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TORE'S HOME #3	65 TORE'S DRIVE BREVARD, NC 28712

(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 03/12/24.	C 000		
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 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 observations, interviews and record reviews the facility failed to clarify an order for 1 of 3 sampled residents (#2) related to lisinopril (used to treat hypertension). The findings are: Review of Resident #2's current FL2 dated 02/12/24 revealed: -Diagnoses included dementia and hypertension. -An order for lisinopril (used to treat hypertension) 10mg daily. Review of Resident #2's February 2024 and March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lisinopril 10mg daily.	C 315		

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C 315	Continued From page 1 -Three was documentation lisinopril 10mg was administered 02/14/24 through 02/29/24. -Three was documentation lisinopril 10mg was administered 03/01/24 through 03/12/24. Observation of Resident 2's medications on hand on 03/12/24 at 10:51am revealed: -Lisinopril 10mg was not available. -A bottle of lisinopril 2.5mg, that was filled at a local pharmacy on 09/22/23, was available. -The bottle of lisinopril 2.5mg had 90 tablets dispensed and 22 were remaining. Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 10:54am revealed: -Resident #2 brought all her medications, including the lisinopril 2.5mg, with her when she was admitted to the facility on 02/12/24. -She was using the bottle of lisinopril 2.5mg when she administered Resident #3's medications. -She did not realize the dosage of the lisinopril that Resident #2 brought with her upon admission did not match the order on the FL2. -She was responsible for comparing medication orders to the eMAR and making sure medications and dosages were accurate when compared to what was ordered. -She completed medication cart audits weekly on Mondays and compared the medications to the orders. -If she had noticed the discrepancy she would have obtained a clarification order. Telephone interview with Resident #2's Primary care Provider (PCP) on 03/12/24 at 2:24pm revealed: -A rehabilitation facility completed Resident #2's current FL2 when she was admitted to the facility. -She did not know why the dose of lisinopril was increased when Resident #2 was at the	C 315		

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C 315	Continued From page 2 rehabilitation facility. -Resident #2 had been ordered lisinopril 2.5mg on 9/22/23 and should continue to receive 2.5mg. Interview with the facility's Manager on 03/12/24 at 4:15pm revealed: -Medications should always be checked for accuracy when residents who were admitted to the facility brought their own medications. -The SIC was responsible for medication cart audits weekly and should have compared the medications on the cart to the medication orders. -She did not know why the SIC did not realize the lisinopril dosage was 2.5mg instead of the ordered 10mg. -The SIC was responsible for obtaining a clarification order if there was any question about a medication order. -She expected the MAs and SIC to administer medications as ordered or contact the pharmacy for the correct dosage of medication to be dispensed.	C 315		
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: TYPE B VIOLATION	C 330		

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C 330	Continued From page 3 Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) related to medications used to treat anxiety, constipation, vitamin D deficiency and vitamin B deficiency. The findings are: Review of the facility's undated policies and procedures on medication administration revealed: -Only the facility's contracted pharmacy was allowed to make changes to the electronic medication administration record (eMAR) for prescription medications. -The Supervisor-in-Charge (SIC) or Manager was responsible for making sure the pharmacy entered new orders and discontinued orders correctly. -There must always be two staff present when administering scheduled controlled medications to residents. -The Supervisor-on-Call (SOC) must be notified first before administration of an as-needed controlled medication. -The SIC will ensure any medication changes that occurred during the hours that the SIC is present in the facility were entered into the eMAR correctly by the pharmacy and the medication delivered was correctly labeled. If medication changes occurred after hours, the SOC was responsible for the above procedure taking place prior to the first medication administration after the change. -The SIC was responsible for faxing new medication orders to the pharmacy. -The SIC and Manager would review all changes and document in the chart notes.	C 330		

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-The SIC was responsible for the documentation of all activities of daily living (ADLs).
-During the medication pass, the medication was selected on the screen, located in the medication cart, compared with the medication on the screen, and once identified as accurate the medication was administered to the resident.
-Any exceptions for medication administration were documented in the eMAR.

Review of Resident #1's current FL2 dated 02/22/24 revealed diagnoses included dementia and anxiety.

Review of Resident #1's Resident Register revealed an admission date of 02/23/24.

a. Review of Resident #1's physician's order dated 03/04/24 revealed lorazepam (a medication used to treat anxiety) 0.5mg take 1 tablet every night as needed for anxiety.

Review of Resident #1's local hospital discharge instructions dated 03/09/24 revealed:
-Resident #1 was seen at the local hospital emergency room (ER) for repeated falls.
-There was a physician's order dated 03/09/24 to hold lorazepam for one week and use a newly prescribed medication instead for agitation.

Review of Resident #1's Incident and Accident (I&A) Reports dated 03/09/24 revealed:
-There were 3 I&A reports filled out for falls dated 03/09/24.
-There were no times documented on the I&A reports.
-A medication aide (MA) found Resident #1 lying on the floor after she heard Resident #1 "grunting".
-She notified the Supervisor-on-Call (SOC) of

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Resident #1's fall and called 911 to have Resident #1 evaluated.

Review of Resident #1's 03/04/24 through 03/12/24 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg take 1 tablet every day as-needed for anxiety.
-There was documentation lorazepam 0.5mg was administered twice on 03/08/24 at 7:42pm and 11:41pm with a comment of "still restless" documented with the second dose.
-There was documentation lorazepam was to be held from 03/10/24-03/16/24.

Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 11:20am revealed:
-Resident #1's lorazepam was ordered to be administered once daily as-needed for anxiety.
-She did not know why the third shift medication aide (MA) administered a second dose of lorazepam to Resident #1 on 03/08/24.
-Resident #1 fell twice the morning of 03/09/24 and was complaining of pain so Resident #1 was sent to the local hospital ER for an evaluation.
-Resident #1 was sent back to the facility on 03/09/24 with an order to hold lorazepam for one week.

Interview with a second shift medication aide (MA) on 03/12/24 at 3:30pm revealed:
-She worked second shift on 03/08/24 and administered lorazepam to Resident #1 at 7:42pm due to being anxious and agitated and Resident #1 was calm and in bed when her shift ended at 11:00pm.
-She worked first shift on 03/09/24 and made rounds with the third shift MA to all the resident rooms.
-The third shift MA reported Resident #1 fell

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"during the night" when she arrived for work on 03/09/24.
-Shortly after leaving Resident #1's room, she heard Resident #1 "hollering" and found him lying on the floor next to his bed around 7:30am.
-She tried to assist Resident #1 off the floor, but he was complaining of pain and Resident #1 could not specify where he was hurting.
-She notified the Supervisor-on-call (SOC) and 911 was called.
-Resident #1 was "more confused" on 03/09/24 than his normal baseline.
-Resident #1 was able to stand and walk prior to the fall on 03/09/24 but was unable to do so now because of pain.

Telephone interview with a third shift MA on 03/12/24 at 3:41pm revealed:
-She administered a second dose of lorazepam to Resident #1 on 03/08/24 about 4 hours after the first dose was administered because the first dose did not help Resident #1, and he was still agitated.
-She called the third shift SOC to get permission to administer a second dose of lorazepam to Resident #1 on 03/08/24 even though it was already administered on 03/08/24.
-The SOC was always notified, and prior approval was required for any as-needed medications that were administered to residents.
-A medication error form should be filled out and given to the SOC or SIC when a medication error takes place, and the form faxed to the primary care provider (PCP).
-She did not fill out a medication error form for Resident #1's lorazepam not being administered as ordered because the SOC approved her to administer the second dose of lorazepam to Resident #1.

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Telephone interview with the night shift SOC on 03/12/24 at 4:21pm revealed:
-The third shift MA on 03/08/24 called to get approval to administer lorazepam to Resident #1.
-She told the MA to administer the lorazepam to Resident #1 at 12:00am so that it would be considered another day.
-She was still working on 03/09/24 when Resident #1 fell and had to be sent to the local hospital ER for an evaluation.
-She did not realize Resident #1's lorazepam was administered on 03/08/24 at 11:41pm.

Telephone interview with Resident #1's primary care provider (PCP) on 03/12/24 at 2:34pm revealed:
-She saw Resident #1 for the first time on 03/04/24 and established him as a new patient.
-Resident #1 was previously administered lorazepam for anxiety and she reordered lorazepam 0.5mg take 1 tablet by mouth as-needed daily at bedtime on 03/04/24.
-Resident #1's falls on 03/09/24 may have been caused by taking an extra dose of lorazepam the evening of 03/08/24.
-An extra dose of lorazepam could cause increased drowsiness, unsteadiness, respiratory depression, hypotension, constipation, urinary retention, fainting, and an increased risk of falls.
-She expected the facility staff to administer Resident #1's medications as ordered.

Interview with the facility's Manager on 03/12/24 at 4:09pm revealed:
-The SOC was responsible for approving the administration of all controlled substances to residents.
-The third shift SOC should have asked the third shift MA when Resident #1's lorazepam was last administered before approving the administration

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of lorazepam to Resident #1 on 03/08/24.
-She knew taking an extra dose of lorazepam when it was not ordered could cause an increased risk of falls.
-She did not know an extra dose of lorazepam was administered to Resident #1 at 11:41pm on 03/08/24.
-She expected the MAs to administer medications as ordered.

b. Review of Resident #1's local hospital discharge instructions dated 03/08/24 revealed:
-Resident #1 was seen at the local hospital emergency room (ER) for lower abdominal pain.
-A computed tomography (CT) scan on the abdomen and pelvis was completed with a diagnosis of moderate diffuse bowel distention without a definitive transition zone to suggest obstruction.
-There was a medication order for polyethylene glycol 17 grams take daily for 7 days for constipation.

Review of Resident #1's 03/08/24-03/12/24 electronic medication administration record (eMAR) revealed:
-There was no entry for polyethylene glycol 17 grams take daily for 7 days for constipation.
-There was no documentation polyethylene glycol was administered.

Observation of Resident #1's medications on hand on 03/12/24 at 11:20am revealed there was no polyethylene glycol available to administer.

Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 11:20am revealed:
-Resident #1's polyethylene glycol was unavailable for administration.
-Resident #1 was prescribed polyethylene glycol

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for constipation when he was seen at the local hospital ER on 03/08/24.
-The facility's contracted pharmacy did not dispense or add polyethylene glycol to Resident #1's eMAR yet.
-She was responsible for faxing new medication orders to the pharmacy.
-She was responsible for following up with the pharmacy when medications were not dispensed or added to the eMAR.
-She thought she had faxed the order for Resident #1's polyethylene glycol to the pharmacy but the facility did not keep fax confirmations to make sure the fax was sent.
-She forgot to fax Resident #1's order for polyethylene glycol to the pharmacy, call the pharmacy to see why the medication was not added to the eMAR, and why the polyethylene glycol was not dispensed.
-Resident #1 had a bowel movement on 03/11/24 but she did not document the bowel movement.
-Bowel movements were documented in the chart notes in the resident's records.
-There were no bowel movements documented for Resident #1 since his admission on 02/23/24.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/12/24 at 11:48am revealed:
-The pharmacy did not receive an order for Resident #1's polyethylene glycol dated 03/08/24.
-The pharmacy had not dispensed polyethylene glycol for Resident #1.
-The last medication orders received for Resident #1 that were faxed to the pharmacy was on 02/23/24.

Telephone interview with Resident #1's primary care provider (PCP) on 03/12/24 at 2:34pm revealed:

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-She saw Resident #1 for the first time on 03/04/24 and established him as a new patient.
-Resident #1's polyethylene glycol was ordered on 03/08/24 by a physician at the local hospital ER.
-Resident #1 could experience increased constipation causing an impaction and/or increased confusion by not receiving the polyethylene glycol.
-She expected the facility to administer medications as ordered.

Interview with the facility's Manager on 03/12/24 at 11:55am revealed:
-The SIC was responsible for faxing new medication orders to the pharmacy and confirming the fax was received.
-The SIC was responsible for making sure the new medication orders were added to the resident's eMAR.
-The SIC was responsible for completing eMAR audits daily.
-The SIC failed to complete daily eMAR audits or the SIC would have found that Resident #1's polyethylene glycol was not added to the eMAR by the pharmacy.
-She completed eMAR audits every 90 days but had not done a eMAR since the polyethylene glycol was ordered for Resident #1.
-The SIC was responsible for completing medication cart audits weekly.
-The SIC just "failed" to fax Resident #1's order for polyethylene glycol to the pharmacy, make sure the medication was added to the eMAR and administer it to Resident #1.

c. Review of Resident #1's physician's orders dated 03/04/24 revealed an order for vitamin D3 (a supplement used to increase calcium and phosphorus absorption to build and maintain

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C 330	Continued From page 11 strong bones) 2000 units (u) take 1 capsule daily. Review of Resident #1's 03/04/24-03/12/24 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 2000u take 1 capsule daily at 8:00am. -There was documentation vitamin D3 2000u was administered from 03/04/24-03/05/24, 03/07/24-03/10/24, and on 03/12/24. -There was documentation vitamin D3 2000u was not administered on 03/06/24 due to Resident #1 was "physically unable to take". -There was documentation vitamin D3 2000u was not administered on 03/11/24 due to not being able to get Resident #1 "awake enough to take". Observation of Resident #1's medications on hand on 03/12/24 at 11:20am revealed: -There was a bottle of vitamin D3 5000u available for administration. -There was no vitamin D3 2000u available for administration. Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 11:20am revealed: -Resident #1 was admitted to the facility on 02/23/24 and brought most of his medications from home including vitamin D3 5000u. -She documented she administered Resident #1 vitamin D3 2000u on 03/04/24, 03/07/24-03/08/24, and 03/12/24 instead of the 5000u available because she did not check the dosage on the bottle before administration. -She did not realize Resident #1's vitamin D3 5000u did not match the physician's order for 2000u. -She was responsible for eMAR audits daily or when a new order was given to check for accuracy of documentation.	C 330		

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-She was responsible for comparing medication orders to the eMAR and making sure medications and dosages were accurate when compared to what was ordered.
-She knew she was supposed to check medications including the dosage against the eMAR when she administered medications, but she did not always check the dosage.
-She was responsible for completing medication cart audits weekly on Mondays and compared the medications to the orders including medication dosages.
-She did not check the dosage of Resident #1's vitamin D3 when she completed the cart audit on 03/04/24 or 03/11/24 and only looked to make sure Resident #1's vitamin D3 was available.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/12/24 at 11:48am revealed:
-The facility was responsible for sending a request for any medications needed.
-There was no request made for Resident #1's vitamin D3 2000u to be dispensed.
-Resident #1's vitamin D3 2000u had never been dispensed by the pharmacy.

Telephone interview with Resident #1's primary care provider (PCP) on 03/12/24 at 2:34pm revealed:
-She ordered Resident #1 vitamin D3 2000u take 1 capsule daily on 03/04/24 for bone health.
-Taking too large of a dosage of vitamin D3 would increase the calcium in the body and could cause nausea, vomiting, or vitamin D3 toxicity which could lead to kidney stones.
-She expected the facility to administer Resident #1's medications as ordered.

Interview with a second shift medication aide

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(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 330	Continued From page 13 (MA) on 03/12/24 at 3:30pm revealed: -She administered Resident #1 vitamin D3 5000u on 03/02/24-03/03/24, and 03/09/24 because she did not realize the vitamin D3 was 5000u instead of the ordered 2000u. -She did not always compare the medication dosage to the eMAR when she administered medications. Interview with the facility's Manager on 03/12/24 at 11:55am revealed: -The SIC was responsible for making sure Resident #1's vitamin D3 dosage on the bottle matched the medication order. -She did not know why the SIC did not realize the dosage was 5000u instead of the ordered 2000u. -The SIC was responsible for medication cart audits weekly and should have compared the medications on the cart to the medication orders. -She expected the MAs and SIC to administer medications as ordered or contact the pharmacy for the correct dosage of medication to be dispensed. d. Review of Resident #1's physician's orders dated 03/04/24 revealed an order for vitamin B12 (a supplement used to keep blood and nerve cells healthy and prevent anemia that causes tiredness and weakness) 1000mcg take 1 tablet daily. Review of Resident #1's 03/04/24-03/12/24 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin B12 1000mcg take 1 tablet daily at 8:00am. -There was documentation vitamin B12 1000mcg was administered from 03/04/24-03/05/24, 03/07/24-03/10/24, and on 03/12/24. -There was documentation vitamin B12 1000mcg was not administered on 03/06/24 due to	C 330		

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Resident #1 was "physically unable to take".
-There was documentation vitamin B12 1000mcg was not administered on 03/11/24 due to not being able to get Resident #1 "awake enough to take".

Observation of Resident #1's medications on hand on 03/12/24 at 11:20am revealed:
-There was a bottle of vitamin B12 5000mcg available for administration.
-There was no vitamin B12 1000mcg available for administration.

Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 11:20am revealed:
-Resident #1 was admitted to the facility on 02/23/24 and brought most of his medications from home including vitamin B12 5000mcg.
-She documented she administered Resident #1 vitamin B12 1000mcg on 03/04/24, 03/07/24-03/08/24, and 03/12/24 instead of the 5000mcg available because she did not check the dosage on the bottle before administration.
-She did not realize Resident #1's vitamin B12 5000mcg did not match the physician's order for 1000mcg.
-She was responsible for eMAR audits daily or when a new order was given to check for accuracy of documentation.
-She was responsible for comparing medication orders to the eMAR and making sure medications and dosages were accurate when compared to what was ordered.
-She knew she was supposed to check medications including the dosage against the eMAR when she administered medications, but she did not always check the dosage.
-She was responsible for completing medication cart audits weekly on Mondays and compared the medications to the orders including medication

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dosages.
-She did not check the dosage of Resident #1's vitamin B12 when she completed the cart audit on 03/04/24 or 03/11/24 and only looked to make sure Resident #1's vitamin B12 was available.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/12/24 at 11:48am revealed:
-The facility was responsible for sending a request for any medications needed.
-There was no request made for Resident #1's vitamin B12 1000mcg to be dispensed.
-Resident #1's vitamin B12 1000mcg had never been dispensed by the pharmacy.

Telephone interview with Resident #1's primary care provider (PCP) on 03/12/24 at 2:34pm revealed:
-She ordered Resident #1 vitamin B12 1000mcg take 1 tablet daily for bone health.
-She expected the facility to administer Resident #1's medications as ordered.

Interview with a second shift medication aide (MA) on 03/12/24 at 3:30pm revealed:
-She administered Resident #1 vitamin B12 5000mcg on 03/02/24-03/03/24, and 03/09/24 because she did not realize the vitamin B12 was 5000mcg instead of the ordered 1000mcg.
-She did not always compare the medication dosage to the eMAR when she administered medications.

Interview with the facility's Manager on 03/12/24 at 11:55am revealed:
-The SIC was responsible for making sure Resident #1's vitamin B12 dosage on the bottle matched the medication order.
-She did not know why the SIC did not realize the

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C 330	Continued From page 16 dosage on the bottle was 5000mcg instead of the ordered 1000mcg. -The SIC was responsible for medication cart audits weekly and should have compared the medications on the cart to the medication orders. -She expected the MAs and SIC to administer medications as ordered or contact the pharmacy for the correct dosage of medication to be dispensed. Attempted telephone interview with the Administrator on 03/08/24 at 4:09pm was unsuccessful. Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable. _____ The facility failed to ensure medications were administered as ordered for Resident #1 when an extra dose of an anti-anxiety medication, which was ordered to be administered once daily as-needed at bedtime, was documented as administered within 3 hours and 59 minutes on 03/08/24, after the first dose was administered at 7:42pm and may have contributed to Resident #1 falling twice on 03/09/24 and failing to administer a medication to treat constipation after Resident #1 was sent to the local hospital emergency room on 03/08/24 and evaluated for lower abdominal pain and being diagnosed with moderate diffuse bowel distention placing Resident #1 at risk of increased constipation, impaction, and/or increased confusion. This failure was detrimental to the health and safety of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/12/24 for this violation.	C 330		

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C 330	Continued From page 17 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 26, 2024.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 2 of 3 sampled residents (#1 and #2) related to documentation of supplements to treat vitamin D deficiency and vitamin B deficiency (#1) and a blood pressure medication (#2).	C 342		

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C 342	Continued From page 18 The findings are: Review of the facility's undated policies and procedures on medication administration revealed: -The Supervisor-in-Charge (SIC) or Manager was responsible for making sure the pharmacy entered new orders and discontinued orders correctly. -The SIC will ensure any medication changes that occurred during the hours that the SIC is present in the facility were entered into the eMAR correctly by the pharmacy and the medication delivered was correctly labeled. If medication changes occurred after hours, the Supervisor-on-Call was responsible for the above procedure taking place prior to the first medication administration after the change. -The SIC and the facility's Manager will note in the record that all medications are correct. -If corrections need to be made, the SIC will contact the pharmacy by telephone and ensure medications were corrected immediately. -During the medication pass, the medication was selected on the screen, located in the medication cart, compared with the medication on the screen, and once identified as accurate the medication was administered to the resident. -Any exceptions for medication administration were documented in the eMAR. 1. Review of Resident #1's current FL2 dated 02/22/24 revealed diagnoses included dementia. Review of Resident #1's Resident Register dated 02/16/24 revealed an admission date of 02/23/24. a. Review of Resident #1's physician's orders dated 03/04/24 revealed an order for vitamin D3	C 342		

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C 342	Continued From page 19 (a supplement used to increase calcium and phosphorus absorption to build and maintain strong bones) 2000 units (u) take 1 capsule daily. Review of Resident #1's 03/04/24-03/12/24 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 2000u take 1 capsule daily at 8:00am. -There was documentation vitamin D3 2000u was administered from 03/04/24-03/05/24, 03/07/24-03/10/24, and on 03/12/24. -There was documentation vitamin D3 2000u was not administered on 03/06/24 due to Resident #1 was "physically unable to take". -There was documentation vitamin D3 2000u was not administered on 03/11/24 due to not being able to get Resident #1 "awake enough to take". Observation of Resident #1's medications on hand on 03/12/24 at 11:20am revealed: -There was a bottle of vitamin D3 5000u available for administration. -There was no vitamin D3 2000u available for administration. Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 11:20am revealed: -Resident #1 was admitted to the facility on 02/23/24 and brought most of his medications from home including vitamin D3 5000u. -She documented she administered Resident #1 vitamin D3 2000u on 03/04/24, 03/07/24-03/08/24, and 03/12/24 instead of the 5000u available because she did not check the dosage on the bottle before administration. -She did not realize Resident #1's vitamin D3 5000u did not match the physician's order for 2000u. -She was responsible for eMAR audits daily or	C 342		

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when a new order was given to check for accuracy of documentation.
-She was responsible for comparing medication orders to the eMAR and making sure medications and dosages were accurate when compared to what was ordered.
-She knew she was supposed to check medications including the dosage against the eMAR when she administered medications, but she did not always check the dosage.

Interview with a second shift medication aide (MA) on 03/12/24 at 3:30pm revealed:
-She administered Resident #1 vitamin D3 5000u on 03/02/24-03/03/24, and 03/09/24 because she did not realize the vitamin D3 was 5000u instead of the ordered 2000u.
-She did not always compare the medication to the eMAR when she administered medications.

Interview with the facility's Manager on 03/12/24 at 11:55am revealed:
-The SIC was responsible for making sure Resident #1's medications and dosages matched the physician's orders.
-She did not know why the SIC did not realize the dosage on the bottle of vitamin D3 was 5000u instead of the ordered 2000u.
-The SIC was responsible for medication cart audits weekly and should have compared the medications on the cart to the medication orders.
-She expected the MAs and SIC to administer medications as ordered and document the administration on the eMAR accurately.

Attempted telephone interview with the Administrator on 03/08/24 at 4:09pm was unsuccessful.

b. Review of Resident #1's physician's orders

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dated 03/04/24 revealed an order for vitamin B12 (a supplement used to keep blood and nerve cells healthy and prevent anemia that causes tiredness and weakness) 1000mcg take 1 tablet daily.

Review of Resident #1's 03/04/24-03/12/24 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin B12 1000mcg take 1 tablet daily at 8:00am.
-There was documentation vitamin B12 1000mcg was administered from 03/04/24-03/05/24, 03/07/24-03/10/24, and on 03/12/24.
-There was documentation vitamin B12 1000mcg was not administered on 03/06/24 due to Resident #1 was "physically unable to take".
-There was documentation vitamin B12 1000mcg was not administered on 03/11/24 due to not being able to get Resident #1 "awake enough to take".

Observation of Resident #1's medications on hand on 03/12/24 at 11:20am revealed:
-There was a bottle of vitamin B12 5000mcg available for administration.
-There was no vitamin B12 1000mcg available for administration.

Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 11:20am revealed:
-Resident #1 was admitted to the facility on 02/23/24 and brought most of his medications from home including vitamin B12 5000mcg.
-She documented she administered Resident #1 vitamin B12 1000mcg on 03/04/24, 03/07/24-03/08/24, and 03/12/24 instead of the 5000mcg available because she did not check the dosage on the bottle before administration.
-She did not realize Resident #1's vitamin B12 5000mcg did not match the physician's order for

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1000mcg.
-She was responsible for eMAR audits daily or when a new order was given to check for accuracy of documentation.
-She was responsible for comparing medication orders to the eMAR and making sure medications and dosages were accurate when compared to what was ordered.
-She knew she was supposed to check medications including the dosage against the eMAR when she administered medications, but she did not always check the dosage.
-She was responsible for completing medication cart audits weekly on Mondays and compared the medications to the orders including medication dosages.
-She did not check the dosage of Resident #1's vitamin B12 when she completed the cart audit on 03/04/24 or 03/11/24 and only looked to make sure Resident #1's vitamin B12 was available.

Interview with a second shift medication aide (MA) on 03/12/24 at 3:30pm revealed:
-She administered Resident #1 vitamin B12 5000mcg on 03/02/24-03/03/24, and 03/09/24 because she did not realize the vitamin B12 was 5000mcg instead of the ordered 1000mcg.
-She did not always compare the medication dosage to the eMAR when she administered medications.

Interview with the facility's Manager on 03/12/24 at 11:55am revealed:
-The SIC was responsible for making sure Resident #1's medications and dosages matched the physician's orders.
-She did not know why the SIC did not realize the dosage on the bottle of vitamin B12 was 5000mcg instead of the ordered 1000mcg.
-The SIC was responsible for medication cart

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audits weekly and should have compared the medications on the cart to the medication orders.
-She expected the MAs and SIC to administer medications as ordered and document the administration on the eMAR accurately.

Attempted telephone interview with the Administrator on 03/08/24 at 4:09pm was unsuccessful.

2. Review of Resident #2's current FL2 dated 02/12/24 revealed:
-Diagnoses included dementia and hypertension.
-An order for lisinopril (used to treat hypertension) 10mg daily.

Review of Resident #2's Resident Register revealed she was admitted to the facility on 02/13/24.

Review of Resident #2's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for lisinopril 10mg daily.
-Lisinopril 10mg daily was documented as administered daily from 02/14/24 through 02/29/24.

Review of Resident #2's March 2024 eMAR revealed:
-There was an entry for lisinopril 10mg daily.
-Lisinopril 10mg daily was documented as administered daily from 03/01/24 through 03/12/24.

Observation of Resident 2's medications on hand on 03/12/24 at 10:51am revealed:
-Lisinopril 10mg was not available to administer.
-A bottle of lisinopril 2.5mg, that was filled at a local pharmacy on 09/22/23, was available to

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C 342	Continued From page 24 administer. Interview with the Supervisor-in-Charge (SIC) on 03/12/24 at 10:54am revealed: -Resident #2 brought all her medications, including lisinopril 2.5mg, with her when she was admitted to the facility on 02/12/24. -She did not realize the dosage of the lisinopril that Resident #2 brought with her upon admission did not match the order on the FL2. -She was responsible for comparing medication orders to the eMAR and making sure medications and dosages were accurate when compared to what was ordered. -She knew she should but she did not always check the medication against the eMAR when she administered medications. -She completed medication cart audits weekly on Mondays and compared the medications to the orders. -She did not check the unit dosage of Resident #2's lisinopril when she completed the cart audits and only looked to make sure it was lisinopril. Interview with a MA on 03/12/24 at 3:32pm revealed: -She administered lisinopril to Resident #2. -She never noticed that the lisinopril 2.5mg in the medication cart was not the dose listed on the eMAR. -She did not always compare the medication to the eMAR when she administered medications. Interview with the facility's Manager on 03/12/24 at 4:15pm revealed: -Medications should always be checked for accuracy when residents who were admitted to the facility brought their own medications. -The MAs were trained to document correctly on the eMAR and they should always check to	C 342		

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C 342	Continued From page 25 confirm the medication and the dose matched the eMAR.	C 342		