to pharmacy and re-fax order. If orders have not been entered by pharmacy or if staff is unable to complete orders as given due to other circumstances (i.e. lab has not picked up specimen), by end of shift, a call to pharmacy, provider, and the manager/admin is required. 7)MANAGER and ADMINISTRATOR will follow up on day two to ensure that orders have been correctly implemented. Manager/ administrator will then notate the written order that orders have been correctly implemented/completed.	11/12/23

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C 249	Continued From page 4 b. Review of Resident #1's physician order sheet dated 08/23/23 revealed there was an order to collect a urinalysis (UA). Review of Resident #1's report of health services to residents sheet dated 08/23/23 revealed: -The Administrator contacted the facility's primary care provider (PCP) to make her aware that Resident #1 had blood in his urine. -The PCP ordered a UA to be done on Resident #1. Review of Resident #1's record revealed there were no UA results for Resident #1. Interview with Resident #1 on 10/05/23 at 11:09am revealed he did not have blood in his urine now nor was he having any burning while urinating or urinary frequency. Interview with a medication aide (MA) on 10/05/23 at 10:50am revealed: -She collected the UA for Resident #1 on 08/23/23. -She placed Resident #1's urine in a refrigerator for the facility's contracted laboratory courier to retrieve it. -She contacted the facility's contracted laboratory courier to make them aware they needed to pick up the UA for Resident #1 and they told her they would come pick it up the next day. -The facility's contracted laboratory courier never came to retrieve Resident #1's UA. -She did not contact the facility's contracted laboratory courier to make them aware the UA had not been picked up. -She did not collect another UA for Resident #1 after 08/23/23. -She had not seen any blood in Resident #1's urine since 08/23/23.	C 249		

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C 249	Continued From page 5 Review of a shift change report dated 08/23/23 revealed there was a notation that "lab notified to pick up UA which never came". Interview with the Administrator on 10/05/23 at 10:52am revealed she expected the facility's contracted laboratory courier to be contacted to remind them to pick up Resident #1's UA. Telephone interview with Resident #1's PCP on 10/05/23 at 4:39pm revealed: -She ordered a UA for Resident #1 to see if he had a urinary tract infection (UTI) since facility staff had reported that he had blood in his urine. -She did not know that the UA was never completed for Resident #1. -She expected the facility to notify the contracted laboratory courier to remind them to pick up Resident #1's urine. -If the contracted laboratory courier did not come to pick up Resident #1's UA she expected the facility to contact her so she could order another UA for the resident. -An untreated UTI could lead Resident #1 to have a severe infection which could cause sepsis. -Sepsis could lead to a prolonged hospitalization or death. -As far as she knew Resident #1 was not having any symptoms of a UTI at this time.	C 249		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family 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	C 315		

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C 315	Continued From page 6 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 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 interviews and record reviews, the facility failed to obtain clarification for 1 of 3 (#1) residents related to an order for a medication used to treat fluid retention. The findings are: Review of Resident #1's current FL-2 dated 09/08/23 revealed: -Diagnosis included congestive heart failure (CHF). -There was an order for Lasix (used to treat fluid retention) 40mg everyday as needed for fluid excess and/or retention. Review of Resident #1's physician order sheet dated 06/29/23 revealed: -There was an order to start daily weights and document in resident's chart. -There was an order to start Lasix 40mg once a day for 4 days, then start as needed for weight gain of 3 pounds in 1 day or 5 pounds in 1 week. Review of Resident #1's FL-2 dated 07/03/23 revealed there was an order for Lasix 40mg daily as needed for weight gain. Review of Resident #1's July 2023 electronic medication administration record (eMAR)	C 315	**See #3 and #6 Clarification to policy and procedure has been implemented. All staff has received written and verbal instruction on policy and procedure regarding new orders. They have acknowledged receipt and understanding with their signature. Clarification is as follows: When orders are received by STAFF whether they are faxed, written or called staff will: 1) immediately notify manager AND administrator of new orders. 2) clarify orders by asking manager/ administrator or calling provider if needed. 3) fax the orders to pharmacy or appropriate recipient 4) put printed copy in resident's chart under "orders" 5)follow orders as written. 6)Once pharmacy inputs orders to eMAR, staff will verify that it matches the original order. If not, a call to pharmacy and re-fax order. If orders have not been entered by pharmacy or if staff is unable to complete orders as given due to other circumstances (i.e. lab has not picked up specimen), by end of shift, a call to pharmacy, provider, and the manager/admin is required. 7)MANAGER and ADMINISTRATOR will follow up on day two to ensure that orders have been correctly implemented. Manager/ administrator will then notate the written order that orders have been correctly implemented/completed.	11/12/23

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C 315	Continued From page 7	C 315		

revealed:
-There was an entry for Lasix 40mg once daily as needed for weight gain.
-Lasix 40mg was documented as administered at 9:04am on 07/28/23 and at 6:51pm on 07/28/23.
-Lasix 40mg was documented as administered at 6:05pm on 07/31/23.

Review of Resident #1's August 2023 eMAR revealed:
-There was an entry for Lasix 40mg daily as needed for weight gain.
-Lasix 40mg was documented as administered at 7:49pm on 08/09/23.
-Lasix 40mg was documented as administered at 7:13pm on 08/21/23.
-Lasix 40mg was documented as administered at 3:33pm on 08/23/23.

Review of Resident #1's September 2023 eMAR revealed:
-There was an entry for Lasix 40mg daily as needed for weight gain.
-Lasix 40mg was documented as administered at 8:11am on 09/05/23.

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry for Lasix 40mg daily as needed for weight gain.
-Lasix 40mg was not documented as administered in October 2023.

Interview with the Administrator on 10/05/23 at 10:52am revealed:
-She performed chart audits "every couple of months" to make sure no orders had gotten missed.
-She did not think she had done a chart audit for Resident #1 since 06/29/23.

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C 315	Continued From page 8 Second interview with the Administrator on 10/05/23 at 3:39pm revealed when the facility received Resident #1's FL-2 on 07/03/23 she should have contacted his primary care provider (PCP) to clarify how much weight gain was needed before Lasix should be administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/23 at 12:10pm revealed: -The FL-2 orders on 07/03/23 did not state how much weight gain should occur before Lasix was administered to Resident #1. -The FL-2 orders on 09/08/23 did not state how much weight gain should occur before Lasix was administered to Resident #1. -The pharmacy placed orders on resident's eMARs based on what was written by the PCP. -The facility should have contacted Resident #1's PCP to find out how much weight gain the resident needed before Lasix should be administered. -Once the facility had clarified the Lasix order with Resident #1's PCP the facility should fax the new order to the pharmacy and they would add it to the resident's eMAR. Telephone interview with Resident #1's PCP on 10/05/23 at 4:39pm revealed: -She ordered for Resident #1's Lasix to be administered for fluid retention. -If Resident #1 had fluid retention he would also have weight gain. -Since the Resident #1's FL-2s did not specify how much weight gain the resident should have prior to receiving Lasix she expected the facility to contact her to clarify exactly when to administer Lasix to the resident.	C 315	See specifically #1, #6, #7 Clarification to policy and procedure has been implemented. All staff has received written and verbal instruction on policy and procedure regarding new orders. They have acknowledged receipt and understanding with their signature. Clarification is as follows: When orders are received by STAFF whether they are faxed, written or called staff will: 1) immediately notify manager AND administrator of new orders. 2) clarify orders by asking manager/ administrator or calling provider if needed. 3) fax the orders to pharmacy or appropriate recipient 4) put printed copy in resident's chart under "orders" 5)follow orders as written. 6)Once pharmacy inputs orders to eMAR, staff will verify that it matches the original order. If not, a call to pharmacy and re-fax order. If orders have not been entered by pharmacy or if staff is unable to complete orders as given due to other circumstances (i.e. lab has not picked up specimen), by end of shift, a call to pharmacy, provider, and the manager/admin is required. 7)MANAGER and ADMINISTRATOR will follow up on day two to ensure that orders have been correctly implemented. Manager/ administrator will then notate the written order that orders have been correctly implemented/completed.	

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C 330	Continued From page 9	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 2 of 3 residents (#1, #3) including a medication used to treat fluid retention (#1) and a medication used to treat mild pain (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 09/08/23 revealed: -Diagnosis included congestive heart failure (CHF). -There was an order for Lasix (used to treat fluid retention) 40mg everyday as needed for fluid excess and/or retention. Review of Resident #1's FL-2 dated 07/03/23 revealed there was an order for Lasix 40mg daily as needed for weight gain. Review of Resident #1's physician order sheet dated 06/29/23 revealed: -There was an order to start daily weights and document in resident's chart.	C 330		

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C 330	Continued From page 10 -There was an to start Lasix 40mg once a day for 4 days, then start as needed for weight gain of 3 pounds in 1 day or 5 pounds in 1 week. a. Review of Resident #1's resident vital signs sheet revealed: -Resident #1's weight was documented as 185 pounds on 06/06/23. -Resident #1's weight was documented as 189 pounds on 07/06/23. -Resident #1's weight was documented as 194 pounds on 07/28/23. -Resident #1's weight was documented as 186.2 pounds on 08/06/23. -Resident #1's weight was documented as 183.6 pounds on 09/06/23. -There were no daily weights recorded. Review of Resident #1's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Lasix 40mg once daily as needed for weight gain. -Lasix 40mg was documented as administered at 9:04am on 07/28/23. -The reason given was documented as "fluid". -Lasix 40mg was documented as administered at 6:51pm on 07/28/23. -The reason given was documented as "fluid". -Lasix 40mg was documented as administered at 6:05pm on 07/31/23. -The reason given was documented as "fluid". -There was no entry for daily weights. Review of Resident #1's August 2023 eMAR revealed: -There was an entry for Lasix 40mg daily as needed for weight gain. -Lasix 40mg was documented as administered at 7:49pm on 08/09/23.	C 330		

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COMPASSIONATE CARE HOME AT FOXCROFT	2413 FOXCROFT RD WILSON, NC 27893

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C 330	Continued From page 11 -The reason given was documented as "fluid". -Lasix 40mg was documented as administered at 7:13pm on 08/21/23. -The reason given was documented as "weight gain/fluid". -Lasix 40mg was documented as administered at 3:33pm on 08/23/23. -The reason given was documented as "fluid buildup". -There was no entry for daily weights. Review of Resident #1's September 2023 eMAR revealed: -There was an entry for Lasix 40mg daily as needed for weight gain. -Lasix 40mg was documented as administered at 8:11am on 09/05/23. -The reason given was documented as "fluid buildup". Observation of Resident #1's lower extremities on 10/05/23 at 11:09am revealed: -The resident had compression stockings on both lower extremities. -There was no edema noted to Resident #1's lower extremities. Interview with a medication aide (MA) on 10/05/23 at 10:50am revealed: -She did not know Resident #1 had an order for daily weights. -She did not realize Resident #1's Lasix was ordered to be given for weight gain. -When she administered Resident #1's Lasix on 07/28/23, 07/31/23, 08/09/23, 08/23/23, and 09/05/23 she did so because his feet were swollen. Interview with the Administrator on 10/05/23 at 10:52am revealed:	C 330		

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	FCL098036	A. BUILDING: _____ B. WING _____	10/05/2023

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C 330	Continued From page 12 -She did not know daily weights were ordered for Resident #1. -She did not realize that Resident #1's Lasix was ordered to be administered based on changes in his weight. -When she administered Lasix to Resident #1 on 08/21/23 she did so because he had swelling in his lower extremities. Telephone interview with Resident #1's primary care provider (PCP) on 10/05/23 at 4:39pm revealed: -She ordered Lasix to be given to Resident #1 because the facility had called and reported to her that he was having swelling in his leg. -She also ordered daily weights for Resident #1. -She ordered Lasix to be given to Resident #1 if he had a weight gain of 3 pounds in 1 day or 5 pounds in one week. -She ordered daily weights for Resident #1 so the facility would know when to administer the Lasix to the resident. -If Resident #1 had a weight gain of 3 pounds in 1 day or 5 pounds in 1 week it meant the resident was retaining fluid and he needed Lasix to be administered to treat the fluid retention. -She expected the facility to administer Lasix to Resident #1 based on his weight gain and not based on swelling in his feet or legs. b. Review of Resident #1's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Lasix 40mg daily as needed for weight gain. -Lasix 40mg was documented as administered at 9:04am on 07/28/23. -Lasix 40mg was documented as administered at 6:51pm on 07/28/23. -Lasix 40mg was documented as administered	C 330		

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C 330	Continued From page 13 twice on 07/28/23. Observation of Resident #1's medications on hand on 10/05/23 at 12:29pm revealed: -There was a medication card containing Lasix 40mg with instructions to take 1 tablet once daily as needed for weight gain. -Thirty tablets of Lasix 40mg were dispensed on 06/30/23. -There were 23 tablets of Lasix 40mg remaining in the medication card. Interview with the medication aide (MA) on 10/05/23 at 3:15pm revealed: -When she administered medications to residents, she checked what the order was on the eMAR and compared it to what was on the medication card. -She checked the medication instructions on the medication card again before returning the medication card to the medication cart. -She checked the medication order 3 times before administering it to a resident. -Resident #1's Lasix was ordered to be given as needed once a day. -She did not remember administering Resident #1's Lasix twice on 07/28/23. -She did not know why she administered Resident #1's Lasix to him twice on 07/28/23. Interview with the Administrator on 10/05/23 at 3:39pm revealed: -She was a Registered Nurse (RN). -She expected MAs to follow orders as written on resident's eMARS. -She expected Resident #1 to only receive Lasix once a day if needed as ordered. -Resident #1 receiving Lasix twice on 07/28/23 could have caused him to lose too much fluid and become dehydrated.	C 330		

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C 330	Continued From page 14 Telephone interview with Resident #1's primary care provider (PCP) on 10/05/23 at 4:39pm revealed: -Resident #1's Lasix was ordered to be given once a day as needed. -Resident #1 receiving Lasix 40mg twice in one day could cause him to become dehydrated which could cause acute kidney injury. 2. Review of Resident #3's current FL-2 dated 08/26/23 revealed: -Diagnoses included age related cognitive decline and altered mental status. -There was an order for Advil dual action (used to treat mild pain) 125mg-250mg 2 tablets every 8 hours as needed for mild muscle pain. Review of Resident #3's Resident Register revealed he was admitted to the facility 09/08/23. Review of Resident #3's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Advil dual action 2 tablets every 8 hours for mild muscle pain scheduled for administration at 6:00am, 2:00pm, and 10:00pm. -Advil dual action 2 tablets was documented as administered at 6:00am on 09/09/23 to 09/30/23 except on 09/11/23, 09/12/23, 09/16/23, 09/18/23 where it was documented as refused and on 09/20/23, 09/25/23, 09/26/23, 09/28/23, and 09/29/23 where it was documented as other. -Advil dual action 2 tablets was documented as administered at 2:00pm on 09/09/23 to 09/30/23 except on 09/10/23, 09/17/23, and 09/30/23 where it was documented as refused and on 09/14/23 and 09/22/23 where it was documented as out of facility. -Advil dual action 2 tablets was documented as	C 330		

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C 330	Continued From page 15 administered at 10:00pm on 09/09/23 to 09/30/23 except on 09/11/23 and 09/13/23 where it was documented as refused and on 09/24/23 and 09/28/23 where it was documented as other. Review of Resident #3's October 2023 eMAR revealed: -There was an entry for Advil dual action 2 tablets every 8 hours for mild muscle pain scheduled for administration at 6:00am, 2:00pm, and 10:00pm. -Advil dual action 2 tablets was documented as administered at 6:00am everyday on 10/01/23 to 10/05/23 except on 10/04/23 where it was documented as other. -Advil dual action 2 tablets was documented as administered at 2:00pm everyday on 10/01/23 to 10/04/23 except on 10/02/23 where it was documented out of facility. -Advil dual action 2 tablets was documented as administered at 10:00pm everyday on 10/01/23 to 10/04/23 except on 10/01/23 where it was documented as other. Observation of Resident #3's medications on hand on 10/05/23 revealed: -There was a medication card containing Advil dual action 125mg-250mg dispensed on 09/09/23. -The administration instructions on the medication card were 2 tablets every 8 hours for mild muscle pain. Interview with a medication aide (MA) on 10/05/23 at 3:15pm revealed: -Resident #3 received 2 Advil dual action tablets everyday at 6:00am, 2:00pm, and 10:00pm. -She did not know that Resident #3's Advil dual action was ordered to be administered as needed because it was on the eMAR to be administered every 8 hours.	C 330		

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C 330	Continued From page 16 -Sometimes Resident #3 refused his Advil. -Resident #3 did not like to be woken up to take his Advil so when he was sleeping, she did not administer his Advil. Interview with the Administrator on 10/05/23 at 3:39pm revealed: -She thought Resident #3's Advil dual action was ordered to be administered every 8 hours because that was what was on his eMAR. -She did not notice that Resident #3's FL-2 had orders to administer his Advil dual action as needed. -She had contacted Resident #3's primary care provider (PCP) to get an order to administer his Advil dual action as needed instead because the resident often refused the medication or was out of the facility with his family when it was supposed to be administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/23 at 3:25pm revealed: -The order she currently saw on file for Resident #3 was Advil dual action 2 tablets every 8 hours scheduled. -The orders for Advil dual action 2 tablets were dated 08/26/23. -The pharmacy placed orders for resident's medications on the eMAR based on the current order. Telephone interview with the facility's contacted primary care provider (PCP) on 10/05/23 at 4:39pm revealed she was not familiar with Resident #3 because he was seen by a hospice provider. Based on observations, interviews, and record reviews it was determined Resident #3 was not	C 330		

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C 330	Continued From page 17 interviewable.	C 330		