STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(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 and the Hoke County Department of Social Services conducted a follow-up survey December 20-21, 2023.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#6) observed during the medication pass including errors with medications to treat mental health/mood disorders, to treat major depressive and social anxiety disorders and vitamin deficiency (#6) and for 2 of 6 sampled residents (#3, #6) who did not receive a prophylactic long term antibiotic medication given to prevent bone infection (#3) and who did not receive medications used to treat depression and social anxiety disorders and sleep disorder as ordered (#6). The findings are: Review of the facility's medication administration policy dated 10/01/2020 revealed:	{D 358}	The community immediately completed a thorough cart audit of each cart on Assisted Living and Memory Care. Any medications identified as missing were reported to the RCC/MCC/Designee 12/22/23 who gave instructions on obtaining the medication in the community. The RCC/MCC/Designee also notified the ED, PCP and family about any missing medications and worked 12/22/23 to obtain the medication and and orders to obtain the medication. Every effort was made to obtain any and all missing medications daily and documented in progress notes with the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Myra J. Sinclair TITLE: Executive Director (X6) DATE: 12/30/23

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{D 358}	Continued From page 1 -It was the facility's policy to assure that the preparation and administration of medications, prescription and nonprescription, and treatments by associates were ordered by a licensed prescribing practitioner which were maintained in the residence record and administered and prepared by associates who met the qualifications to do so. -Medications were to be administered to the residents within 1 hour before or 1 hour after the prescribed or scheduled time. -The recording of the administration on the medication administration record would be done immediately following the administration of the medication to the resident and the observation of the resident taking the medication and prior to administration of another medication to another resident. (Pre-charting was prohibited) -The facility assured the development and implementation of policies and procedures governing medication errors and adverse medication reactions that included documentation of: -Notification of the physician or appropriate healthcare professional and supervisor. -Action taken by the facility according to the orders by the physician or appropriate health professional -Charting or documentation errors, unavailability of medication and resident, refusal of medication, any adverse medication reactions, and notification of the residence physician when necessary. 1. The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the 8:00am medication passes on 12/20/23 and 12/21/23. a. Review of Resident #6's current FL-2 dated	{D 358}	attempts and outcomes of all efforts. The RCC/MCC/Lead Med Tech reviewed and documented all efforts to obtain medication daily to ensure that residents are not without medication. 12/22/23 The EQI Designee review weekly cart audits to ensure a proactive plan was initiated to obtain any medications missing medications 12/22/23 The community will continue to complete weekly cart audits to assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with orders by a licensed prescribing practitioner which are maintained in the residents records. 2/4/24 Those cart audits will be documented and the findings given to the RCC/MCC	

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{D 358}	Continued From page 2 09/22/23 revealed: -Diagnoses included Alzheimer's disease, chronic kidney disease stage 3, history of anxiety, history of insomnia, and atrial fibrillation. -There was an order for Risperdal 0.5mg (used to treat certain mental/mood disorders) give 1 daily for mood. Observation of the 8:00am medication pass on 12/21/23 revealed: -The medication aide (MA) prepared morning medications for Resident #6 which did not include her Risperdal. -The MA documented on the electronic medication administration record (eMAR) that Risperdal was not available for administration. Observation of Resident #6's medications on hand on 12/12/23 at 2:12pm revealed there was no Risperdal 0.5mg (used to treat certain mental/mood disorders) on hand for administration. Review of Resident #6's December 2023 eMAR revealed: -There was an entry for Risperdal 0.5mg to give 1 daily for mood scheduled at 8:00am. -Risperdal 0.5mg was documented as not being administered at 8:00am from 12/17/23 - 12/21/23. -The reason listed for Risperdal not being administered was documented as 09 (other/see nurses notes) from 12/17/23 - 12/21/23. Review of Resident #6's December 2023 nurses notes for 12/17/23 - 12/21/23 revealed: -The reason for Risperdal not being administered on 12/20/23 was documented as awaiting meds. -The reason for Risperdal not being administered on 12/17/23 - 12/19/23 and 12/21/23 was documented as on order.	{D 358}	Lead Med-Tech/Designee. Once those findings are passed to the RCC/MCC/Lead Med-Tech/Designee, they will be responsible for following up on any issues identified from/during the cart audit. If any issues arise that require a missing medication to be ordered or obtained, the ED/PCP/family will be notified to obtain an order or medication whichever is needed. 2/4/24 The RCC/MCC/Lead med Tech/Designee will review/document all efforts to obtain medication/order daily to ensure that residents are not without medications. 2/4/24 The ED/Designee will review weekly cart audits to ensure that a proactive plan has been initiated to obtain any medications or orders missing. 2/4/24	

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{D 358}	Continued From page 3 Review of the 24-hour shift report book revealed documentation dated 12/20/23: -The first shift remarks report for Resident #6 documented "Behaviors" with no other documentation. -The second shift remarks report for Resident #6 documented "check report for Resident's name" with no other documentation. -The third shift documented Resident #6 was "out of her regular medication and pharmacy was contacted" with no other documentation. -The assigned MAs signed the entries for the date 12/20/23. Review of Resident #6's December 2023 nurses notes dated 12/03/23 revealed: -There was documentation that Resident #6 was aggressive towards the staff when assisting with personal care and transfer. -There was documentation that Resident #6 screamed out and attempted to hit staff when redirection was attempted. Telephone interview a pharmacist at the facility's contracted pharmacy on 12/12/23 at 4:37pm revealed: -A 30-day supply of Risperdal 0.5mg was dispensed on 11/08/23 for Resident #6. -The effects of missing the number of combined doses of Risperdal, along with her other 2 medications that were used for major depressive disorder and social anxiety disorder could cause a more confused mental status; it could cause her dementia to be heightened. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6.	{D 358}		

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{D 358}	Continued From page 4 -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to interview with a personal care aide (PCA) on 12/21/23 at 3:40pm. Refer to interview with a medication aide (MA) on 12/21/23 at 3:35pm. Refer to interview with a second medication aide (MA) on 12/20/23 at 3:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm. b. Review of Resident #6's current FL-2 dated 09/22/23 revealed there was an order for Zoloft 100mg (used to treat some types of depression and social anxiety disorder) give 1 daily for mood. Observation of the 8:00am medication pass on 12/21/23 revealed: -The medication aide (MA) prepared morning medications for Resident #6 which did not include her Zoloft. -The MA documented on the electronic medication administration record (eMAR) that Zoloft was not available for administration. Observation of Resident #6's medications on hand on 12/21/23 at 2:12pm revealed there was no Zoloft 100mg on hand for administration. Review of Resident #6's December 2023 eMAR revealed:	{D 358}		

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{D 358}	Continued From page 5 -There was an entry for Zoloft 100mg give 1 daily for mood scheduled at 8:00am. -Zoloft 100mg was documented as not being administered at 8:00am from 12/07/23, 12/08/23, 12/10/23 -12/13/23, and 12/15/23 - 12/21/23. -The reason listed for Zoloft not being administered was documented as 09 (other/see nurses notes) from 12/07/23, 12/08/23, 12/10/23 -12/13/23, and 12/15/23 - 12/21/23. Review of Resident #6's December 2023 nurses notes for 12/07/23, 12/08/23, 12/10/23 -12/13/23, and 12/15/23 - 12/21/23 revealed: -The reason for Zoloft not being administered on 12/21/23 was documented as waiting pharmacy to deliver. -The reason for Zoloft not being administered on 12/20/23 was documented as awaiting meds. -The reason for Zoloft not being administered on 12/15/23 - 12/19/23 was documented as on order. -The reason for Zoloft not being administered on 12/11/23 - 12/13/23 was documented as on order. -The reason for Zoloft not being administered on 12/10/23 was documented as N/A (not available). -The reason for Zoloft not being administered on 12/08/23 was documented as awaiting meds. -The reason for Zoloft not being administered on 12/07/23 was documented as meds not on cart. Review of the 24-hour shift report book revealed documentation dated 12/20/23: -The first shift remarks report for Resident #6 documented "Behaviors" with no other documentation. -The second shift remarks report for Resident #6 documented "check report for Resident's name" with no other documentation. -The third shift documented Resident #6 was "out of her regular medication and pharmacy was	{D 358}		

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{D 358}	Continued From page 6 contacted" with no other documentation. -The assigned MAs signed the entries for the date 12/20/23. Review of Resident #6's December 2023 nurses notes dated 12/03/23 revealed: -There was documentation that Resident #6 was aggressive towards the staff when assisting with personal care and transfer. -There was documentation that Resident #6 screamed out and attempted to hit staff when redirection was attempted. Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/21/23 at 4:37pm revealed: -A 30-day supply of Zoloft 100mg was dispensed on 10/26/23 for Resident #6. -The effects of missing the number of combined doses of Zoloft, along with her other 2 medications that were used for mental/mood disorders and major depressive disorder could cause a more confused mental status; it could cause her dementia to be heightened. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to interview with a personal care aide (PCA) on 12/21/23 at 3:40pm. Refer to interview with a medication aide (MA) on 12/21/23 at 3:35pm.	{D 358}		

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{D 358}	Continued From page 7 Refer to interview with a second medication aide (MA) on 12/20/23 at 3:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm. c. Review of Resident #6's current FL-2 dated 09/22/23 revealed there was an order for Vitamin D3 2000U (used as a dietary supplement for vitamin D deficiency) give 1 tablet daily. Observation of the 8:00am medication pass on 12/21/23 revealed: -The medication aide (MA) prepared morning medications for Resident #6 which did not include her Vitamin D. -The MA documented on the electronic medication administration record (eMAR) that Vitamin D was not available for administration. Observation of Resident #6's medications on hand on 12/21/23 at 2:12pm revealed there was no Vitamin D3 2000U on hand for administration. Review of Resident #6's December 2023 eMAR revealed: -There was an entry for Vitamin D3 2000U give 1 tablet daily scheduled at 8:00am. -Vitamin D3 was documented as not being administered at 8:00am from 12/06/23-12/08/23, 12/10/23 -12/13/23, and 12/15/23 - 12/21/23. -The reason listed for Vitamin D3 not being administered was documented as 09 (other/see nurses notes) from 12/06/23-12/08/23, 12/10/23-12/13/23, and 12/15/23-12/21/23. Review of Resident #6's December 2023 nurses	{D 358}		

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{D 358}	Continued From page 8 notes for 12/06/23-12/08/23, 12/10/23-12/13/23, and 12/15/23 -12/21/23 revealed: -The reason for Vitamin D3 not being administered on 12/21/23 was documented as waiting pharmacy to deliver. -The reason for Vitamin D3 not being administered on 12/20/23 was documented as awaiting meds. -The reason for Vitamin D3 not being administered on 12/15/23-12/19/23 was documented as on order. -The reason for Vitamin D3 not being administered on 12/13/23 was documented as N/A (not available). -The reason for Vitamin D3 not being administered on 12/11/23-12/12/23 was documented as on order. -The reason for Vitamin D3 not being administered on 12/10/23 was documented as N/A (not available). -The reason for Vitamin D3 not being administered on 12/08/23 was documented as awaiting meds. -The reason for Vitamin D3 not being administered on 12/07/23 was documented as meds not on cart. -The reason for Vitamin D3 not being administered on 12/06/23 was documented as on order. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to interview with a second medication aide	{D 358}		

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{D 358}	Continued From page 9 (MA) on 12/20/23 at 3:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm. 2. Review of Resident #6's current FL-2 dated 09/22/23 revealed: -Diagnoses included Alzheimer's disease, chronic kidney disease stage 3, history of anxiety, history of insomnia, and atrial fibrillation. -There was an order for Trazodone 100mg (used to treat major depressive disorder) give 1 at bedtime for sleep. Observation of Resident #6's medications on hand on 12/21/23 at 2:12pm revealed there was no Trazodone on hand for administration. Review of Resident #6's December 2023 eMAR revealed: -There was an entry for Trazodone 100mg give 1 at bedtime for sleep scheduled at 8:00pm. -Trazodone was documented as not being administered at 8:00pm from 12/10/23 -12/20/23. -The reason listed for Trazodone not being administered was documented as 09 (other/see nurses notes) from 12/10/23 -12/20/23. Review of Resident #6's December 2023 nurses notes for 12/10/23 -12/20/23 revealed: -The reason for Trazodone not being administered on 12/20/23 was documented as 'medication isn't available' attempted to call 'pharmacy name' at 5:15pm and was on hold for 43 minutes to no avail will try again tomorrow". -The reason for Trazodone not being administered on 12/20/23 was documented as	{D 358}		

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{D 358}	Continued From page 10 awaiting meds. -The reason for Trazodone not being administered on 12/17/23 - 12/19/23 was documented as N/A (not available). -The reason for Trazodone not being administered on 12/16/23 was documented as 'medication isn't available'. -The reason for Trazodone not being administered on 12/15/23 was documented as N/A (not available). -The reason for Trazodone not being administered on 12/14/23 was documented as 'medication isn't available'. -The reason for Trazodone not being administered on 12/13/23 was documented as N/A (not available). -There was no reason documented for Trazodone not being administered on 12/11/23 and 12/12/23. -The reason for Trazodone not being administered on 12/10/23 was documented as medication ordered. Review of the 24-hour shift report book revealed documentation dated 12/20/23: -The first shift remarks report for Resident #6 documented "Behaviors" with no other documentation. -The second shift remarks report for Resident #6 documented "check report for Resident's name" with no other documentation. -The third shift documented Resident #6 was "out of her regular medication and pharmacy was contacted" with no other documentation. -The assigned MAs signed the entries for the date 12/20/23. Review of Resident #6's December 2023 nurses notes dated 12/03/23 revealed: -There was documentation that Resident #6 was aggressive towards the staff when assisting with	{D 358}		

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{D 358}	Continued From page 11 personal care and transfer. -There was documentation that Resident #6 screamed out and attempted to hit staff when redirection was attempted. Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/21/23 at 4:37pm revealed -A 30-day supply of Trazodone 100mg was dispensed on 11/08/23 for Resident #6. -The effects of missing the number of combined doses of Trazodone, along with her other 2 medications that were used for mental/mood disorders and social anxiety disorder could cause a more confused mental status; it could cause her dementia to be heightened. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to interview with a personal care aide (PCA) on 12/21/23 at 3:40pm. Refer to interview with a medication aide (MA) on 12/21/23 at 3:35pm. Refer to interview with the medication aide (MA) on 12/20/23 at 3:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm.	{D 358}		

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{D 358}	Continued From page 12 3. Review of Resident #6's current FL-2 dated 09/22/23 revealed: -Diagnoses included Alzheimer's disease, chronic kidney disease stage 3, history of anxiety, history of insomnia, and atrial fibrillation. here was an order for Melatonin 3mg (used to treat sleeplessness/insomnia) give 1 tablet at bedtime for insomnia. Observation of Resident #6's medications on hand on 12/21/23 at 2:12pm revealed there was no Melatonin 3mg on hand for administration. Review of Resident #6's December 2023 eMAR revealed: -There was an entry for Melatonin 3mg give 1 tablet at bedtime for insomnia scheduled at 8:00pm. -Melatonin 3mg give 1 tablet at bedtime for insomnia was documented as not being administered at 8:00pm from 12/01/23-12/07/23 and 12/09/23-12/20/23. -The reason listed for Melatonin 3mg not being administered was documented as 09 (other/see nurses notes) from 12/01/23-12/07/23 and 12/09/23-12/20/23. Review of Resident #6's December 2023 nurses notes for 12/01/23-12/07/23 and 12/09/23-12/20/23 revealed: -There was no reason documented for Melatonin 3mg not being administered on 12/19/23 and 12/20/23. -The reason for Melatonin not being administered on 12/18/23 was documented as not available. -The reason for Melatonin not being administered on 12/17/23 was documented as N/A (not available). -The reason for Melatonin not being administered	{D 358}		

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{D 358}	Continued From page 13 on 12/16/23 was documented as 'medication isn't available'. -The reason for Melatonin not being administered on 12/15/23 was documented as N/A (not available). -The reason for Melatonin not being administered on 12/14/23 was documented as medication not available. -The reason for Melatonin not being administered on 12/13/23 was documented as N/A (not available). -The reason for Melatonin not being administered on 12/12/23 was documented as 'medication isn't available'. -There was no entry on the nurses notes on 12/11/23 for the reason the Melatonin was not administered. -The reason for Melatonin not being administered on 12/10/23 was documented as medication ordered. -The reason for Melatonin not being administered on 12/06/23 and 12/09/23 was documented as N/A (not available). -The reason for Melatonin not being administered on 12/05/23 was documented as waiting on provider. -The reason for Melatonin not being administered on 12/02/23-12/04/23 was documented as N/A (not available). -The reason for Melatonin not being administered on 12/01/23 was documented as out of refills, waiting on provider. Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable. Attempted telephone interview with Resident #6's power of attorney on 12/21/23 at 3:10pm was unsuccessful.	{D 358}		

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{D 358}	Continued From page 14 Interview on 12/21/23 at 3:40pm with a personal care aide (PCA) revealed: -Resident #6 had been worse as she fought more than usual; she had tried to hit and punch this month (December). -Last month in November, she would just talk as opposed to becoming physical. Interview with a second medication aide (MA) on 12/21/23 at 3:35pm revealed: -He had worked at the facility for two weeks. -He described Resident #6 as feisty because she got loud and tried to hit and pinch staff when being assisted with personal care, to bed, and upon awakening. -She cursed at staff and called staff vulgar names. -When she was in her own element, she was good (when staff was not assisting her). -She may have an outburst at dinner time, but she was calm for the most part, as long as no one bothered her. Telephone interview with Resident #6's primary care provider (PCP) on 12/21/23 at 4:53pm revealed: -She was not aware that Resident #6 had missed any of her medications. -The hospice nurse had not requested any refills or prescriptions for Resident #6. -The hospice nurse no longer worked with hospice; it had been 2 weeks since she had worked with hospice. -Her main concern was the numerous doses of Risperdal, Zoloft, and Trazodone that Resident #6 had missed. -Missing a dose or 2 could cause some nausea and vomiting but missing a week or more straight would cause more serious effects like	{D 358}		

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{D 358}	Continued From page 15 depression, hallucinations, difficulty sleeping, dizziness, irritability, and uncontrolled muscle movements. -She would contact the facility for new orders for resuming the Risperdal, Zoloft and Trazodone medications and gradually increase the dosages with a slow taper until the previous ordered doses were achieved. Attempted telephone interview with the hospice nurse on 12/21/23 at 4:50pm was unsuccessful. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to interview with the medication aide (MA) on 12/20/23 at 3:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm. 4. Review of Resident #3's current FL-2 dated 10/12/23 revealed: -Diagnoses included infection and inflammatory reaction due to internal left hip prosthesis, staphylococcal arthritis left hip, essential hypertension major depressive disorder, diabetes mellitus, and atrial fibrillation. -There was an order for Minocycline HCL 50mg (used to treat bacterial infections) to give 1 capsule at bedtime for bone infection.	{D 358}		

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{D 358}	Continued From page 16 Interview with Resident #3 on 12/20/23 at 8:55am revealed: -She was supposed to get her antibiotic every day and she had missed 3 days so far. -It was given to her to prevent MRSA-Methicillin Resistant Staphylococcus Aureus. -If she did not get her antibiotic, it could cause MRSA to start infecting her and she could wind up in the hospital and be deathly sick. -She had told several of the MAs about running out of her antibiotic. -She said it did not do any good to talk to the Resident Care Coordinator (RCC) or the Executive Director (ED) as they did not know what was happening at the facility since they stayed in their offices all the time. Review of Resident #3's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Minocycline HCL 50mg give 1 capsule at bedtime for bone infection scheduled at 8:00pm. - Minocycline HCL 50mg was documented as not being administered at 8:00pm from 12/17/23 - 12/19/23. -The reason listed for Minocycline HCL 50mg not being administered was documented as 09 (other/see nurses notes) from 12/17/23 - 12/19/23. Observation of Resident #3's medications on hand on 12/21/23 at 2:43pm revealed there were 30 capsules of Minocycline HCL 50mg on hand for administration which were dispensed on 12/18/23 for Resident #3. Review of Resident #3's December 2023 nurses notes for 12/16/23-12/19/23 revealed:	{D 358}		

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{D 358}	Continued From page 17 -The reason for Minocycline HCL not being administered on 12/19/23 was documented as being ordered. -The reason for Minocycline HCL not being administered on 12/18/23 was documented as meds not on cart. -The reason for Minocycline HCL not being administered on 12/17/23 was documented as medication not available. -The reason for Minocycline HCL not being administered on 12/16/23 was documented as n/a - not available. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/21/23 at 4:37pm revealed: -A 30-day supply of Minocycline HCL 50mg was dispensed on 12/18/23 for Resident #3. -A 30-day supply of Minocycline HCL 50mg was dispensed on 11/14/23 for Resident #3. -The effects of missing 4 doses of Minocycline HCL 50mg could cause leg cramps and diarrhea. -Resident #3 had received Minocycline HCL as a prophylactic medication since May 2023. Interview with Resident #3's family member on 12/20/23 at 12:40pm revealed: -Her family member (Resident #3) was supposed to get her antibiotic every day and she had missed 3 days so far. -She took it to prevent MRSA-Methicillin Resistant Staphylococcus Aureus. -If she got a little scratch, it could cause a severe infection and she would be hospitalized. -Resident #3 had told several of the MAs about running out of her medications, especially her antibiotic. -She and Resident #3 had talked to several staff and the ED to no avail.	{D 358}		

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{D 358}	Continued From page 18 Interview with Resident #3's Primary Care Provider (PCP) on 12/21/23 at 5:22pm revealed: -He had not been notified of Resident #3 missing 3 doses of her Minocycline. -He would expect to be notified if she missed more than 2 doses but was not concerned as she had been taking it for some time now. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #3. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Interview with a personal care aide (PCA) on 12/21/23 at 3:40pm revealed: -Resident #6 had been worse as she fought more than usual; she had tried to hit and punch this month (December). -Last month in November, she would just talk as opposed to becoming physical. Interview with a medication aide (MA) on 12/21/23 at 3:35pm revealed: -He had worked at the facility for two weeks. -He described Resident #6 as feisty because she got loud and tried to hit and pinch staff when being assisted with personal care, to bed, and upon awakening. -She cursed at staff and called staff vulgar names. -When she was in her own element, she was good (when staff was not assisting her). -She may have an outburst at dinner time, but she was calm for the most part, as long as no one bothered her.	{D 358}		

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{D 358}	Continued From page 19 Interview with a second medication aide (MA) on 12/20/23 at 3:31pm revealed: -The MAs document a number on the electronic medication administration record (eMAR). -The 09 was other/see nurses notes. -The n/a that was noted on the nurse's notes means not available. -When the MA documented the 09 on the eMAR, the nurse's notes would explain why 09 was used. -The MAs reordered meds when there was a 7-10-day supply remaining. -The Resident Care Coordinator (RCC), Memory Care Director (MCD), and the Supervisor in Charge (SIC) did the cart audits but not sure when those were done. -Any behaviors or issues that any resident would have should be documented in the nurse's notes. Interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm revealed: -The medication aides (MAs) were responsible to contact the Primary Care Provider (PCP) when the resident missed doses of their medications. -The MAs were responsible for ordering the refills from the medication packs. -If no refills were available, the MAs were responsible for contacting the PCP to get a new order. -The MAs documented in the nurses notes when medications were missed, refused, etcetera. with the reasons, when the PCP was contacted, when the pharmacy was contacted, if the resident was showing any behaviors or having any problems. -There was a 24-hour shift report book that the MAs used to help report any issues from their shifts to help the next oncoming shift be aware. Interview with the Executive Director (ED) on 12/21/23 at 2:10pm revealed: -If a resident ran out of medication, the	{D 358}		

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{D 358}	Continued From page 20 medication aides (MAs) were to notify the supervisor. -The MA was expected to contact the pharmacy or remove the sticker from the medication card and send it to the pharmacy for a refill when there was a 7-10-day supply remaining. -The Resident Care Coordinator (RCC) was responsible for checking behind the MAs to make sure medications were refilled. -Cart audits were done by the Memory Care Director (MCD), RCC and the Lead MA weekly on Thursdays and it was done last Thursday. -The cart audit consisted of checking the cart, the meds on the cart to the orders, checking for expired meds, and comparing the actual order to the electronic Medication Administration Record (eMAR), and if there were any missing meds or meds that were running low that would be reordered. -There was no excuse for any resident being out of any of their meds as their back up pharmacy was right next door. The facility failed to administer medications as ordered to 1 of 4 residents observed during the medication passes on 12/20/23 and 12/21/23 resulting in a 10% medication error rate. Resident #6 was not administered a medication used to treat mental health disorders/mood and had missed 5 consecutive days; she missed 13 doses of her medication used to treat depression; and she missed 13 doses of vitamin used to treat a vitamin deficiency and Resident #3 who had a history of an antibiotic resistant community acquired infection and missed 4 consecutive doses of her antibiotic in December 2023, placing her at risk for an exacerbation of the bone infection and Resident #6 had missed 11 consecutive days of her medication used to treat major depressive disorder and missed 9	{D 358}		

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{D 358}	Continued From page 21 consecutive days of her medication used to treat insomnia. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/21/23 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2024.	{D 358}		