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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 03/19/24 - 03/22/24 with an exit conference via telephone on 03/22/24. The complaint investigation was initiated by the Wilson County Department of Social Services on 03/14/24.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure documentation for 3 of 6 sampled medication aides who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff A, Staff B, Staff D), and the state approved medication clinical skills validation checklist (Staff A). The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 06/19/23 as a medication aide (MA).	D 125		

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D 125	Continued From page 1 -There was no documentation Staff A completed the state approved 5 and 10 or 15-hour medication aide training. -There was no documentation Staff A completed the medication clinical skills validation checklist. Interview with Staff A on 03/21/24 at 6:03pm revealed: -She remembered completing the 15-hour medication training and the medication clinical skills about a year ago. -The training was provided by the facility's contracted Registered Nurse (RN). Review of residents' February 2024 and March 2024 medication administration records (MARs) revealed: -Staff A documented administration of medications on 15 of 29 days from 02/01/24 - 02/29/24 including 02/01/24, 02/05/24, 02/07/24, 02/08/24, 02/10/24 - 02/12/24, 02/16/24, 02/19/24, 02/21/24, 02/24/24 - 02/26/24, 02/28/24, and 02/29/24. -Staff A documented administration of medications on 4 of 21 days from 03/01/24 - 03/21/24 including 03/06/24, 03/07/24, 03/09/24, and 03/10/24. Review of a resident's February 2024 MAR and controlled substance (CS) logs revealed Staff A made errors by documenting administration of Lorazepam (a controlled substance for anxiety and agitation) on the CS log on 02/24/24, 02/25/24, 02/26/24, and 02/28/24 but failed to document the administration of Lorazepam on the February 2024 MAR on those 4 occasions, rendering the MAR inaccurate. Telephone interview with the facility's contracted RN on 03/22/24 at 1:40pm.	D 125		

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-She provided clinical services to the facility that included medication clinical skills validations about a year ago.
-She remembered providing the medication clinical skills check for Staff A.
-She did not keep documentation of the training and provided the document to the facility.
-She did not provide the 5-hour and 10-hour or 15-hour medication training services to the facility that may have been done by the previous contracted RN.

Refer to interview with the Director of Resident Care (DRC) and the Administrator on 03/22/24 at 10:56am.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 12/15/23 as a medication aide (MA).
-There was no documentation Staff B completed the state approved 5-hour and 10-hour, or 15-hour medication aide training.

Review of residents' February 2024 and March 2024 medication administration records (MARs) revealed:
-Staff B documented the administration of medications on 6 of 29 days from 02/01/24 - 02/29/24 including 02/01/24, 02/08/24, 02/15/24, 02/22/24, 02/24/24, and 02/25/24.
-Staff B documented the administration of medications on 7 of 21 days from 03/01/24 - 03/21/24 including 03/04/24, 03/07/24, 03/11/24, 03/13/24, 03/14/24, 03/15/24, and 03/18/24.

Attempted telephone interview with Staff B on 03/22/24 at 1:45pm was unsuccessful.

Refer to interview with the Director of Resident Care (DRC) and the Administrator on 03/22/24 at

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D 125	Continued From page 3 10:56am. 3. Review of Staff D's personnel record revealed: -Staff D was hired on 09/23/17 as a medication aide (MA). -There was no documentation Staff D completed the state approved 5-hour and 10-hour or 15-hour medication aide training. Review of residents' February 2024 and March 2024 medication administration records (MARs) revealed: -Staff D documented administration of medications on 2 of 29 days from 02/01/24 - 02/29/24 including 02/18/24 and 02/19/24. -Staff D documented administration of medications on 4 of 21 days from 03/01/24 - 03/21/24 including 03/03/24, 03/04/24, 03/17/24, and 03/18/24. Review of a resident's March 2024 MAR revealed: -Staff D made errors by documenting not administering Morphine (a controlled substance used to treat severe pain and breathing difficulties associated with end of life symptoms) as ordered. -Staff D documented holding Morphine on 03/03/24 and 03/04/24 due to the resident being asleep but Morphine was ordered to be administered if awake or asleep. Attempted telephone interview with Staff D on 03/22/24 at 1:47pm was unsuccessful. Refer to interview with the Director of Resident Care (DRC) and the Administrator on 03/22/24 at 10:56am. _____ Interview with the DRC and the Administrator on	D 125		

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D 125	Continued From page 4 03/22/24 at 10:56am revealed: -The Business Office Manager (BOM) or Administrator were responsible for ensuring staff records were up-to-date and contained the required information and training. -An audit of staff records should be conducted every 6 months. -She did not know when the last audit of staff records was conducted. -The facility had a contracted RN that provided the medication clinical skills validation check off for staff. -She contacted the pharmacy to provide the 5-hour, 10-hour and 15-hour medication aide training for staff. Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration. Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration. Refer to Tag 399 10A NCAC 13F .1008(a) Controlled Substances. _____ The facility failed to provide documentation that Staff A, B, and D were qualified to administer medications to residents as evidenced by staff not completing the required state approved 5 and 10 or 15-hour medication aide training and the medication clinical skills validation checklist resulting in medication errors and inaccurate MARs. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/22/24 for this violation.	D 125		

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D 125	Continued From page 5 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 6, 2024.	D 125		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon 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 ensure clarification of medication orders for 1 of 7 sampled residents (#5) including a medication used to treat chronic pain. The findings are: Review of Resident #5's current FL-2 dated 01/16/24 revealed: -Diagnoses included fibromyalgia, trigeminal neuralgia and anxiety disorder. -The resident was ordered Gabapentin 600mg three times a day for chronic pain. (Gabapentin may be used to treat nerve pain.) Review of Resident #5's Resident Register revealed the resident admitted to the facility	D 344		

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01/18/24.

Review of Resident #5's January 2024 medication administration record (MAR) revealed:
-There was an entry for Gabapentin 600mg three times daily for chronic pain.
-Staff documented Gabapentin 600mg was administered to Resident #5 three times daily from 01/19/24 to 01/31/24.
-There were no additional entries for different dosages Gabapentin.

Review of Resident #5's February 2024 MAR revealed:
-There was an entry for Gabapentin 600mg three times daily for chronic pain.
-Staff documented Gabapentin 600mg was administered three times daily 02/01/24 through 02/10/24.
-The entry for 600mg Gabapentin three times a day was marked discontinued on 02/11/24.
-Gabapentin 600mg three times daily was not documented as administered from 02/11/24 to 02/29/24.
-There were no additional entries for different dosages of Gabapentin.

Review of Resident #5's March 2024 MAR from 03/01/24 - 03/19/24 revealed:
-There was an entry for Gabapentin 600mg three times daily for chronic pain.
-The entry for 600mg Gabapentin three times a day was marked discontinued on 02/11/24.
-Gabapentin 600mg three times daily was not documented as administered 03/01/24 to 03/19/24.
-There were no additional entries for different dosages of Gabapentin.

Interview with the Director of Resident Care

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(DRC) on 03/20/24 at 11:38am revealed Resident #5 had recently switched pharmacies, but she was not sure of the actual date for the change in service.

Telephone interview with a Pharmacy Technician at the facility's contracted pharmacy on 03/20/24 at 3:10pm revealed:
-Resident #5 was admitted to their services on 01/18/24 as a "profile only" resident.
-A profile only resident was usually in place when the resident used a different primary pharmacy, but the contracted pharmacy could provide refills of medications upon the facility's request.
-The pharmacy had a current order for Gabapentin 600mg three times a day for chronic pain dated 01/16/24.
-The pharmacy did not have any orders to discontinue Gabapentin 600mg three times daily.

Telephone interview with a Pharmacy Technician at Resident #5's previous pharmacy on 03/20/24 at 3:36pm revealed:
-The resident had current orders, dated 01/17/24, for Gabapentin 300mg in the morning, 300mg at noon and 600 mg at night for other diseases of the neurological system.
-There was an order dated 01/17/24, to discontinue Gabapentin 600mg three times daily and start Gabapentin 300mg in the morning, 300mg at noon and 2 tablets (600mg) at night.

Interview with a medication aide (MA) on 03/21/24 at 4:45pm revealed:
-Resident #5's family member brought a new medication bubble pack to the facility with a new dosage of Gabapentin on 02/11/24.
-The family member did not have the signed medication order, so the MA called the pharmacy to clarify the order on 02/11/24.

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-The pharmacy told the MA the 600mg Gabapentin three times daily had been discontinued.
-The pharmacy faxed the order to the facility and the MA attached the order to the medication bubble pack and placed it back in the medication cart.
-She was not aware Resident #5 had an order to start Gabapentin 300mg in the morning, 300mg at noon and 2 tablets (600mg) at night, so she did not enter that order on Resident #5's MAR.
-She wrote the entry to discontinue the Gabapentin on Resident #5's MAR.
-She was not able to locate the order she had attached to the bubble pack
-She had not contacted the resident's primary care provider (PCP) or pain clinic provider because she thought the pharmacy had clarified the order and sent the order to the facility.

Interview with Resident #5's PCP on 03/21/24 at 2:25pm revealed:
-Facility staff told her that the resident's Gabapentin 600mg three times daily was discontinued by the resident's pain clinic provider on 02/11/24.
-She did not see the discontinue order in the resident's chart, but she did not manage the resident's Gabapentin as it was managed by the pain clinic's medical provider.
-She was not aware of the orders that the pharmacy had for Gabapentin 300mg in the morning, 300mg at noon and 600mg at night.
-She was concerned the facility had not contacted the pain clinic provider to obtain clarification for Resident #5's orders for Gabapentin when the family brought in the new medication packs.

Interview with the Administrator on 03/21/24 at 5:18pm revealed when the MA received the new

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D 344	Continued From page 9 medication pack from Resident #5's family member, she should have contacted the pharmacy for the orders and she should have contacted the residents PCP or pain clinic provider to obtain clarification before she discontinued the Gabapentin on MAR. Attempted telephone interviews with Resident #5's medical provider at the pain clinic on 03/21/24 at 8:26am and 12:41pm, were unsuccessful.	D 344		
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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#9, #10) observed during the medication pass including errors with a topical antifungal powder and a topical antibiotic ointment (#9) and a medication for mild to moderate pain (#10); and for 5 of 7 sampled residents (#2, #4, #5, #7, #8) including errors with a narcotic used to treat pain and shortness of breath at end of life (#7, #8), a narcotic used to treat anxiety (#7), a medication	D 358		

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used to treat nerve pain and chronic pain (#5), an antipsychotic (#2), and a diuretic for excess fluid and swelling (#4).

The findings are:

1. The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the 8:00am and 9:00am medication passes on 03/20/24.

a. Review of Resident #9's most recent FL-2 dated 03/02/23 revealed diagnoses included Alzheimer's disease, paroxysmal atrial fibrillation, essential hypertension, and major depressive disorder.

Review of Resident #9's primary care provider (PCP) order dated 03/07/24 at 12:37pm revealed an order for Triple Antibiotic Ointment, apply and bandage to left foot wound once daily until healed. (Triple Antibiotic Ointment is a topical medication used to treat infections.)

Observation of the 9:00am medication pass on 03/20/24 revealed:
-The medication aide (MA) prepared and administered oral medications at 8:35am and a topical medicated powder at 8:36am.
-The MA did not prepare or attempt to apply Triple Antibiotic Ointment to Resident #9 when the resident received her other medications scheduled for 9:00am.

Interview with the MA on 03/20/24 at 8:50am revealed she had completed administering all scheduled morning medications for Resident #9.

Review of Resident #9's March 2024 medication administration record (MAR) revealed:

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D 358	Continued From page 11 -There was a handwritten entry to apply Triple Antibiotic Ointment and bandage to left foot wound once daily until healed with a start date of 03/07/24. -Triple Antibiotic Ointment was scheduled for administration at 9:00am. -Triple Antibiotic Ointment was documented as administered daily from 03/07/24 - 03/19/24. -Documentation for Triple Antibiotic Ointment for 03/20/24 was blank with no reason noted. Observation of Resident #9's medications on hand on 03/20/24 at 11:05am revealed: -There was no Triple Antibiotic Ointment for Resident #9 available for administration. -There was no house stock supply or first aid kit supply of Triple Antibiotic Ointment available for administration. Second interview with the MA on 03/20/24 at 11:05am revealed: -New medication orders were either sent to the pharmacy via electronic prescription (e-script) by the provider or the MAs faxed new orders to the pharmacy. -She did not recall if she was on duty when Resident #9's order for Triple Antibiotic Ointment was received. -She did not know if Resident #9's order for Triple Antibiotic Ointment was faxed to the pharmacy. -She usually administered Resident #9's Triple Antibiotic Ointment after she finished administering oral medications. -She did not administer Resident #9's Triple Antibiotic Ointment that morning, 03/20/24, because she could not find any in the medication cart to administer. -She used a house stock tube of Triple Antibiotic Ointment to apply to Resident #9's wound yesterday, 03/19/24, but she could not find it	D 358		

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today.
-The tube was not empty yesterday, so she was not sure why it was not in the cart today.
-She had also used some small packets of Triple Antibiotic Ointment from the facility's first aid kit in the past but they did not have any more of those packets.

Observation of Resident #9 with the MA and the hospice nurse on 03/20/24 at 11:19am revealed there was a 1cm round unopened yellow area surrounded by red tissue about the size of a dime on the resident's left foot on a bony prominence below the great toe.

Interview with Resident #9's hospice nurse on 03/20/24 at 11:19am revealed:
-This was the first time she had seen the resident's foot wound.
-The resident's foot wound was red and needed the Triple Antibiotic Ointment to be applied as ordered by the PCP.
-It was important to use the Triple Antibiotic Ointment on the foot wound because she did not want the wound to open which could increase the risk of infection.

Interview with the Memory Care Director (MCD) on 03/20/24 at 11:46am revealed:
-The PCP usually sent e-scripts to the pharmacy.
-She told the MAs to always fax orders to the pharmacy as well.
-She was not aware Resident #9's order for Triple Antibiotic Ointment was not received by the pharmacy and none was dispensed for the resident.
-The facility did not have standing orders, so they did not keep house stock medications.
-The facility's first aid kit usually had some packets of Triple Antibiotic Ointment.

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D 358	Continued From page 13 Interview with the Director of Resident Care (DRC) on 03/20/24 at 1:00pm revealed: -The facility usually had small packets of Triple Antibiotic Ointment in the first aid kits. -The pharmacy usually sent medication for each individual resident after receiving an order. -Resident #9 should have received her own supply of Triple Antibiotic Ointment when the medication was ordered by the PCP. -The MCD was responsible for ensuring new orders were transcribed onto the MARs, faxed to the pharmacy, and implemented. Interview with the Administrator on 03/20/24 at 1:17pm revealed: -The MAs usually sent medication orders to the pharmacy via fax. -Once an order was faxed to the pharmacy, the pharmacy would send the medication to the facility. -Resident #9's order for Triple Antibiotic Ointment should have been sent to the pharmacy to be dispensed by the pharmacy. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/20/24 at 3:20pm revealed: -They had not dispensed any Triple Antibiotic Ointment for Resident #9 since one 28-gram tube was dispensed in October 2022. -The pharmacy did not receive Resident #9's order for Triple Antibiotic Ointment dated 03/07/24. -If the pharmacy had received the order, they would have dispensed and sent the medication to the facility when received. Interview with Resident #9's PCP on 03/21/24 at 2:21pm revealed:	D 358		

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-She wrote the order for Triple Antibiotic Ointment to be applied due to the redness on the resident's foot.
-She did not want the area to open which would require further wound care to prevent infection.

Interview with Resident #9 on 03/20/24 at 11:10am revealed:
-The resident was unable to answer specific questions about her medication.
-The resident denied any current foot pain.

b. Review of Resident #9's most recent FL-2 dated 03/02/23 revealed an order for Nystatin Powder 100,000 units/gram, apply to right lower abdomen every day. (Nystatin Powder is a topical powder used to treat fungal infections of the skin.)

Review of Resident #9's physician's orders dated 08/30/23 and 12/21/23 revealed orders for Nystatin Powder 100,000 units/gram, apply under breasts and abdominal skin folds once daily.

Observation of the 9:00am medication pass on 03/20/24 revealed:
-The medication aide (MA) prepared and administered Nystatin Powder under Resident #9's abdominal folds.
-The areas under Resident #9's abdominal folds had pink rashes.
-The MA lifted Resident #9's breasts but did not apply any Nystatin Powder under her breasts.
-The area under Resident #9's breasts were clear with no rashes observed.
-The MA did not apply Nystatin Powder under the resident's breasts as ordered.

Review of Resident #9's March 2024 medication administration record (MAR) revealed:

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-There was a handwritten entry for Nystatin Powder 100,000 units/gram apply under breasts, abdomen daily scheduled for 9:00am.
-Nystatin Powder was documented as administered daily from 03/01/24 - 03/20/24.

Observation of Resident #9's medications on hand on 03/20/24 at 11:37am revealed:
-There was a supply of Nystatin Powder dispensed on 09/19/23 with instructions to apply topically to lower abdomen 4 times a day as needed for skin irritation.
-There was a supply of Nystatin Powder dispensed on 09/28/23 with instructions to apply to right groin twice daily for 10 days.

Interview with the MA on 03/20/24 at 11:34am revealed:
-She did not apply Nystatin Powder under Resident #9's breast because the skin was not red.
-She did not notice the instructions on the MAR were to apply under the breasts as well.
-She thought the order to apply Nystatin Powder under the resident's breast had been discontinued.

Interview with the Director of Resident Care (DRC) on 03/20/24 at 1:00pm revealed:
-The MAs should apply the Nystatin Powder to the areas indicated in the order.
-If an area was healed, the MAs should notify the resident's provider to see if the order could be discontinued.
-Until there was a discontinue order, the MAs should follow the order to administer the medication, including under the breasts.

Interview with the Administrator on 03/20/24 at 1:17pm revealed:

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-The MA should administer Nystatin Powder where it was ordered to be administered.
-The MA should notify the resident's provider if an area was healed.

Interview with Resident #9's primary care provider (PCP) on 03/21/24 at 2:21pm revealed:
-Resident #9 had experienced a consistent fungal rash under her breasts and abdominal folds with itching, burning, and discomfort.
-Nystatin Powder was ordered to help treat and prevent fungal rashes.
-She was concerned if Nystatin Powder was not applied under the resident's breasts, the rash would reoccur in that area.

Interview with Resident #9 on 03/20/24 at 11:10am revealed:
-The resident was unable to answer specific questions about her medication.
-The resident denied any current symptoms of burning, itching, or discomfort under her breasts.

c. Review of Resident #10's current FL-2 dated 11/06/23 revealed diagnosis included dementia.

Review of Resident #10's physician's order dated 12/14/23 revealed an order for Acetaminophen 325mg 2 tablets twice a day. (Acetaminophen is used to treat mild to moderate pain.)

Observation of the 9:00am medication pass on 03/20/24 revealed:
-The medication aide (MA) prepared and administered 1 Acetaminophen 325mg tablet to Resident #10 at 8:46am.
-The MA administered 1 Acetaminophen 325mg tablet instead of 2 tablets as ordered.

Review of Resident #10's March 2024 medication

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administration record (MAR) revealed:
-There was an entry for Acetaminophen 325mg 2 tablets 2 times a day scheduled for 9:00am and 8:00pm.
-Acetaminophen 325mg was documented as administered from 03/01/24 - 03/20/24 (9:00am).

Observation of Resident #10's medications on hand on 03/20/24 at 11:05am revealed:
-There was a supply of Acetaminophen 325mg tablets dispensed on 03/06/24 with instructions to take 2 tablets 2 times a day.
-There were 15 of 30 Acetaminophen 325mg tablets remaining in the bubble card.

Interview with the MA on 03/20/24 at 11:05am revealed:
-She usually administered 2 Acetaminophen 325mg tablets to Resident #10.
-She thought she administered 2 Acetaminophen 325mg tablets to Resident #10 that morning, 03/20/24.
-The resident received Acetaminophen because she usually complained of left hip and left knee pain.
-Resident #10 should have received 2 Acetaminophen 325mg tablets that morning on 03/20/24; it was an oversight.

Interview with the Memory Care Director (MCD) on 03/20/24 at 11:48am revealed:
-The MA should have administered 2 Acetaminophen 325mg tablets to Resident #10 that morning on 03/20/24.
-The MAs were supposed to read the MARs when administering medications and administer the medications according to the orders.

Interview with the Director of Resident Care (DRC) on 03/20/24 at 1:00pm revealed:

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-The MAs should read the MARs and medication labels and administer medication as ordered.
-Resident #10 should have been administered 2 Acetaminophen 325mg tablets instead of 1 tablet on 03/20/24.

Interview with the Administrator on 03/20/24 at 1:17pm revealed the MAs were supposed to compare the medication labels and MARs and administer the medications as ordered.

Interview with Resident #10's primary care provider (PCP) on 03/21/24 at 2:21pm revealed:
-Resident #10 was prescribed Acetaminophen for arthritis pain.
-Receiving only half the dose of Acetaminophen could increase the resident's arthritic pain.

Based on observations, interviews, and record reviews, it was determined that Resident #10 was not interviewable.

Observation of Resident #10 on 03/20/24 at 10:54am revealed:
-There were 2 staff in the room providing incontinence care to Resident #10, including the MA who was administering an arthritis gel to the resident's left knee and left hip.
-Resident #10 moaned and grimaced when staff turned her from side to side during incontinence care and application of the arthritis gel.

Interview with the MA on 03/20/24 at 10:54am revealed the resident usually moaned when they provided care to the resident because of the resident's hip and knee pain.

2. Review of Resident #7's closed record FL-2 dated 01/25/24 revealed diagnoses included anxiety disorder, atrial fibrillation, heart failure,

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age-related osteoporosis, and insomnia.

a. Review of Resident #7's closed record FL-2 dated 01/25/24 revealed an order for Morphine Sulfate 100mg/5ml Solution prefilled syringes give 0.5ml (10mg) every 4 hours as needed (prn) for pain/shortness of breath. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.)

Review of Resident #7's facility nurses' notes dated 02/14/24 (7:00am - 3:00pm) revealed:
-The resident returned to the facility with a broken arm from a fall during the previous night.
-Hospice was contacted.
-The resident was in pain.
-Facility staff would continue to monitor the resident.

Review of Resident #7's primary care provider (PCP) electronic prescription (e-script) dated 02/28/24 at 7:20pm revealed an order for Morphine 100mg/5ml take 0.5ml every 4 hours, scheduling Morphine due to increased pain, decline in resident's condition, and per family's request.

Review of Resident #7's February 2024 medication administration record (MAR) revealed:
-There was an entry for Morphine Sulfate 100mg/5ml Solution prefilled syringes give 0.5ml (10mg) every 4 hours prn for pain/shortness of breath.
-There were 12 doses of prn Morphine Sulfate documented as administered from 02/16/24 - 02/28/24.
-There was a handwritten entry for Morphine 100mg/5ml give 1 syringe (0.5ml) every 4 hours for pain or shortness of breath scheduled at

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9:00am, 1:00pm, 5:00pm, 9:00pm, 1:00am, and 5:00am.
-The first dose of scheduled Morphine was documented as administered on 02/29/24 at 9:00am and again at 1:00pm, 5:00pm, and 9:00pm.
-There was no scheduled dose of Morphine documented as administered on 02/28/24 when it was ordered to be administered via e-script at 7:20pm.
-The resident would have been due to receive scheduled Morphine on 02/28/24 at 9:00pm and on 02/29/24 at 1:00am and 5:00am.

Review of Resident #7's March 2024 MAR dated 03/01/24 - 03/22/24 revealed:
-There was an entry for Morphine 100mg/5ml prefilled syringes give 0.5ml (10mg) every 4 hours for pain/shortness of breath scheduled at 9:00am, 1:00pm, 5:00pm, 9:00pm, 1:00am, and 5:00am.
-The scheduled Morphine was documented as administered on 3 occasions at 1:00am, 5:00am, and 9:00am on 03/01/24.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/21/24 at 5:00pm revealed:
-The pharmacy only dispensed Morphine for Resident #7 one time on 07/11/23.
-The pharmacy dispensed 30 prefilled syringes of Morphine 100mg/5ml on 07/11/23.

Review of Resident #7's pharmacy dispensing records from the facility's contracted pharmacy for Morphine dated 07/01/23 - 03/20/24 revealed:
-There were 30 prefilled syringes of Morphine 100mg/5ml dispensed on 07/11/23.
-There were no other supplies of Morphine dispensed for Resident #7.

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D 358	Continued From page 21 Review of Resident #7's controlled substance (CS) logs for Morphine 100mg/5ml revealed: -There was a supply of 30 prefilled syringes with Morphine Sulfate 100mg/5ml received on 07/12/23 with instructions to give 0.5ml (10mg) every 4 hours prn for pain/shortness of breath. -The first prn dose of Morphine was documented as administered at 10:15am on 10/29/23. -There were prn doses of Morphine documented as administered at 11:35am and 8:00pm on 02/28/24. -The next documented dose of Morphine was administered on 02/29/24 at 9:00am, a 13-hour gap from the dosage administered at 8:00pm on 02/28/24 when the resident should have received a scheduled dose every 4 hours. -There were 19 doses of Morphine documented as administered from 10/29/23 through 1:00pm on 02/29/24, leaving a balance of 11. -There was handwritten documentation that the prn dose was discontinued on 02/29/24 at 1:15pm. -There was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 100mg/5ml documented as received (carried over from the supply received on 07/12/23). -The instructions on the handwritten CS log were to give 1 syringe (0.5ml) every 4 hours for pain or shortness of breath. -The first dose was documented as administered at 2:20pm on 02/29/24. -There were 2 other doses documented as administered at 6:00pm and 10:00pm on 02/29/24. -There were 3 doses documented as administered on 03/01/24 at 2:00am, 6:00am, and 9:00am, leaving a balance of 5 syringes. -The last dose documented was on 03/01/24 at	D 358		

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D 358	Continued From page 22 9:00am, then handwritten documentation indicated, "resident deceased". Review of Resident #7's hospice note dated 03/01/24 revealed the resident's time of death was 9:50am on 03/01/24. Interview with a MA on 03/21/24 at 2:49pm revealed: -Resident #7 was in pain because she had broken her arm. -The resident was short of breath and always on oxygen. -Morphine helped with the resident's pain and shortness of breath. -She did not always administer the Morphine because if the resident was "knocked out cold", she did not want to put more in the resident's mouth. -The MAs were responsible for implementing order changes when the order was received. -She was not sure why Resident #7's scheduled Morphine order was not started until the next day after it was received. -There was a supply of Morphine on hand that could be used for the scheduled Morphine because it was the same dosage. Telephone interview with a second MA on 03/21/24 at 5:16pm revealed: -She did know why there was a delay in transcribing Resident #7's scheduled Morphine order. -She did not know who transcribed the order on the MAR because there were no initials documented. -She administered prn Morphine to Resident #7 before the order was changed to schedule because the resident was in distress, yelling really loud.	D 358		

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-She passed on to first shift staff and hospice that resident was in distress.
-When she administered the prn Morphine, the resident would yell less and rest for a while until it wore off.
-She did not notice any breathing issues with the resident.

Interview with the Director of Resident Care (DRC) on 03/21/24 at 3:07pm revealed:
-Any MA on duty at the time an order was received was responsible for transcribing orders on the MARs.
-There were new order tracking forms that could be used to track the medication orders.
-She usually got the medication orders and used the tracking form to track the orders.
-She was not sure why there was a delay in the MAs transcribing Resident #7's scheduled Morphine order onto the MAR.
-She had to remind the MAs to check the fax machine at the front office for orders because the orders did not usually go to the fax machine in the medication room.

Telephone interview with Resident #7's hospice nurse on 03/21/24 at 4:30pm revealed:
-Resident #7's Morphine was changed to scheduled due to increased pain all over and decline in her condition.
-Resident #7 had pain to touch all over as she had facial grimacing, moaning, and calling out "help me, help me".
-Resident #7 also had increased pain due to a broken arm from a fall.

Telephone interview with Resident #7's PCP on 03/19/24 at 2:56pm revealed:
-On 02/28/24, the hospice nurse called her and said Resident #7 had tachypnea (abnormally

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rapid breathing) so she changed the order for Morphine to be scheduled every 4 hours around 7:30pm that night.
-She faxed the order to the facility on 02/28/24 around 7:30pm.
-When she arrived to the facility the next morning, 02/29/24, the resident had increased work of breathing, shortness of breath, and agitation.
-She checked the MAR and the Morphine order had not been changed to scheduled.
-The facility staff indicated they did not receive the order but she received fax confirmation that the order was received when faxed on 02/28/24.

A second interview with Resident #7's PCP on 03/21/24 at 1:50pm revealed:
-Resident #7's scheduled Morphine order went directly to the facility via fax and email at the date and time stamped on the prescription.
-She did not send a copy of the Morphine order increasing to a scheduled dose to the pharmacy because the resident already had Morphine available for administration at the facility and did not need any sent from the pharmacy.
-At least 2 or 3 doses of the scheduled Morphine should have been administered from the time the order was received on 02/28/24 until the MAs started administering it the next day, 02/29/24.
-The resident was really agitated, visibly uncomfortable, fidgety, and moaning a little on the morning of 02/29/24.
-After the resident received the scheduled Morphine dose at 9:00am on 02/29/24, the resident's symptoms improved.
-The resident was no longer moaning and she was resting and asleep.

Attempted telephone interview with Resident #7's family member on 03/21/24 at 12:40pm was unsuccessful.

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D 358	Continued From page 25 b. Review of Resident #7's current FL-2 dated 01/25/24 revealed: -There was an order for Lorazepam 0.5mg take 1 tablet every day for sleep. (Lorazepam is a controlled substance used to treat anxiety, agitation, and restlessness.) -There was an order for Lorazepam 0.5mg take 1 tablet every 4 hours as needed (prn) for anxiety or agitation or restlessness. Review of Resident #7's primary care provider (PCP) verbal orders dated 02/29/24 revealed: -There was an order to discontinue Lorazepam 0.5mg at bedtime. -There was an order to discontinue Lorazepam 0.5mg every 4 hours prn. -There was an order to start Lorazepam 0.5mg give 1 tablet every 4 hours for agitation, may crush and put in sides of cheeks. -There was an electronic prescription (e-script) dated 02/29/24 at 10:26am for Lorazepam 0.5mg every 4 hours with a quantity of 120 tablets to be dispensed. Review of Resident #7's January 2024 medication administration record (MAR) revealed: -There was an entry for Lorazepam 0.5mg 1 tablet every day for sleep scheduled for 8:00pm. -Documentation for the scheduled Lorazepam had circled initials from 01/27/24 - 01/31/24 with no reason noted to indicate why Lorazepam was not administered. Review of Resident #7's February 2024 MAR revealed: -There was an entry for Lorazepam 0.5mg 1 tablet every day for sleep scheduled for 8:00pm. -Documentation for the 8:00pm dose of Lorazepam 0.5mg was blank 02/01/24 and	D 358		

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02/15/24 with no reason documented as to why Lorazepam was not administered.
-Lorazepam 0.5mg was documented as not administered from 02/02/24 - 02/11/24 and 02/18/24 due to "awaiting pharmacy".
-Lorazepam 0.5mg was documented as administered at 8:00pm from 02/12/24 - 02/14/24 and on 02/19/24, then noted to be discontinued.
-There was a second entry for Lorazepam 0.5mg 1 tablet every 4 hours prn for anxiety or agitation or restlessness.
-The prn Lorazepam was documented as administered on one occasion on 02/19/24 at 4:00am for anxiety.
-There was a third handwritten entry for Lorazepam 0.5mg give 1 tablet every 4 hours for agitation scheduled for administration at 9:00am, 1:00pm, 5:00pm, 9:00pm, 1:00am, and 5:00am.
-Lorazepam 0.5mg was documented as administered at 5:00pm and 9:00pm on 02/29/24.
-The Lorazepam 0.5mg doses for 1:00am and 5:00am on 02/29/24 were blank with no reason noted.

Review of Resident #7's March 2024 MAR revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet at bedtime for sleep schedule for 8:00pm.
-There was no Lorazepam 0.5mg at bedtime documented as administered in March 2024.
-There was a second entry for Lorazepam 0.5mg 1 tablet every 4 hours scheduled for 9:00am, 1:00pm, 5:00pm, 9:00pm, 1:00am, and 5:00am.
-Lorazepam 0.5mg was documented as administered on 3 occasions at 1:00am, 5:00am, and 9:00am on 03/01/24.

Review of Resident #7's hospice note dated 03/01/24 revealed the resident's time of death was 9:50am.

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D 358	Continued From page 27 Review of Resident #7's controlled substance (CS) logs for Lorazepam 0.5mg revealed: -There was a CS log with 15 Lorazepam 0.5mg tablets received on 01/09/24. -There were 15 Lorazepam 0.5mg tablets documented as administered from 01/11/24 at 8:00pm through 01/25/24 at 8:00pm, leaving a balance of 0. -There was no CS log indicating any doses of Lorazepam 0.5mg were administered as ordered at 8:00pm from 01/26/24 - 02/11/24. -There was a CS log with 30 Lorazepam 0.5mg tablets received on 02/12/24 and administration of Lorazepam started again on 02/12/24 at 8:00pm. Review of Resident #7's pharmacy dispensing records from the facility's contracted pharmacy for Lorazepam dated 07/01/23 - 03/20/24 revealed: -There were 15 Lorazepam 0.5mg tablets dispensed on 07/08/23, 08/08/23, 09/13/23, 10/05/23, 11/09/23, 12/10/23, 12/23/23, and 01/06/24. -There were 30 Lorazepam 0.5mg tablets dispensed on 08/08/23, 08/31/23, and 02/11/24. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/21/24 at 5:00pm revealed: -The pharmacy dispensed 15 Lorazepam 0.5mg tablets on 01/06/24. -The facility requested a refill on the Lorazepam on 02/08/24 but there were no refills. -The pharmacy faxed the facility on 02/08/24 and let them know they needed a new prescription for the Lorazepam. -A new prescription was received and dispensed on 02/11/24 with 30 Lorazepam 0.5mg tablets.	D 358		

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D 358	Continued From page 28 Interview with a medication aide (MA) on 03/21/24 at 2:49pm revealed: -If a medication was unavailable, the MAs should call the pharmacy and the provider. -She was not sure about Resident #7's Lorazepam being unavailable or discontinued. -She did not recall issues with the resident's Lorazepam. Interview with the Director of Resident Care (DRC) on 03/21/24 at 3:07pm revealed: -The MAs were responsible for ordering medications. -If a medication was unavailable, the MAs were supposed to notify her and the provider. -She was not aware Resident #7's Lorazepam had been unavailable and not administered as ordered. Interview with Resident #7's PCP on 03/21/24 at 1:50pm revealed: -Resident #7's bedtime dose of Lorazepam was not discontinued until 02/29/24 when she increased the scheduled dose to every 4 hours and discontinued the prn Lorazepam. -The resident should have continued to receive the scheduled bedtime dose of Lorazepam until that time. -She was not aware the resident missed any doses during that time and it should not have been documented as discontinued until the verbal order on 02/29/24 changing it to every 4 hours. -The resident was "real agitated and anxious" which was the reason she increased the scheduled dose. -Not receiving the Lorazepam during that time probably contributed to the resident's anxiety and agitation. -She was not aware the Lorazepam was	D 358		

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unavailable during that time.
-If the facility needed a new hard prescription, they could contact her because their office had service available 24 hours a day if needed.
-She was also at the facility every Monday and Thursday and they could request a prescription if needed.
-The facility staff should let her know a new prescription was needed when they got down to a 5-day supply.

3. Review of Resident #8's closed record FL-2 dated 08/23/23 revealed diagnoses included dementia and hypertension.

Review of Resident #8's primary care provider (PCP) note dated 02/28/24 revealed:
-The resident was started on an antibiotic on 02/27/24 for treatment of a presumed respiratory infection.
-Today, 02/28/24, the resident's condition had deteriorated substantially.
-The resident had a respiratory rate of 60 breaths per minute and did not appear to be comfortable.
-After discussion with the resident's family, the resident was started on as needed (prn) Morphine for management of shortness of breath. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.)
-The resident was on oxygen via nasal cannula today as well.

Review of Resident #8's PCP order dated 02/28/24 revealed:
-There was an electronic prescription (e-script) for Morphine 10mg/0.5ml Oral Solution, take 0.5ml every 4 hours as needed for pain or shortness of breath.
-It was electronically signed on 02/28/24 at

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7:17pm.
-There was documentation the order was sent via fax and email to the facility on 02/28/24 at 7:19pm.

Review of Resident #8's hospice visit note by the hospice social worker (SW) dated 03/01/24 revealed:
-Upon SW arrival, the resident was laying supine in bed.
-The resident appeared to be declining.
-The resident complained of pain all over.
-The hospice nurse was aware.

Review of Resident #8's hospice visit note by the hospice nurse dated 03/01/24 revealed:
-The resident was tachycardic (fast heart rate) with tachypnea (abnormally rapid breaths).
-The resident complained of pain, had facial grimacing, and was sore to touch.
-The hospice nurse noted the resident had an order for Morphine scheduled every 4 hours.

Review of Resident #8's hospice verbal order dated 03/01/24 revealed an order for Morphine Sulfate 100mg/5ml give 0.5ml every 4 hours scheduled.

Review of Resident #8's note signed by a hospice nurse on 03/02/24 revealed:
-The facility's concern was the resident's scheduled Morphine was possibly too strong.
-The hospice nurses' suggestion was a possible decrease in Morphine after reassessment on 03/03/24.

Review of Resident #8's hospice order dated 03/03/24 revealed:
-The resident was actively dying, continue comfort medications.

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-Give scheduled Morphine if the resident was awake or asleep.
-A second note again indicated "administer Morphine if pt (patient) awake or asleep".

Review of a second hospice order on 03/03/24 for Resident #8 revealed:
-The resident was actively dying, having respiratory distress.
-The resident was comfortable but uncomfortable with respiratory changes when moved/repositioned.
-There was an order to increase scheduled Morphine from every 4 hours to every 2 hours for severe pain or respiratory distress, do not hold, administer if the resident awake or asleep.

Review of Resident #8's February 2024 medication administration record (MAR) revealed:
-There was a handwritten entry for Morphine Sulfate 0.5ml every 4 hours for severe pain or shortness of breath.
-There was no Morphine documented as administered in February 2024.
-There were no other orders for Morphine transcribed onto the February 2024 MAR.

Review of Resident #8's March 2024 MAR revealed:
-There was a handwritten entry for Morphine Sulfate 100mg/5ml take 0.5ml every 4 hours as needed for pain or shortness of breath.
-There was no prn Morphine documented as administered for this entry.
-There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am.
-There was a handwritten note underneath the

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entry dated 03/03/24 with an asterisk and instructions to administer if awake or asleep.
-Morphine was documented as not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am due to the resident asleep/no distress.
-Staff initials were circled on 03/01/24 at 8:00am and 8:00pm with no reason for not administering the medication.
-There was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, and 6:00am.
-The first documented dose was administered at 10:00pm on 03/03/24.
-A second dose was documented as administered at 12:00am on 03/04/24.
-There were no other doses documented as administered in March 2024.
-There was a handwritten note that the resident expired on 03/04/24 at 12:37am.

Review of Resident #8's controlled substance (CS) log for Morphine revealed:
-There was only one CS log for Morphine with 30 prefilled syringes received on 02/29/24.
-There was a dispense date of 02/29/24 and there was a direction change sticker placed over the instructions on the prescription label at the top of the CS log.
-There were no doses of Morphine documented as administered in February 2024.
-The first dose documented as administered was 03/01/24 at 12:00pm.
-There was a second dose documented as administered on 03/01/24 at 4:00pm.
-There were no other scheduled doses documented as administered on 03/01/24 as ordered.

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D 358	Continued From page 33 -There were 4 scheduled doses documented as administered on 03/02/24 at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -The next dose was not documented as administered until 03/03/24 at 8:45am, over 12 hours after the last dose. -The last dose was documented as administered on 03/04/24 at 12:00am. Review of Resident #8's pharmacy dispensing records from 07/01/23 - 03/20/24 revealed: -The pharmacy dispensed 30 prefilled syringes of Morphine Sulfate 100mg/5ml on 02/29/24. -The date the order was written was 02/28/24. -The instructions were to take 0.5ml (10mg) every 4 hours as needed for pain or shortness of breath. Review of Resident #7's incident report dated 03/04/24 at 12:20am revealed hospice came to assess the resident and the resident had expired. Interview with a medication aide (MA) on 03/21/24 at 2:55pm revealed: -Resident #8 was in a lot of pain and having trouble breathing. -The resident was gasping for air. -She could tell the resident was in pain because the resident was frowning and moaning the last 2 to 3 days of her life. -There were two MAs who did not administer the resident's Morphine because they did not feel like the resident was transitioning because they did not think the resident was in distress. -Those MAs documented the resident was asleep when they did not administer the Morphine. Telephone interview with a second MA on 03/21/24 at 5:16pm revealed: -Resident #8 was declining and hospice ordered	D 358		

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scheduled Morphine every 4 hours.
-When she assessed the resident, if the resident said she was not in pain or not short of breath or if the resident could get up and walk to the bathroom, she held the resident's scheduled Morphine because she did not think the resident needed it.
-She did not notify the hospice nurse that she held the resident's Morphine because she had not been told to notify the hospice nurse.

Attempted telephone interview with a third MA on 03/21/24 at 5:41pm was unsuccessful.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/21/24 at 5:00pm revealed:
-They received an order for Resident #8's Morphine on 02/28/24 after 7:00pm.
-The order was processed the next day, 02/29/24, because there was no one at the pharmacy after 7:00pm to process orders.
-Resident #8's Morphine was dispensed on 02/29/24 and delivered to the facility on 02/29/24 at 4:08pm.
-The back up pharmacy would not be able to dispense Morphine without the hard copy prescription.
-There was a pharmacist on call after hours if the facility needed to contact them.

Interview with the Director of Resident Care (DRC) on 03/21/24 at 3:07pm revealed:
-If the MAs were having trouble getting a medication from the pharmacy, they should let her and the provider know.
-She was not sure why there was a delay in starting the Morphine order for Resident #8.
-There had been some issues with the administration of Resident #8's Morphine brought

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to her attention by a hospice nurse.
-Some of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAs.
-They had to get a clarification order to administer the Morphine when the resident was asleep or awake.
-The MAs did not realize the Morphine was also for shortness of breath.
-Some of the MAs did not think the resident needed Morphine if the resident was able to get up independently and go to the bathroom.
-She asked the hospice nurse to provide more education to the MAs.

Telephone interview with Resident #8's family member on 03/21/24 at 12:27pm revealed:
-Resident #8's Morphine was ordered every 4 hours and then every 2 hours near the end of her life.
-She only saw Resident #8 draw her eyebrows together once or twice on the day she died so she thought the facility was administering enough Morphine.
-At one time the resident's breathing was irregular and she had "a death rattle" when she breathed but she thought that was part of the dying process.

Telephone interview with Resident #8's hospice nurse on 03/21/24 at 4:30pm revealed:
-Resident #8 was in pain, having pain to touch and she was rapidly breathing at 60 breaths per minute.
-The last several days of Resident #8's life, the resident would withdraw from touch, furrow her forehead, and had facial grimacing, indicating she was in pain.

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D 358	Continued From page 36 -The MAs at the facility needed to administer the resident's Morphine as ordered so she would not be in pain. -She had educated staff when at the facility to make sure they administered the Morphine as ordered. -Resident #8 was not administered Morphine as ordered on 2 nights before she passed away during the weekend. -The weekend hospice nurse reported the MAs were not administering Resident #8's Morphine when the resident was sleeping. -Not receiving Morphine as ordered would cause the resident to be in pain and could contribute to rapid breathing. Attempted telephone interviews on 03/21/24 at 4:30pm and 03/22/24 at 4:01pm with Resident #8's hospice nurse who worked on the weekend was unsuccessful. Interview with Resident #8's PCP on 03/21/24 at 2:06pm revealed: -Resident #8 complained of right leg pain for a few weeks and needed the prn Morphine dated 02/28/24. -The resident had right hip pain and difficulty breathing as well. -The hospice nurse reported the resident's respiratory rate was 60 breaths per minute on 02/28/24 and when she got to the facility and checked it was 40 breaths per minute. -The hospice nurses reported the MAs had not been administering Morphine as ordered because they did not feel like the resident needed it and/or the resident was asleep. -The weekend hospice nurse called her on Monday, 03/04/24, and reported she did not feel like the resident was as comfortable as she should be.	D 358		

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-She discussed with the DRC, who was aware staff had not administered the Morphine as ordered because some of the MAs did not think the resident needed it.
-The order was changed to administer whether the resident was awake or asleep because the resident was actively dying and having continuous air hunger (feeling of severe breathlessness).
-Not receiving the Morphine while actively dying could cause the resident to be more uncomfortable and have terminal restlessness with a feeling of air hunger.

4. Review of Resident #5's current FL-2 dated 01/16/24 revealed:
-Diagnoses included fibromyalgia, trigeminal neuralgia and anxiety disorder.
-The resident was ordered Gabapentin 600mg three times a day for chronic pain. (Gabapentin may be used to treat nerve pain.)

Review of Resident #5's Resident Register revealed the resident admitted to the facility 01/18/24.

Review of Resident #5's pain clinic visit notes dated 02/21/24 revealed:
-Resident #5 was seen at the pain clinic related to Trigeminal Nerve Pain (pain in the head and face).
-A refill of Gabapentin 300mg in the morning, 300mg at noon, and 600mg at night was initiated by the provider on 02/21/24.
-The provider documented Resident #5's Gabapentin would not be titrated down further because the resident reported she had noticed an increase in pain since the Gabapentin dosage had been reduced.

Review of Resident #5's pain clinic visit notes

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dated 02/26/24 revealed:
-The resident was seen at the pain clinic for a planned treatment (Trigeminal Nerve Block) for Trigeminal Nerve Pain.
-The resident was not able to tolerate the procedure, therefore it was not completed.
-The medication list was reviewed and verified by the provider.
-The current medication list included orders for Gabapentin 300mg, 1 capsule twice daily and 2 capsules at night.

Review of Resident #5's January 2024 medication administration record (MAR) revealed:
-There was an entry for Gabapentin 600mg three times daily for chronic pain.
-Gabapentin 600mg was documented as administered to Resident #5 three times daily from 01/19/24 to 01/31/24.
-There were no additional entries for different dosages Gabapentin.

Review of Resident #5's February 2024 MAR revealed:
-There was an entry for Gabapentin 600mg three times daily for chronic pain.
-Staff documented Gabapentin 600mg had been administered three times daily 02/01/24 through 02/10/24.
-The entry for 600mg Gabapentin three times a day was marked discontinued on 02/11/24.
-Gabapentin 600mg three times daily was not documented as administered from 02/11/24 to 02/29/24.
-There were no additional entries for different dosages of Gabapentin.

Review of Resident #5's March 2024 MAR dated 03/01/24 - 03/19/24 revealed:
-There was an entry for Gabapentin 600mg three

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times daily for chronic pain.
-The entry for 600mg Gabapentin three times a day was marked discontinued on 02/11/24.
-Gabapentin 600mg three times daily was not documented as administered 03/01/24 to 03/19/24.
-There were no additional entries for different dosages of Gabapentin.

Observations of Resident #5's medications on hand on 03/20/24 at 10:32am revealed Gabapentin 600mg three times daily was not on hand for Resident #5.

Interview with the Director of Resident Care (DRC) on 03/20/24 at 11:38am revealed Resident #5 had recently switched pharmacies, but she was not sure of the actual date for the change in service.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/20/24 at 3:10pm revealed:
-Resident #5 was admitted to their services on 01/18/24 as a "profile only" resident.
-A profile only resident was usually in place when the resident used a different primary pharmacy, but the contracted pharmacy could provide refills of medications upon the facility's request.
-The pharmacy had a current order for Gabapentin 600mg three times a day for chronic pain dated 01/16/24.
-The pharmacy had not dispensed Gabapentin 600mg because the facility had not requested the medication to be filled.
-The pharmacy did not have any orders to discontinue Gabapentin 600mg three times daily.

Telephone interview with a pharmacy technician at Resident #5's previous pharmacy on 03/20/24

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at 3:36pm revealed:
-The resident had current orders, dated 01/17/24, for Gabapentin 300mg in the morning, 300mg at noon, and 600mg at night for other diseases of the neurological system.
-There was an order dated 01/17/24, to discontinue Gabapentin 600mg three times daily and start Gabapentin 300mg in the morning, 300mg at noon, and 2 tablets (600mg) at night with a 21-day supply dispensed and picked up from the pharmacy on 01/18/24 and a 28-day supply dispensed on 02/28/24 and picked up from the pharmacy on 03/09/24.

Telephone interview with a pharmacist at Resident #5's previous pharmacy on 03/20/24 at 3:43pm revealed:
-The pharmacy was not aware Resident #5 had been admitted to an assisted living facility.
-Resident #5 had previously been using the pharmacy for home services and the resident's family usually picked up medications from the pharmacy.
-Side effects of abruptly stopping Gabapentin could include an increase in anxiety.

Telephone interview with a second pharmacist at Resident #5's previous preferred pharmacy on 03/21/24 at 2:40pm revealed:
-The pharmacy had not received any communication from the facility to request a refill or obtain clarification for any Gabapentin orders.
-Abruptly stopping Gabapentin could contribute to an increase in pain.

Interview with a medication aide (MA) on 03/20/24 at 10:35am revealed:
-When the facility received new or changed medication orders, the MA's faxed the order to the pharmacy, transcribed the new order on the

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residents' MAR with the MA's initials and date of the order, and placed the order in the resident' chart.
-She thought Resident #5's Gabapentin had been discontinued because the February and March 2024 MARs, noted Resident #5's Gabapentin had been discontinued on 02/11/24.
-She was not the MA who received the order to discontinue Gabapentin and she was not the MA who had entered the documentation to discontinue Gabapentin on the MAR on 02/11/24.
-She had not administered Gabapentin to Resident #5 after it was discontinued on Resident #5's MAR on 02/11/24.
-The resident frequently complained of headaches, but she had not noticed an increase in the resident headaches, complaints of dizziness or changes in the resident's behavior since the resident's Gabapentin had been discontinued.

Interview with a second MA on 03/21/24 at 4:45pm revealed:
-Resident #5's family member brought a new medication bubble pack to the facility with a new dosage of Gabapentin on 02/11/24.
-The family member did not have the signed medication order so the MA called the pharmacy to clarify the order on 02/11/24.
-The pharmacy told the MA the 600mg Gabapentin three times daily had been discontinued.
-The pharmacy faxed the order to the facility and the MA attached the order to the medication bubble pack and placed it back in the medication cart.
-She wrote the discontinue order on Resident #5's MAR on 02/11/24.
-She was not able to locate the order she had attached to the bubble pack.

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D 358	Continued From page 42 -She was not aware there was an order to start Gabapentin 300mg in the morning, 300mg at noon, and 2 tablets (600mg) at night, so she did not enter that order on Resident #5's MAR. Interview with Resident #5 on 03/20/24 at 11:00am revealed: -The facility administered all of her medications. -She had been taking Gabapentin for over one year to help with pain after she had an episode of shingles. -She thought one of her doctors had lowered the dose of Gabapentin recently, but she was not sure when. -She always had some pain in her legs and head, but she had not noticed a difference in her pain since the Gabapentin dosage had been reduced. Telephone interview with Resident #5's family member/power of attorney on 03/21/24 at 12:25pm revealed: -The facility had been administering Resident #5's medication since she was admitted. -She had recently, in the last couple of weeks, switched Resident #5's pharmacy to the facility's contracted pharmacy. -Before the pharmacy changed, she picked up Resident #5's medication bubble packs from the pharmacy and took them to the facility. -Since the resident's admission to the facility, she had picked up several medication packs from the pharmacy and delivered them to the facility, but she could not recall the exact dates of delivery for each medication. -The facility had not told her she needed to bring the medication orders to the facility, she assumed the pharmacy had the orders because they filled the prescriptions. -The resident had been taking Gabapentin for over one year related to pain from shingles.	D 358		

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-One of Resident #5's pain clinic physicians had reduced Resident #5's Gabapentin dose during a recent appointment.
-The facility had not told her to bring appointment visit notes to the facility, but she had sent Resident #5's most recent visit notes to the facility earlier that day on 03/21/24.
-She thought Resident #5 did great for the first month she was living in the facility.
-After the first month living in the facility, she noticed Resident #5 did not seem to be doing as well and was showing more signs of anxiety and called the family member much more frequently with complaints about various issues including her mood and pain.
-She was not aware the facility had not been administering Resident #5's Gabapentin and she was concerned because the resident had been taking that medication for a long time and she was concerned this may have contributed to the resident's recent changes in mood and anxiety.

Review of Resident #5's facility nurses' notes revealed:
-On 03/10/24 at 3:00pm, staff documented the resident was sent to the hospital due to dizziness, left sided weakness and loss of mobility.
-On 03/11/24 at 11:00pm, staff documented the resident returned from the emergency room (ER) at 1:45am; no new orders.

Review of Resident #5's hospital records dated 03/10/24 revealed:
-The resident was seen in the ER related to weakness with uncertain cause on 03/10/24.
-There were no new or changed medication orders or treatments.

Interview the facility's DRC and Regional Director of Health and Wellness (RDHW) on 03/21/24 at

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D 358	Continued From page 44 11:57am revealed: -The facility's process for medication administration was the MAs received the orders and sent the orders to the pharmacy, the MAs then entered the medication, dosage, instructions and use on the MAR. -The staff entering the information on the MAR was supposed to date and initial the entry on the MAR. -The MAs completed medication cart audits two times per week and reported their findings to her for further direction or clarification. -The facility had implemented a new process about two weeks prior where she would follow behind the MAs cart audit one time per week to check for order changes and errors. -Resident #5's family had decided to change pharmacies and use the facility's contracted pharmacy. -The MAs were supposed to use the residents' current supply of medications and requests the refills through the facility's contracted pharmacy as the medication ran out. -She was not aware of a facility process for following up on the status of the transitions when residents changed pharmacies. -She was not aware Resident #5's Gabapentin 600mg three times a day was discontinued without physician orders. -She was not aware the Resident #5's orders to start Gabapentin 300mg in the morning, 300mg at noon, and 600mg at night were not entered on the MAR and were not administered to the resident. Interview with Resident #5's primary care provider (PCP) on 03/21/24 at 2:25pm revealed: -Facility staff told her that the resident's Gabapentin 600mg three times daily was discontinued by the resident's pain clinic provider	D 358		

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on 02/11/24.
-She did not see the discontinue order in the resident's chart, but she did not manage the resident's Gabapentin as it was managed by the pain clinic's medical provider.
-She was not aware of the orders that the pharmacy had for Gabapentin 300mg in the morning, 300mg at noon, and 600mg at night.
-She was not aware of the pain clinic visit note on 02/21/24 which noted the pain clinic medical provider had provided refills for Resident #5's Gabapentin 300mg in the morning, 300mg at noon, and 600mg at night.
-She was concerned the facility had not followed Resident #5's orders for Gabapentin as prescribed by the pain clinic.
-She was concerned that Resident #5 was abruptly stopped without orders from the pain clinic's medical provider.
-When discontinuing or stopping treatment with Gabapentin, the medication should be reduced with a gradual taper to help prevent side effects.
-Side effects of abruptly stopping Gabapentin could include nausea, headaches, dizziness, and anxiety.
-She was aware the resident was sent out to the ER on 03/10/24 related to dizziness.
-Resident #5's dizziness on 03/10/24 could have potentially been related to her Gabapentin being abruptly stopped on 02/11/24 but she was not certain.

Interview with the Administrator on 03/21/24 at 5:18pm revealed:
-The DRC notified her of errors in Resident #5's administration of Gabapentin on 03/21/24 but she was not previously aware of the errors.
-When the MA received the new medication pack from Resident #5's family member she should have contacted the pharmacy for the orders and

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she should have contacted the resident's PCP or pain clinic to obtain clarification before she discontinued the Gabapentin on the MAR.
-The DRC typically completed the process for residents who were transitioning to a new pharmacy, this was not something that she had previously followed up on or something that would have been reported to her.

Attempted telephone interviews with the medical provider at the pain clinic on 03/21/24 at 8:26am and 12:41pm were unsuccessful.

5. Review of Resident #2's current FL-2 dated 02/23/24 revealed:
-Diagnoses included dementia, hypertension, hypothyroidism, and major depressive disorder.
-The FL-2 was generated from a local hospital.
-There was a documented hospital admission date of 01/28/24.
-The date of discharge from the hospital was documented as 02/23/24.
-There was a physician's order for Olanzapine (generic for Zyprexa and used to treat behaviors such as agitation) 5mg tablet two times a day.
-There was additional information printed on the FL-2 dated 02/23/24 documenting medications would need to be updated once it was known for sure what medications the resident would be discharged on.
-There were no additional FL-2s dated after 02/23/24 for Resident #2.

Review of subsequent physician's orders for Resident #2 revealed:
-There was a hospital physician prescription dated 02/23/24 for Olanzapine 5mg rapid dissolve tablets 10mg two times a day.
-There was a "call in order" dated 03/07/24 for Zyprexa 5mg tablet two times a day.

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D 358	Continued From page 47 -There was a physician's order documented on a physician visit form dated 03/16/24 increasing the Zyprexa to 10mg two times a day for facility concerns of resident "agitation" and "up all night". Review of Resident #2's February 2024 medication administration records (MARs) revealed: -There was a handwritten entry for Zyprexa 5mg tablet take one tablet two times a day and scheduled for 9:00am and 8:00pm. -There were circled medication aide (MA) initials in the section for documentation of administration for the Zyprexa for the 9:00am and 8:00pm dosages from 02/23/24 through 02/29/24. -There was MA documentation on the back of the MAR for 02/23/24 through 02/29/24 the Zyprexa 5mg tablet was not administered because the medication was on order from the pharmacy. -There was no documentation of administration for the Zyprexa for February 2024 following Resident #2's discharge from the hospital. Review of Resident #2's March 2024 MARs revealed: -There was a printed entry for Zyprexa 20mg tablet take one tablet every night. -There was a horizontal line drawn through the printed 20mg dosage and 5mg was handwritten in the instructions for administration. -There was a horizontal line drawn through the printed frequency for every night and a frequency of two times a day was handwritten in the instructions for administration. -The Zyprexa was scheduled for administration twice daily at 9:00am and 8:00pm. -There were circled MA initials in the section for documentation of administration for the Zyprexa for the 9:00am and 8:00pm dosages from 03/01/24 through 03/07/24 at 9:00am.	D 358		

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-There was MA documentation on the back of the MAR for 03/01/24 through 03/07/24 the Zyprexa 5mg tablet was not administered because the medication was on order from the pharmacy.
-There was documentation of administration for the first dose of the Zyprexa 5mg tablet following discharge from the hospitalization being administered on 03/07/24 at 9:00am.

Observation of Resident #2's medications on hand on 03/20/24 at 1:00pm revealed:
-Zyprexa 10mg tablet with instructions for one tablet twice daily was dispensed on 03/16/24.
-There was a quantity of 59 tablets on hand.

Review of staff notes for Resident #2 from 02/23/24 through 03/18/24 revealed:
-On 02/23/24 at 2:43pm, Resident #2 returned to the facility from the hospital.
-Resident #2 refused dinner on 02/23/24.
-Resident #2 refused breakfast and lunch on 02/24/24.
-On 02/29/24 during the 11:00pm - 7:00pm, staff documented Resident #2 walked to the staff desk asking if anyone had seen his family member.
-On 02/29/24 during the 3:00pm - 11:00pm shift, staff documented Resident #2 got agitated, and was shaking the exit doors.
-On 03/01/24 during the 11:00pm - 7:00am shift, staff documented Resident #2 was agitated (no specific behaviors documented) after second shift staff left and the hospice nurse was contacted.
-The resident was administered Haldol per the hospice nurse instructions and the resident became calm.
-On 03/11/24 during the 3:00pm - 11:00pm shift, Resident #2 did not eat dinner, became agitated before bed, would not take his medications, knocked the medications out of the MA hand, and would not allow the MA to stay in the room to look

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for all the medications. The MA was able to return in the room after an hour to look for the remainder of the medications once Resident #2 was calm.
-On 03/15/24 at 3:00am, staff documented Resident #2 was throwing himself on the door of the memory care unit trying to get out. The staff could not redirect the resident. Resident #2 required an as needed (prn) medication.

Interview with the Memory Care Director (MCD) on 03/20/24 at 3:29pm revealed:
-She remembered faxing the 02/23/24 FL-2 and 02/23/24 Zyprexa prescription to the pharmacy when Resident #2 returned from the hospital.
-Another MA transcribed the instructions to Resident #2's MAR for administration of the Zyprexa based on the order on the 02/23/24 FL-2 and not the instructions on the 02/23/24 prescription from the hospital physician.
-She noticed Resident #2 was not being administered Zyprexa because the medication was not available in the facility, and the MAs were circling their initials on the MAR but did not remember the exact date she noticed the omission.
-Circled initials on the MAR meant the medication was not administered.
-The MA reported to her (no specific date provided) that the pharmacy was contacted about the Zyprexa and would not dispense the Zyprexa because of an expense issue so the MA contacted the hospice nurse who assisted in getting the Zyprexa for administration to Resident #2.

Interview with the MCD on 03/21/24 at 3:38pm revealed:
-She was responsible for reviewing the physician orders for Resident #2.

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-The MAs transcribed physician orders to the MARs.
-If she was not in the facility, the MA on duty was responsible to review any physician orders received for the residents in the memory care unit.
-On 03/05/24, she saw that the MAs were circling their initials for the Zyprexa so she asked the MA about it and sent a message to the primary care provider (PCP).

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 03/21/24 at 12:03pm revealed:
-The pharmacy received an order for Resident #2 dated 02/23/24 for Zyprexa 5mg rapid dissolve tablets take two tablets twice daily.
-The pharmacy never dispensed the Zyprexa 5mg rapid dissolve tablets because of an insurance coverage issue.
-The facility was faxed a non-coverage form for the Zyprexa 5mg rapid dissolve tablets on 02/24/24.
-The facility was responsible for contacting the PCP regarding the non-covered medication issue for alternatives.
-On 03/07/24, the pharmacy dispensed Zyprexa 5mg tablets, quantity of 30 tablets for a 15-day supply to the facility from a verbal order received on 03/07/24.
-There was no additional Zyprexa dispensed to the facility for Resident #2 until 03/16/24 when Zyprexa 10mg tablets were dispensed.

Telephone interview with Resident #2's mental health provider (MHP) on 03/21/24 at 2:45pm revealed:
-The facility had not notified her of any issues regarding Resident #2's Zyprexa medication, nor was she aware Resident #2 was not administered

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any Zyprexa from 02/23/24 to 03/07/24.
-Resident #2 would be more irritable, hitting staff, and more likely to have behaviors and harm someone or injure himself without the administration of the Zyprexa.
-The resident could experience withdrawal symptoms of Zyprexa that included irritability, restlessness, poor sleep, and agitation.
-When she visited the facility on 03/12/24, she got reports that Resident #2 had been up and down with his mood, had grabbed a staff and dug his nails into the skin, was anxious and restless in the morning, and bouncing his feet and legs up and down under the breakfast table which were associated with Zyprexa withdrawal.
-She increased Resident #2's Clonazepam (used to treat behaviors) on 03/12/24 when she visited because she assumed Resident #2 was being administered the Zyprexa 20mg daily, which was the dosage he was prescribed prior to hospitalization.
-If Resident #2 had been administered the Zyprexa 5mg tablet take two tablets twice a day, the resident would have still been getting Zyprexa 20mg daily but in a divided dosage.
-She contacted the hospital prior to Resident #2 being discharged because the resident needed to stay longer to ensure his behavior medications were "back to the normal dosages".

Interview with the Administrator on 03/21/24 at 4:41pm revealed:
-She was not aware of any insurance issue with Resident #2's Zyrexa medication.
-She expected the MCD to handle medication issues for residents in the memory care unit.
-She expected the facility nurse and herself to be made aware if there were concerns or issues.
-All resident medications were expected to be administered as ordered by the PCP.

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D 358	Continued From page 52 Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. 6. Review of Resident #4's current FL-2 dated 03/07/24 revealed: - Diagnoses included hypertension crisis, dementia, chronic kidney disease, translucent ischemic attack, and generalized weakness. -There was no order for Furosemide 20mg, 1 tablet daily. Review of Resident #4's Resident Register revealed an admission date of 02/24/22. Review of Resident #4's electronically signed physician's order dated 03/01/24 revealed an order for Furosemide 20mg, 1 tablet daily. (Furosemide is a medication used to treat fluid retention). Review of Resident #4's March 2024 medication administration record (MAR) revealed there was no entry for Furosemide 20mg, 1 tablet daily. Telephone interview with the the facility's contracted pharmacist on 03/21/24 at 3:30pm revealed there was no documentation the pharmacy received an order from the facility for Resident #4 for Furosemide 20mg 1 tablet daily, so the medication was not placed on the MAR or dispensed. Interview with Resident #4 on 03/22/24 at 3:00pm revealed the resident reported that her hands and feet hurt. Observation of Resident #4 on 03/22/24 at 3:00pm revealed the resident's left hand was	D 358		

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D 358	Continued From page 53 slightly swollen. Interview with the medication aide (MA) on 03/21/24 at 5:09pm revealed: -Medication orders were received in the facility via fax (facsimile) from the prescribing practioner. -The MAs were responsible for faxing the order to pharmacy and transcribing the order on the MAR if needed. -She was not aware of the Furosemide order for Resident #4 or how the order got into the resident's record without being sent to pharmacy. -She did not know why the Furosemide order for Resident #4 was not sent to pharmacy. Interview with the Director of Resident Care (DRC) on 03/21/24 at 1:48pm revealed: -Medication orders were faxed to the pharmacy and the facility by the prescribing practitioner. -She or the Wellness Secretary would take the order to the MA's station. -The MAs were responsible for faxing the order to the pharmacy to ensure the pharmacy received the order from the prescribing practioner and to transcribe the order on the MAR if the MAR had already been prepared by pharmacy for the month. -She was not aware the Furosemide was not sent to pharmacy for processing. Interview with the Administrator on 03/21/24 at 1:55pm revealed: -The MAs usually sent medication orders to pharmacy and transcribed the order on the MAR if needed when the order was received in the facility by the prescribing practitioner. -She did not know why the process was not followed or why the failure occurred. -The facility recently started conducting an MAR audit which included reviewing the MARs for	D 358		

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D 358	Continued From page 54 accuracy. Telephone interview with Resident #4's primary care provider (PCP) on 03/21/24 at 1:23pm revealed: -She periodically prescribed Furosemide for Resident #4 due to a tendency for her left hand to be swollen as a result of a past stroke. -Her expectation was for the Furosemide 20mg 1 tablet daily to be administered to Resident #4 for 7 days. -She was not aware the Furosemide was not sent to the pharmacy and the resident did not receive the medication. -She usually sent a medication order to the pharmacy and the facility at the same time. -She visited Resident #4 today and observed her left hand was swollen and the resident reported pain in her hands and feet. -The Furosemide could have relieved some of the swelling of the hand and foot pain for the resident. _____ The facility failed to administer medications as ordered to 2 of 3 residents observed during the medication passes on 03/20/24 including a resident with a reddened foot wound with a yellow center that was not treated with an antibiotic ointment putting the wound at risk of opening and becoming infected. The facility failed to administer Morphine, a controlled substance used to relieve end of life symptoms such as severe pain, shortness of breath, air hunger, and restlessness, as ordered to Resident #7 and Resident #8 who were receiving terminal hospice services resulting in the residents experiencing undertreated pain and shortness of breath while actively dying. Resident #2 did not receive an antipsychotic medication as ordered resulting in the resident exhibiting agitated behaviors.	D 358		

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D 358	Continued From page 55 Resident #5 did not receive a medication for nerve pain as ordered that was abruptly stopped without an order putting the resident at risk for headaches and dizziness and the resident was seen at the emergency room for dizziness during the time of the missed doses. Resident #4 did not receive a diuretic for swelling and excess fluid as ordered resulting in her left hand being swollen and having pain in her left hand. The failure of the facility to administer medications as ordered resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/21/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 21, 2024.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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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 medication administration records were accurate for 4 of 7 sampled residents (#3, #4, #7, #8) including medications used to treat high blood pressure (#3, #4), used to reduce the risk of heart attack and stroke (#3, #4), anxiety (#3), schizophrenia and mood disorders (#3), depression (#3), folate deficiency (#3), , hay fever, bi-polar disorder, Vitamin B-12 deficiency, nerve pain, depression and insomnia (#3), high cholesterol (#4), Alzheimer's dementia (#4), urinary retention (#4), nerve pain (#4), seasonal allergies (#3), Vitamin B12 deficiency (#3), Vitamin D deficiency (#4), topical medications for dry, irritated skin (#3, #4), topical skin protectants (#4), topical antifungal powder (#4), topical anesthetic for pain (#4), and a controlled substance used to treat severe pain and breathing difficulties at end of life (#7, #8).

The findings are:

1. Review of Resident #7's closed record FL-2 dated 01/25/24 revealed diagnoses included anxiety disorder, atrial fibrillation, heart failure, age-related osteoporosis, and insomnia.

Review of Resident #7's closed record FL-2 dated 01/25/24 revealed an order for Morphine Sulfate 100mg/5ml Solution prefilled syringes

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give 0.5ml (10mg) every 4 hours as needed (prn) for pain/shortness of breath. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.)

Review of Resident #7's primary care provider (PCP) electronic prescription (e-script) dated 02/28/24 at 7:20pm revealed an order for Morphine 100mg/5ml take 0.5ml every 4 hours, scheduling Morphine due to increased pain, decline in resident's condition, and per family's request.

Review of Resident #7's controlled substance (CS) logs for Morphine 100mg/5ml revealed:
-There was a supply of 30 prefilled syringes with Morphine Sulfate 100mg/5ml received on 07/12/23 with instructions to give 0.5ml (10mg) every 4 hours prn for pain/shortness of breath.
-There was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 100mg/5ml documented as received (carried over from the supply received on 07/12/23).
-There were 20 prefilled syringes of Morphine documented as administered from 02/16/24 - 02/29/24.

Review of Resident #7's February 2024 medication administration record (MAR) revealed:
-There was an entry for Morphine Sulfate 100mg/5ml Solution prefilled syringes give 0.5ml (10mg) every 4 hours prn for pain/shortness of breath.
-There was a second handwritten entry for Morphine 100mg/5ml give 1 syringe (0.5ml) every 4 hours for pain or shortness of breath scheduled at 9:00am, 1:00pm, 5:00pm, 9:00pm, 1:00am, and 5:00am.

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D 367	Continued From page 58 -There were 17 doses of Morphine Sulfate documented as administered from 02/16/24 - 02/29/24. -Morphine Sulfate was not documented as administered on the MAR on 02/23/24 at 9:00am, 02/25/24 at 8:00pm, and 2:20pm on 02/29/24 but these doses were documented as administered on the CS log. -Documentation for the administration of Morphine Sulfate on the MAR was not accurate and did not match documentation on the CS logs. Interview with a medication aide (MA) on 03/19/24 at 9:19am revealed: -The MAs were supposed to document the administration of a controlled substance on the MAR and the CS log. -Sometimes the MAs would forget to document the administration of a controlled substance on the MAR but would document it on the CS log. Interview with a second MA on 03/21/24 at 2:49pm revealed: -Morphine helped with the Resident #7's pain and shortness of breath. -She did not always administer the Morphine because if the resident was "knocked out cold", she did not want to put more in the resident's mouth. -If a medication was not administered, the MAs were supposed to document the reason on the MAR. -She thought she usually documented a reason on the MAR. Interview with the Director of Resident Care (DRC) on 03/21/24 at 3:07pm revealed: -The MAs were supposed to document the administration of controlled substances on the MAR and the CS log.	D 367		

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D 367	Continued From page 59 -The MAR should be accurate and match the documentation on the CS log. Refer to interview with a medication aide (MA) on 03/21/24 at 11:00am. Refer to interview with the Memory Care Director (MCD) on 03/21/24 at 11:20am. Refer to interview with the Director of Resident Care (DRC) on 03/21/24 at 11:40am. Refer to telephone interview with the Administrator on 03/22/24 at 10:56am. 2. Review of Resident #8's closed record FL-2 dated 08/23/23 revealed diagnoses included dementia and hypertension. Review of Resident #8's primary care provider (PCP) order dated 02/28/24 revealed an electronic prescription (e-script) for Morphine 10mg/0.5ml Oral Solution, take 0.5ml every 4 hours as needed for pain or shortness of breath. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.) Review of Resident #8's hospice verbal order dated 03/01/24 PCP order dated 03/01/24 revealed an order for Morphine Sulfate 100mg/5ml give 0.5ml every 4 hours scheduled. Review of Resident #8's hospice order dated 03/03/24 revealed: -The resident was actively dying, continue comfort medications. -Give scheduled Morphine if the resident was awake or asleep. -A second note again indicated "administer	D 367		

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D 367	Continued From page 60 Morphine if pt (patient) awake or asleep". Review of a second hospice order on 03/03/24 for Resident #8 revealed: -The resident was actively dying, having respiratory distress. -The resident was comfortable but uncomfortable with respiratory changes when moved/repositioned. -There was an order to increase scheduled Morphine form every 4 hours to every 2 hours for severe pain or respiratory distress, do not hold, administer if the resident awake or asleep. Review of Resident #8's March 2024 medication administration record (MAR) revealed: -There was a handwritten entry for Morphine Sulfate 100mg/5ml take 0.5ml every 4 hours as needed for pain or shortness of breath. -There was no prn Morphine documented as administered for this entry. -There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am. -There was a handwritten note underneath the entry dated 03/03/24 with an asterisk and instructions to administer if awake or asleep. -Staff initials were circled on 03/01/24 at 8:00am and 8:00pm with no reason for not administering the medication. -Documentation for the administration of Morphine was blank on 03/01/24 at 12:00am and 4:00am with no reason for the omissions documented. -There was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am,	D 367		

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4:00am, and 6:00am.
-There was a handwritten note that the resident expired on 03/04/24 at 12:37am.

Review of Resident #8's controlled substance (CS) log for Morphine revealed:
-There was only one CS log for Morphine with 30 prefilled syringes received on 02/29/24.
-There was a dispense date of 02/29/24 and there was a direction change sticker placed over the instructions on the prescription label at the top of the CS log.
-The first dose documented as administered was 03/01/24 at 12:00pm.
-There was a second dose documented as administered on 03/01/24 at 4:00pm.
-There were no other scheduled doses documented as administered on 03/01/24 as ordered.
-There were 4 scheduled doses documented as administered on 03/02/24 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The next dose was not documented as administered until 03/03/24 at 8:45am, over 12 hours after the last dose.
-The last dose was documented as administered on 03/04/24 at 12:00am.

Interview with a medication aide (MA) on 03/21/24 at 2:55pm revealed:
-Resident #8 was in a lot of pain and having trouble breathing.
-The resident was gasping for air.
-She could tell the resident was in pain because the resident was frowning and moaning the last 2 to 3 days of her life.
-There were two MAs who did not administer the resident's Morphine because they did not feel like the resident was transitioning because they did not think the resident was in distress.

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-She thought those MAs documented the resident was asleep when they did not administer the Morphine.
-She was not sure why there were blanks on the MAR.

Interview with the Director of Resident Care (DRC) on 03/21/24 at 3:07pm revealed:
-There had been some issues with the administration of Resident #8's Morphine brought to her attention by a hospice nurse.
-Some of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAs.
-They had to get a clarification order to administer the Morphine when the resident was asleep or awake.
-The MAs were supposed to document a reason on the MAR when a medication was not administered.

Refer to interview with a medication aide (MA) on 03/21/24 at 11:00am.

Refer to interview with the Memory Care Director (MCD) on 03/21/24 at 11:20am.

Refer to interview with the Director of Resident Care (DRC) on 03/21/24 at 11:40am.

Refer to telephone interview with the Administrator on 03/22/24 at 10:56am.

3. Review of Resident #3's current FL-2 revealed diagnoses included muscle weakness, difficulty walking, Alzheimer's disease, and unspecified asthma.

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D 367	Continued From page 63 a. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Amlodipine 5mg, tablet daily at 9:00am. (Amlodipine is a medication used to treat high blood pressure). Review of Resident #3's March 2024 medication administration record (MAR) revealed: -There was an entry for Amlodipine 5mg, 1 tablet daily at 9:00am. -There was no documentation Amlodipine 5mg, 1 tablet was administered at 9:00am on 03/17/23, that was blank and no reason given as to why the medication was not administered. b. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Aspirin 81mg, 1 chewable tablet daily at 9:00am. (Aspirin is a medication that may be used to reduce the risk of heart attack and stroke). Review of Resident #3's March 2024 MAR revealed: -There was an entry for Aspirin 81mg, 1 chewable tablet daily at 9:00am -There was no documentation Aspirin 81mg, 1 chewable tablet was administered at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered. c. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Elfolate 15mg, 1 tablet daily at 9:00am. (Elfolate is a supplement used to treat folate deficiency). Review of Resident #3's March 2024 MAR revealed: -There was an entry for Elfolate 15mg, 1 tablet daily at 9:00am. -There was no documentation Elfolate 15mg, 1 tablet was administered at 9:00am on 03/17/24,	D 367		

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that was blank and no reason given as to why the medication was not administered.

d. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Fluticasone Propionate 50mcg, 1 spray in each nostril daily at 9:00am. (Fluticasone Propionate is a medication used treat sneezing, itchy or runny nose associated with seasonal allergies).

Review of Resident #3's March 2024 revealed:
-There was an entry for Fluticasone Propionate 50mcg, 1 spray in each nostril daily at 9:00am.
-There was no documentation Fluticasone Propionate 50mcg, 1 spray in each nostril was administered at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered.

e. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Lamotrigine 200mg, 2 tablets daily at 9:00am. (Lamotrigine is a medication used to treat seizures and bipolar disorder).

Review of Resident #3's March 2024 MAR revealed:
-There was an entry for Lamotrigine 200mg, 2 tablets daily at 9:00am.
-There was no documentation Lamotrigine 200mg, 2 tablets were administered at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered.

f. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Lithium Carbonate 150mg, 1 capsule daily at 9:00am. (Lithium Carbonate is a medication used to treat bipolar disorder).

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Review of Resident #3's March 2024 revealed:
-There was an entry for Lithium Carbonate 150mg, 1 capsule daily at 9:00am.
-There was documentation Lithium Carbonate 150 mg, 1 capsule was not administered on 03/14/24 denoted by circled initials with no reason as to why the medication was not administered, and no documentation that Lithium Carbonate 150mg,1 capsule was administered at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered.

g. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Vitamin B-12 1000mcg, 1 tablet daily at 9:00am. (Vitamin B-12 used to treat Vitamin B-12 deficiency).

Review of Resident #3's January 2024 MAR revealed:
-There was an entry for Vitamin B-12 1000mcg, 1 tablet daily at 9:00am.
-There was no documentation Vitamin B-12 1000mcg, 1 tablet was administered on 01/19/24 at 9:00am, that was blank and no reason given as to why the medication was not administered.

Review of Resident #3's March 2024 MAR revealed:
-There was an entry for Vitamin B-12 1000mcg, 1 tablet daily at 9:00am.
-There was no documentation Vitamin B-12 1000mcg, 1 tablet was administered at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered.

h. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Mirtazapine 15mg, 1 tablet at bedtime at 8:00pm. (Mirtazapine is a medication used to treat depression.)

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Review of Resident #3's February 2024 MAR revealed:
-There was an entry for Mirtazapine 15mg, 1 tablet at bedtime at 8:00pm.
-There was no documentation Mirtazapine 15mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.

Review of Resident #3's March 2024 MAR revealed:
-There was an entry for Mirtazapine 15mg, 1 tablet at betime at 8:00pm.
-There was no documentation Mirtazapine 15mg, 1 tablet was administered at 8:00pm on 03/12/24, that was blank and no reason given as to why the medication was not administered.

i. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Zyprexa 2.5mg, 1 tablet at bedtime at 8:00pm. (Zyprexa is a medication used to treat schizophrenia and bipolar disorder).

Review of Resident #3's January 2024 MAR revealed:
-There was an entry for Zyprexa 2.5mg, 1 tablet at bedtime at 8:00pm.
-There was documentation Zyprexa 2.5mg, 1 tablet was not administered on 01/14/24 denoted by circled initials and no reason given as to why the medication was not administered.

Review of Resident #3's February 2024 MAR revealed:
-There was an entry for Zyprexa 2.5mg, 1 tablet at bedtime at 8:00pm.
-There was no documentation Zyprexa 2.5mg, 1 tablet was administered at 8:00pm on 02/20/24,

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01/23/24, and 02/27/24 that was blank and no reason given as to why the medication was not administered.

j. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Trazodone 100mg, 1 tablet every evening at 8:00pm. (Trazodone is a medication used to treat depression).

Review of Resident #3's January 2024 MAR revealed:
-There was an entry for Trazodone 100mg, 1 tablet at 8:00pm.
-There was documentation Trazodone 100mg, 1 tablet was not administered on 01/29/24 and 01/30/24 denoted by circled initials and no reason given as to why the medication was not administered.

Review of Resident #3's February 2024 MAR revealed:
-There was an entry for Trazodone 100mg, 1 tablet at 8:00pm.
-There was no documentation Trazodone 100mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.

Review of Resident #3's March 2024 MAR revealed:
-There was an entry for Trazodone 100mg, 1 tablet at 8:00pm.
-There was no documentation Trazodone 100mg, 1 tablet at 8:00pm was administered on 03/12/24 at 8:00pm.

k. Review of Resident #3's physician orders dated 0 1/01/24 revealed an order for Ammonium Lactate 12% Lotion, apply to bilateral feet every

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day at 9:00am. (Ammonium Lactate is a medication used to treat dry and scaly skin).

Review of Resident #3's February 2024 MAR revealed:
-There was an entry for Ammonium Lactate 12% Lotion, apply to bilateral feet every day at 9:00am.
-There was no documentation Ammonium Lactate 12% Lotion was applied to bilateral feet on 9:00am on 02/05/24, 02/14/24, and 02/24/24, that was blank and no reason given as to why the medication was not administered.

Review of Resident #3's March 2024 MAR revealed:
-There was an entry for Ammonium Lactate 12% Lotion, apply to bilateral feet every day at 9:00am.
-There was no documentation Ammonium Lactate 12% Lotion was applied to bilateral feet at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered.

l. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Thera-Derma Lotion, apply topically to face every day at 9:00am. (Thera-Derma is a lotion used to treat dry skin).

Review of Resident #3's February 2024 MAR revealed:
-There was an entry for Thera-Derma Lotion, apply topically to face every day at 9:00am.
-There was no documentation Thera-Derma Lotion was applied to the face at 9:00am on 02/14/24, 02/16/24, and 02/24/24, that was blank and no reason given as to why the medication was not administered.

Review of Resident #3's March 2024 MAR

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revealed:
-There was an entry for Thera-Derma Lotion, apply topically to face every day at 9:00am
-There was no documentation Thera-Derma Lotion was applied to the face at 9:00am on 03/17/24, that was blank and no reason given as to why the medication was not administered.

m. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Ativan 0.5mg, 1 tablet every 4 hours as needed (prn) for anxiety. (Ativan is a controlled substance used to treat anxiety).

Review of Resident #3's February MAR 2024 revealed:
-There was an entry for Ativan 0.5mg, 1 tablet every 4 hours as needed for anxiety.
-There was documentation Ativan 0.5mg, 1 tablet was administered on 02/21/24, 02/25/24 and 02/28/24 but no reason was given as to why it was administered and effectiveness as a prn medication.

Refer to interview with a medication aide (MA) on 03/21/24 at 11:00am.

Refer to interview with the Memory Care Director (MCD) on 03/21/24 at 11:20am.

Refer to interview with the Director of Resident Care (DRC) on 03/21/24 at 11:40am.

Refer to telephone interview with the Administrator on 03/22/24 at 10:56am.

4. Review of Resident #4's current FL-2 dated 03/07/24 revealed diagnoses included hypertension crisis, dementia, chronic kidney disease, transient ischemic attack, and

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D 367	Continued From page 70 generalized weakness. a. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Aloe Vesta Skin Conditioner Lotion, apply to sacral/rectal area due to skin irritation every day at 9:00am. (Aloe Vesta Skin Conditioner Lotion is a medication used to treat dry, rough, scaly, itchy skin and minor skin irritations). Review of Resident #4's January 2024 medication administration record (MAR) revealed: -There was an entry for Aloe Vesta Skin Conditioner Lotion, apply to sacral/rectal area due to skin irritation every day at 9:00am. -There was documentation Aloe Vesta Skin Conditioner Lotion was not administered at 9:00am on 01/04/24 denoted by circled initials and no reason given as to why the medication was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Aloe Vesta Skin Conditioner Lotion, apply to sacral/rectal area due to skin irritation every day at 9:00am. -There was no documentation Aloe Vesta Skin Conditioner Lotion was applied to the sacral/rectal area at 9:00am on 02/26/24, that was blank and no reason given as to why the medication was not administered. b. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Aspirin 81mg, chewable 1 tablet daily at 9:00am. (Aspirin is a medication that may be used to reduce the risk of heart attack and stroke). Review of Resident #4's January 2024 MAR revealed:	D 367		

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D 367	Continued From page 71 -There was an entry for Aspirin 81mg, chewable 1 tablet daily at 9:00am. -There was documentation Aspiring 81mg, chewable 1 tablet was not administered at 9:00am on 01/04/24 denoted by circled initials and no reason given as to why the medication was not administered. c. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Diltiazem ER 360mg, 1 capsule daily at 9:00am. (Diltiazem is a medication uses to treat high blood pressure). Review of Resident #4's January 2024 MAR revealed: -There was an entry for Diltiazem ER 360mg, 1 capsule daily at 9:00am. -There was documentation Diltiazem ER 360mg, 1 capsule was not administered at 9:00am on 01/04/24 denoted by circle initials and no reason given as to why the medication was not administered. d. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Losartan-HCTZ 100mg-25mg, 1 tablet daily at 9:00am. (Losartan-HCTZ is a medication used to treat high blood pressure, reducing he risk of stroke and heart attack). Review of Resident #4's January 2024 MAR revealed: -There was an entry for Losartan-HCTZ 100mg-25mg, 1 tablet daily at 9:00am. -There was documentation Losartan-HCTZ 100mg-25mg, 1 tablet was not administered at 9:00am on 01/04/24 denoted by circled initials and no reason given as to why the medication was not administered.	D 367		

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Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Losartan-HCTZ 100mg-25mg, 1 tablet daily at 9:00am.
-There was no documentation Losartan-HCTZ 100mg-25mg, 1 tablet was administered at 9:00am on 02/26/24, that was blank and no reason given as to why the medication was not administered.

e. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Vitamin D3 50mcg, 1 capsule daily at 9:00am. (Vitamin D3 is a medication used to treat vitamin D deficiency).

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Vitamin D3 50mg, 1 capsule daily at 9:00am.
-There was documentation Vitamin D3 50mg, 1 capsule was not administered at 9:00am on 01/04/24 and 01/23/24 denoted by circled initials and no reason given as to why the medication was not administered.

f. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Aspercreme Lidocaine 4%, apply to right neck/right shoulder top two times daily for pain at 9:00am. (Aspercreme Lidocaine is a topical pain reliever.)

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Aspercreme Lidocaine 4%, apply to right neck/right should top times daily for pain at 9:00am.
-There was documentation Aspercreme Lidocaine 4% was not administered at 9:00am on 01/04/24, 01/17/24, 01/20/24, 01/21/24, and 01/22/24 denoted by circled initials and no reason given as

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to why the medication was not administered.
-There was documentation Aspercreme Lidocaine 4% was not administered at 8:00pm from 01/01/24 through 01/07/24, from 01/17/24 through 01/19/24, 01/22/24, and 01/24/24 denoted by circled initials and no reason given as to why the medication was not administered and no documentation Aspercreme Lidocaine 4% was administered at 8:00pm on 01/08/24 and 01/11/24, that was blank and no reason as to why the mediation was not administered.

Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Aspercreme Lidocaine 4% apply to right neck/right shoulder top tow times daily for pain at 9:00am.
-There was documentation Aspercreme Lidocaine 4% was not applied to the right neck/right shoulder top at 8:00pm denoted by circled initials on 02/06/24, 02/07/24, 02/09/24 and 02/10/24 with no reason as to why the medication was not administered, and there was no documentation Aspercreme Lidocaine 4% was applied to the right neck/right shoulder at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason was given as to why the medication was not administered.

Review of Resident #4's March 2024 MAR revealed:
-There was an entry for Aspercreme Lidocaine 4%, apply to right neck-right should to two times daily at 9:00am and 8:00pm.
-There was no documentation Aspercreme Lidocaine 4% was applied to the right neck/right shoulder at 8:00pm on 03/12/24 and 03/15/24 that was blank and no reason as to why the medication was not administered.

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D 367	Continued From page 74 g. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Clonidine 0.1mg, 1 tablet two times daily at 9:00am and 8:00pm. (Clonidine is a medication used to treat high blood pressure). Review of Resident #4's January 2024 MAR revealed: -There was an entry for Clonidine 0.1mg, 1 tablet two times daily at 9:00am and 8:00pm. -There was documentation Clonidine 0.1mg, 1 tablet was not administered at 9:00am on 01/04/24 denoted by circled initials with no reason given as to why the medication was not administered. -There was documentation Clonidine 0.1mg, 1 tablet was not administered at 8:00pm from 01/01/24 through 01/07/24, and 01/19/24, 01/22/24 and 01/24/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Clonidine 0.1mg, 1 tablet was administered at 8:00pm at 01/14/24, that was blank and no reason given as to why the medication was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Clonidine 0.1mg, 1 tablet two times daily at 9:00am and 8:00pm. -There was documentation Clonidine 0.1mg, 1 tablet was not administered at 8:00pm on 02/04/24, 02/06/24 , 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Clonidine 0.1mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, 02/27/24, and 02/29/24, that was blank with no reason given as to why the medication was not administered.	D 367		

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D 367	Continued From page 75 Review of Resident #4's March 2024 MAR revealed: -There was an entry for Clonidine 0.1mg, 1 tablet two times daily at 9:00am and 8:00pm. -There was no documentation Clonidine 0.1mg, 1 tablet was not administered at 8:00pm on 03/11/24 and 03/12/24, that was blank and no reason as to why the medication was not administered. h. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Metoprolol Tartrate 25mg, 0.5 tablet two times daily at 9:00am and 8:00pm. (Metoprolol Tartrate is a medication used to treat high blood pressure.) Review pf Resident #4 January 2024 revealed: -There was an entry for Metoprolol Tartrate 25mg, 0.5 tablet two times daily at 9:00am and 8:00pm. -There was documentation Metoprolol Tartrate 25mg, 0.5 tablet as not administered at 9:00am on 01/04/24 denoted by circled initials with no reason given as to why the medication was not administered. -There was documentation Metoprolol Tartrate 25mg, 0.5 tablet was not administered at 8:00pm from 01/01/24 through 01/07/24, and 01/19/24, 01/22/24 and 01/24/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Metoprolol Tartrate 25mg, 0.5 tablet was administered at 8:00pm on 01/14/24, that was blank and no reason given as to why the medication was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Metoprolol Tartrate 25mg, 0.5 tablet two times daily at 9:00am and 8:00pm.	D 367		

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D 367	Continued From page 76 -There was documentation Metoprolol Tartrate 25mg, 0.5 tablet was not administered at 8:00pm on 02/04/24, 02/06/24 , 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Metoprolol Tartrate 25mg, 0.5 tablet was administered at 8:00pm on 02/20/24, 02/23/24, 02/27/24, and 02/29/24, that was blank with no reason given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Metoprolol Tartrate 25mg, 0.5 tablet two times daily at 9:00am and 8:00pm. -There was no documentation Metoprolol Tartrate 25mg, 0.5 tablet was administered at 8:00pm at 03/12/24, that was blank with no reason given as to why the medication was not administered. i. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Nystatin 100,000 unit/gm Powder, apply topically to groin two times daily at 9:00am and 8:00pm. (Nystatin is a medication used to treat fungal or yeast infections of the skin). Review of Resident #4's January 2024 MAR revealed: -There was an entry for Nystatin 100,000 unit/gm Powder, apply topically to groin two times daily at 9:00am and 8:00pm. -There was documentation Nystatin 100,000 unit/gm Powder was not administered 9:00am on 01/04/24 denoted by circled initials and no reason as to why the medication was not administered. -There was documentation Nystatin 100,000 unit/gm Powder was not administered at 8:00pm from 01/01/24 through 01/07/24, and 01/19/24, 01/22/24 and 01/24/24 denoted by circled initials	D 367		

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with no reason given as to why the medication was not administered, and no documentation Nystatin 100,000 unit/gm Powder was administered at 8:00pm at 01/14/24 that was blank and no reason given as to why the medication was not administered.

Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Nystatin 100,000 unit/gm Powder, apply topically to groin two times daily at 9:00am and 8:00pm.
-There was documentation Nystatin 100,000 unit/gm Powder was not administered at 8:00pm on 02/04/24, 02/06/24 , 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Nystatin 100,000 unit/gm Power was administered at 8:00pm on 02/20/24, 02/23/24, 02/27/24, and 02/29/24 that was blank with no reason given as to why the medication was not administered.

Review of Resident #4's March 2024 MAR revealed:
-There was an entry for Nystatin 100,000 unit/gm Power, apply topically to groin two times a day at 9:00am and 8:00pm.
-There was no documentation Nystatin 100,000 unit/gm Power was applied to the groin at 8:00pm on 03/12/24 that was blank with no reason given as to why the medication was not administered.

j. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Hydralazine 25mg, 1 tablet three times daily at 9:00am, 2:00pm, and 8:00pm. (Hydralazine is a medication used to treat high blood pressure).

Review of Resident #4's January 2024 MAR

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D 367	Continued From page 78 revealed: -There was an entry for Hydralazine 25mg 1 tablet three times daily at 9:00am, 2:00pm, and 8:00pm, -There was documentation Hydralazine was not administered at 9:00am on 01/04/24 denoted by circled initials and no reason given as to why the medication was not administered. -There was documentation Hydralazine was not administered at 2:00pm from 01/01/24 through 01/07/24 denoted by circled initials and no reason given as to why the medication was not administered. -There was documentation Hydralazine was not administered at 8:00pm from 01/01/24 through 01/07/24, and 01/19/24, 01/22/24, and 01/24/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Hydralazine was administered at 8:00pm on 01/14/24, that was blank and no reason given as to why the mediation was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Hydralazine 25mg, 1 tablet three times a day at 9:00am, 2:00pm, and 8:00pm. -There was documentation Hydralazine 25mg, 1 tablet was not administered at 2:00pm on 02/28/24 that was blank and no reason given as to why the medication was not administered. -There was documentation Hydralazine 25mg, 1 tablet, 1 tablet was not administered at 8:00pm on 02/04/24, 02/06/24 , 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Hydralazine 25mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, 02/27/24, and 02/29/24, that	D 367		

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was blank with no reason given as to why the medication was not administered.

Review of Resident #4 March 2024 MAR revealed:
-There was an entry Hydralazine 25mg, tablet three times a day at 9:00am, 2:00pm, and 8:00pm.
-There was no documentation Hydralazine 25mg, 1 tablet was administered at 8:00pm on 03/12/24 and 03/13/24, that was blank and no reason was given as to why the medication was not administered.

k. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Atorvastatin 80mg, 1 tablet every evening at 8:00pm. (Atorvastatin is used to treat high cholesterol).

Review of Resident #4's January 2024 MAR revealed:
-There was an entry Atorvastatin 80mg, 1 tablet every evening at 8:00pm.
-There was documentation Atorvastatin 80mg, 1 tablet was not administered at 8:00pm on from 01/01/24 through 01/07/24, 01/19/24, and 01/22/24 denoted by circled initials with no reason given as to why the medication was not administered.

Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Atorvastatin 80mg, 1 tablet every evening at 8:00pm.
-There was documentation Atorvastatin 80mg, 1 tablet was not administered at 8:00pm on 02/04/24, 02/06/24, 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Atorvastatin

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80mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.

Review of Resident #4's March 2024 MAR revealed:
-There was an order for Atorvastatin 80mg, 1 tablet every evening at 8:00pm.
-There was no documentation Atorvastatin 80mg, 1 tablet was administered at 8:00pm on 03/11/24 and 03/12/24, that was blank and no reason given as to why the medication was not given.

I. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Donepezil 5mg, 1 tablet every evening at 8:00pm. (Donepezil is a medication used to treat Alzheimer's disease).

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Donepezil 5mg, 1 tablet every evening at 8:00pm.
-There was documentation Donepezil 5mg, 1 tablet was not administered at 8:00pm from 01/01/24 through 01/07/24, 01/19/24, and 01/22/24 denoted by circled initials with no reason given as to why the medication was not administered

Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Donepezil 5mg, 1 tablet every evening at 8:00pm.
-There was documentation Donepezil 5mg, 1 tablet every evening was administered at 8:00pm on 02/04/24, 02/06/24, 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Donepezil

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5mg, 1 tablet every evening was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.

Review of Resident #4's March 2024 MAR revealed:
-There was an entry for Donepezil 5mg, 1 tablet every evening at 8:00pm.
-There was no documentation Donepezil 5mg, 1 tablet was not administered at 8:00pm on 03/12/24, that was blank and no reason given as to why the medication was not administered.

m. Review of Resident #4's physician orders dated 01/01//24 revealed an order for Doxazosin 8mg, 1 tablet every evening at 8:00pm. (Doxazosin is used to treat high blood pressure and urinary retention).

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Doxazosin 8mg, 1 tablet every evening at 8:00pm.
-There was documentation Doxazosin 8mg, 1 tablet was not administered at 8:00pm on from 01/01/24 through 01/07/24, 01/19/24, and 01/22/24 denoted by circled initials with no reason given as to why the medication was not administered

Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Doxazosin 8mg, 1 tablet every evening at 8:00pm.
-There was documentation Doxazosin 8mg, 1 tablet was not administered at 8:00pm on 02/04/24, 02/06/24, 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not

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administered, and there was no documentation Doxazosin 8mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/2, that was blank and no reason given as to why the medication was not administered.

Review of Resident #4's March 2024 revealed:
-There was an entry for Doxazosin 8mg, 1 tablet every evening at 8:00pm.
-There was no documentation Doxazosin 8mg, 1 tablet was administered at 8:00pm on 03/12/24, that was blank and no reason given as to why the medication was not administered.

n. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Gabapentin 100mg, 1 capsule at bedtime at 8:00pm. (Gabapentin may be used to treat nerve pain).

Review of Resident #4's January 2024 MAR revealed:
-There was an entry for Gabapentin 100mg, 1 capsule at bedtime at 8:00pm.
-There was documentation Gabapentin 100mg, 1 capsule was not administered at 8:00pm on from 01/01/24 through 01/07/24, 01/19/24, and 01/22/24 denoted by circled initials with no reason given as to why the medication was not administered

Review of Resident #4's February 2024 MAR revealed:
-There was an entry for Gabapentin 100mg, 1 capsule at bedtime at 8:00pm.
-There was documentation Gabapentin 100mg, 1 capsule was not administered at 8:00pm on 02/04/24, 02/06/24, 02/07/24, 02/09/24, and 02/19/24 denoted by circled initials with no reason given as to why the medication was not administered, and no documentation Gabapentin

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D 367	Continued From page 83 100mg, 1 capsule was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Gabapentin 100mg, 1 capsule at bedtime at 8:00pm. -There was no documentation Gabapentin 100mg, 1 capsule was administered at 8:00pm on 03/12/24, that was blank and no reason given as to why the medication was not administered. o. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Baza Protect 1%-12% cream, apply to left hip and sacrum daily at 9:00am. (Baza Protect is a skin protectant used to treat and prevent skin irritation). Review of Resident #4's January 2024 MAR revealed: -There was an entry for Baza Protect 1%-12% cream, apply to left hip ad sacrum daily at 9:00am. -There was documentation Baza Protect 1%-12% cream was not administered at 9:00am on 01/04/24 denoted by circled initials and no reason given as to why the medication was not administered. p. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Eucerin Unscented cream, apply topically to back daily at 9:00am. (Eucerin is a topical cream used to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations). Review of Resident #4's January 2024 MAR	D 367		

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D 367	Continued From page 84 revealed: -There was an entry for Eucerin Unscented cream, apply topically to back daily at 9:00am. -There was documentation Eucerin Unscented cream was not administered at 9:00am on 01/04/24 denoted by circled initials and no reason given as to why the medication was not administered. Refer to interview with a medication aide (MA) on 03/21/24 at 11:00am. Refer to interview with the Memory Care Director (MCD) on 03/21/24 at 11:20am. Refer to interview with the Director of Resident Care (DRC) on 03/21/24 at 11:40am. Refer to telephone interview with the Administrator on 03/22/24 at 10:56am. _____ Interview with a MA on 03/21/24 at 11:00am revealed: -The process was for the MAs to document the medication was not administered by circling their initials and on the back of the MARs and give a reason the medication was not administered including the name of the medication, date, and time. -There should never be blanks or holes on the MARs. Interview with the MCD on 03/21/24 at 11:20am revealed: -The MAs should circle her initials and document on the back of the MARs the reason a medication was not administered. -The MARs should not be left blank. Interview with the DRC on 03/21/24 at 11:40am	D 367		

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D 367	Continued From page 85 revealed: -The procedure was for the MAs was to initial and circle their initials and document on the back of the MARs the reason the medication was not administered such as resident out of the facility, refused, awaiting medication from pharmacy. -If a medication was administered as needed, documentation should include the reason the medication was given and the effectiveness. -The facility would be changing to electronic MARs which should help with the accuracy of the MARs. Telephone interview with the Administrator on 03/22/24 at 10:56am revealed: -Documentation on the MARs should be accurate with the initials of the MA who administered the medication. -If the medication was not administered, the MA should circle her initials and document on the back of the MAR the reason the medication was not given. -The MARs should not be left blank.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure accurate reconciliation of a controlled substance for 1 of 7 residents (#8)	D 392		

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sampled with orders for a controlled substance used to treat severe pain and breathing difficulties at end of life, resulting in missing and unaccounted for dosages of the medication.

The findings are:

Review of Resident #8's closed record FL-2 dated 08/23/23 revealed diagnoses included dementia and hypertension.

Review of Resident #8's primary care provider (PCP) note dated 02/28/24 revealed:
-Today, 02/28/24, the resident's condition had deteriorated substantially.
-The resident had a respiratory rate of 60 breaths per minute and did not appear to be comfortable.
-After discussion with the resident's family, the resident was started on as needed (prn) Morphine for management of shortness of breath. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.)
-The resident was on oxygen via nasal cannula today as well.

Review of Resident #8's PCP order dated 02/28/24 revealed:
-There was an electronic prescription (e-script) for Morphine 10mg/0.5ml Oral Solution, take 0.5ml every 4 hours as needed for pain or shortness of breath.
-It was electronically signed on 02/28/24 at 7:17pm.
-There was documentation the order was sent via fax and email to the facility on 02/28/24 at 7:19pm.

Review of Resident #8's hospice verbal order dated 03/01/24 PCP order dated 03/01/24

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revealed an order for Morphine Sulfate 100mg/5ml give 0.5ml every 4 hours scheduled.

Review of Resident #8's hospice order dated 03/03/24 revealed:
-The resident was actively dying, continue comfort medications.
-Give scheduled Morphine if the resident was awake or asleep.
-A second note again indicated "administer Morphine if pt (patient) awake or asleep".

Review of a second hospice order on 03/03/24 for Resident #8 revealed:
-The resident was actively dying, having respiratory distress.
-The resident was comfortable but uncomfortable with respiratory changes when moved/repositioned.
-There was an order to increase scheduled Morphine form every 4 hours to every 2 hours for severe pain or respiratory distress, do not hold, administer if the resident awake or asleep.

Review of Resident #8's February 2024 medication administration record (MAR) revealed:
-There was a handwritten entry for Morphine Sulfate 0.5ml every 4 hours for severe pain or shortness of breath.
-There was no Morphine documented as administered in February 2024.
-There were no other orders for Morphine transcribed onto the February 2024 MAR.

Review of Resident #8's March 2024 MAR revealed:
-There was a handwritten entry for Morphine Sulfate 100mg/5ml take 0.5ml every 4 hours as needed for pain or shortness of breath.
-There was no prn Morphine documented as

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administered for this entry.
-There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am.
-There was a handwritten note underneath the entry dated 03/03/24 with an asterisk and instructions to administer if awake or asleep.
-Morphine was documented as not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am due to the resident asleep/no distress.
-Staff initials were circled on 03/01/24 at 8:00am and 8:00pm with no reason for not administering the medication.
-There was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, and 6:00am.
-The first documented dose was administered at 10:00pm on 03/03/24.
-A second dose was documented as administered at 12:00am on 03/04/24.
-There were no other doses documented as administered in March 2024.
-There was a handwritten note that the resident expired on 03/04/24 at 12:37am.

Review of Resident #8's incident report dated 03/04/24 at 12:20am revealed hospice came to assess the resident and the resident had expired.

Review of Resident #8's controlled substance (CS) log for Morphine revealed:
-There was only one CS log for Morphine with 30 prefilled syringes received on 02/29/24.
-There was a dispense date of 02/29/24 and there was a direction change sticker placed over

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the instructions on the prescription label at the top of the CS log.
-There were no doses of Morphine documented as administered in February 2024.
-The first dose documented as administered was 03/01/24 at 12:00pm.
-The last dose was documented as administered on 03/04/24 at 12:00am.
-There were 12 of 30 prefilled syringes of Morphine documented as administered, leaving a balance of 18 prefilled syringes.

Review of Resident #8's pharmacy dispensing records from 07/01/23 - 03/20/24 revealed:
-The pharmacy dispensed 30 prefilled syringes (15mls) of Morphine Sulfate 100mg/5ml on 02/29/24.
-The date the order was written was 02/28/24.
-The instructions were to take 0.5ml (10mg) every 4 hours as needed for pain or shortness of breath.

Review of Resident #8's pharmacy returns/discards audit report dated 07/01/23 - 03/21/24 revealed there was no documentation of any Morphine prefilled syringes being returned to the pharmacy.

Review of Resident #8's Controlled Substance Prescription Returned to Pharmacy form documented by facility staff and dated 03/04/24 revealed:
-There was an entry for Morphine 100mg/5ml with a quantity returned documented as 18.
-The reason code documented for return was the resident expired.
-The form was signed by a MA.
-The section for pharmacy signature was blank.
-There was a fax stamped transmission log date of 03/04/24 at 9:55am.

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D 392	Continued From page 90 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/21/24 at 5:00pm revealed: -They received an order for Resident #8's Morphine on 02/28/24 after 7:00pm. -The order was processed the next day, 02/29/24, because there was no one at the pharmacy after 7:00pm to process orders. -Resident #8's Morphine was dispensed on 02/29/24 with 15ml dispensed in 30 prefilled syringes of 0.5ml each. -The 30 prefilled syringes of Morphine were delivered to the facility on 02/29/24 at 4:08pm. -She did not see a return process in the pharmacy computer system for the resident's Morphine. -The pharmacist who processed returns was not at the pharmacy today, 03/21/24. Telephone interview with the Administrator on 03/22/24 at 10:57am revealed: -She thought Resident #8's Morphine Sulfate had been returned to the facility's contracted pharmacy after the resident passed. -She just emailed someone at the facility's contracted pharmacy about Resident #8's Morphine and attached a copy of the controlled substance return sheet. -She had not received a response from the pharmacy yet. Telephone interview with the General Manager at the facility's contracted pharmacy on 03/22/24 at 12:41pm revealed: -The Morphine Sulfate returned from the facility for Resident #8 was received "likely" within the last seven days and did not get processed and keyed into the pharmacy system by the pharmacy technician until 03/22/24.	D 392		

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D 392	Continued From page 91 -The pharmacy technician keyed in receiving seven milliliters (mls) of morphine sulfate for a total of 14 prefilled syringes. Telephone interview with the Operational Servicing Department Pharmacist at the facility's contracted pharmacy on 03/22/24 1:13pm revealed: -He was able to review the electronic database regarding the Morphine Sulfate dispensed for Resident #8. -On 02/29/24, Morphine Sulfate was dispensed to the facility, a quantity of 15mls for a total of 30 prefilled syringes of 0.5ml each. Second telephone interview with the General Manager at the facility's contracted pharmacy on 03/22/24 at 2:50pm revealed: -The pharmacy had only located a return of 14 prefilled syringes of Morphine Sulfate 0.5ml for Resident #8 with a return date of 03/05/24. -The accompanying controlled substance return sheet indicated there was supposed to be 18 syringes of Morphine Sulfate which would have been 9mls of Morphine Sulfate. -The pharmacy had gone through the medication return box and there were no loose prefilled syringes of Morphine Sulfate found in the box. -She was not able to read the last name of the person signing as preparing the return medication sheet but could read the first name. Telephone interview with the Administrator on 03/22/24 at 2:58pm revealed: -She provided the name for the MA that completed the form for the return of Morphine Sulfate for Resident #8. -She just found out on 03/22/24 there was a discrepancy in the count documented as returned to the pharmacy for the Morphine Sulfate for	D 392		

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D 392	Continued From page 92 Resident #8. -She was told by the MA that she remembered writing up the return medication form and there were 18 prefilled syringes of Morphine Sulfate returned to the pharmacy on 03/04/24. -The last dose of Morphine Sulfate administered was administered at 12:00am on 03/04/24 with a remaining count of 18 Morphine Sulfate prefilled syringes. Telephone interview with the MA on 03/22/24 at 3:30pm revealed: -When she prepared controlled medications for return to the pharmacy, she completed the medication return form, counted every medication, and placed the controlled medications and medication count sheet in a numbered, sealed plastic bag. -She placed the controlled medications in the locked area of the medication cart. -She informed the MA that relieved her that the controlled medications were in the narcotic section of the medication cart for pharmacy pickup.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 399		

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facility failed to ensure a suspected drug diversion of 30 tablets of a controlled substance used to treat anxiety and agitation by Staff A was reported to the facility's contracted pharmacy in November 2023.

The findings are:

Review of a 24-hour Health Care Personnel Registry (HCPR) Initial Allegation Report for Staff A revealed:
-The accused employee was Staff A, a medication aide (MA).
-Staff A's date of hire was documented as 06/19/23.
-The allegation was diversion of resident drugs.
-The date of the incident was documented as 11/03/23.
-The date at time the facility became aware of the incident was documented as 11/03/23 at 12:45pm.
-The allegation details included a resident's medication, Xanax (a controlled substance used to treat anxiety) prescription was showing delivered on 10/10/23.
-The Xanax and the controlled substance (CS) log for the medication was missing from the facility.
-The local county Adult Home Specialist (AHS) contacted the Administrator and notified her that it was reported to the AHS on 11/03/23 that the facility was missing controlled substances, and it was stolen by an employee at the facility.
-Physical or Mental injury/harm was documented as none noted at this time.
-It was documented there was reasonable suspicion of a crime and the incident was reported to the local police department on 11/03/23 at 3:22pm.
-There was no documentation the suspected drug

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diversion was reported to the facility's contracted pharmacy.
-The report was signed by the Administrator and dated 11/03/23.

Review of a 5-day HCPR Investigation Report for Staff A revealed:
-The accused employee was Staff A, a MA.
-The allegation was diversion of resident drugs.
-The date of the incident was documented as 11/03/23.
-There were no witnesses documented.
-The attached summary included 3 paragraphs of an investigation summary.
-On 10/10/23, a resident's Xanax was ordered from the facility pharmacy and delivered to the facility at 12:02am on 10/11/23.
-The Xanax was signed in by a third shift MA and another third shift MA assisted on signing in the medications and putting them up.
-The resident's order was to take Xanax every night at 8:00pm.
-When the medication arrived on 10/11/23, the resident still had 7 pills remaining in the current package.
-The 7 remaining pills were given as ordered.
-On 10/18/23, there was no Xanax in the medication cart for the resident.
-The Administrator was notified on 11/03/23 upon her return from leave that the 30 Xanax pills that were delivered on 10/11/23 were missing and they were stolen by Staff A.
-The Administrator immediately began an investigation.
-After interviews, record review, and observation, the allegation was unsubstantiated.
-The medication was confirmed delivered and the medication was not found.
-No witnesses of Staff A stealing the medication was documented and Staff A did not work when

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the medication was delivered.
-Staff A did not work until 3 days after the medication was delivered and she did not recall seeing the medication on the cart.
-All MAs were interviewed and the Director of Resident Care (DRC) would be completing a training on Narcotic Count Guidelines for all MAs.
-For investigative actions, the allegation was not substantiated and the accused employee was not terminated.
-The incident was reported to the local county Department of Social Services (DSS) on 11/03/23 and to local law enforcement on 11/03/23.
-There was no documentation the suspected drug diversion was reported to the facility's contracted pharmacy.
-The report was signed by the Administrator and dated 11/13/23.

Telephone interview with the DRC on 03/22/24 at 10:57am revealed:
-She or the Administrator were responsible for notifying the facility's contracted pharmacy provider about an allegation of drug diversion at the facility.
-She called the facility's contracted pharmacy during the alleged drug diversion investigation and spoke with someone at the pharmacy to find out when the Xanax was delivered to the facility.
-She did not recall who she spoke with or the date and time she called.
-She was not sure if she documented the contact with the facility's contracted pharmacy.
-She could not locate any documentation of contact with the pharmacy.
-She was not sure if she told anyone at the facility's contracted pharmacy about the allegation of suspected drug diversion.

Telephone interview with the Administrator on

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D 399	Continued From page 96 03/22/24 at 10:57am revealed: -Either she or the DRC were responsible for reporting suspected drug diversions to the facility's contracted pharmacy. -She had not been able to locate any documentation by facility staff for notification of the allegation of suspected drug diversion to the facility's contracted pharmacy. -She knew the DRC had been talking with the facility's contracted pharmacy about the suspected drug diversion of 30 Xanax tablets in November 2023. -She did not notify the facility's contracted pharmacy of the allegation of suspected drug diversion at the facility in November 2023 because she assumed the DRC reported it to the pharmacy. -She contacted the facility's contracted pharmacy on 03/22/24 and was waiting on a reply from them regarding receipt of notification of the drug diversion allegation. -When she contacted the facility's contracted pharmacy, she was provided the date of delivery for the Xanax and she notified the pharmacy the medication had not been located anywhere at the facility. Telephone interview with the General Manager at the facility's contracted pharmacy on 03/22/24 at 12:41pm revealed: -She was the pharmacist at the facility's contracted pharmacy at the time of 11/03/23. -She had not received any report of an allegation of drug diversion at the facility. -The facility could have notified the Operational Servicing Department about the alleged drug diversion. Telephone interview with the Operational Servicing Department Pharmacist at the facility's	D 399		

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D 399	Continued From page 97 contracted pharmacy on 03/22/24 1:13pm revealed he did not have any records of notification of suspected drug diversion at the facility.	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure residents were protected from harm while a Health Care Personnel Registry (HCPR) investigation was in progress for 1 of 1 staff (Staff A), a medication aide who allegedly diverted a controlled substance was not suspended but continued to administer medications, including controlled substances at the facility, while the facility was also aware Staff A had criminal drug charges pending. The findings are: Review of a 24-hour Health Care Personnel Registry (HCPR) Initial Allegation Report for Staff A revealed: -The accused employee was Staff A, a medication aide (MA). -Staff A's date of hire was documented as 06/19/23. -The allegation was diversion of resident drugs. -The date of the incident was documented as	D 438		

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11/03/23.
-The date at time the facility became aware of the incident was documented as 11/03/23 at 12:45pm.
-The allegation details included a resident's medication, Xanax (a controlled substance used to treat anxiety) prescription was showing delivered on 10/10/23.
-The Xanax and the controlled substance (CS) log for the medication was missing from the facility.
-The local county Adult Home Specialist (AHS) contacted the Administrator and notified her that it was reported to the AHS on 11/03/23 that the facility was missing controlled substances, and it was stolen by an employee at the facility.
-Physical or Mental injury/harm was documented as none noted at this time.
-It was documented there was reasonable suspicion of a crime and the incident was reported to the local police department on 11/03/23 at 3:22pm.
-The report was signed by the Administrator and dated 11/03/23.

Review of the facility's fax confirmation sheet revealed the 24-hour report was faxed to the HCPR on 11/03/23 at 4:32pm.

Review of a 5-day HCPR Investigation Report for Staff A revealed:
-The accused employee was Staff A, a MA.
-The allegation was diversion of resident drugs.
-The date of the incident was documented as 11/03/23.
-It was documented the incident did not result in physical harm or injury or mental anguish.
-There were no witnesses documented.
-The attached summary included 3 paragraphs of an investigation summary.

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D 438	Continued From page 99 -On 10/10/23, a resident's Xanax was ordered from the facility pharmacy and delivered to the facility at 12:02am on 10/11/23. -The Xanax was signed in by a third shift MA and another third shift MA assisted on signing in the medications and putting them up. -The resident's order was to take Xanax every night at 8:00pm. -When the medication arrived on 10/11/23, the resident still had 7 pills remaining in the current package. -The 7 remaining pills were given as ordered. -On 10/18/23, there was no Xanax in the medication cart for the resident. -The Administrator was notified on 11/03/23 upon her return from leave that the 30 Xanax pills that were delivered on 10/11/23 were missing and they were stolen by Staff A. -The Administrator immediately began an investigation. -After interviews, record review, and observation, the allegation was unsubstantiated. -The medication was confirmed delivered and the medication was not found. -No witnesses of Staff A stealing the medication were documented and Staff A did not work when the medication was delivered. -Staff A did not work until 3 days after the medication was delivered and she did not recall seeing the medication on the cart. -All MAs were interviewed and the Director of Resident Services (DRC) would be completing a training on Narcotic Count Guidelines for all MAs. -For investigative actions, the allegation was not substantiated and the accused employee was not terminated. -The incident was reported to the local county Department of Social Services (DSS) on 11/03/23 and to local law enforcement on 11/03/23. -The accused was not charged with any crime	D 438		

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related to the facility allegation.
-The report was signed by the Administrator and dated 11/13/23.

Review of the facility's fax confirmation sheet revealed the 5-day investigation report was faxed to the HCPR on 11/13/23 at 12:28pm.

Review of a letter from the NC HCPR Investigations dated 11/29/23 revealed:
-The incident referenced was Staff A allegedly misappropriated a resident's property on or about 11/03/23.
-After carefully reviewing the reported allegation, the Department had determined that an investigation would not be conducted in this case.

Review of the residents' CS logs revealed:
-Staff A documented administration of medications, including controlled substances, during the investigation (conducted from 11/03/23 - 11/13/23) into allegations of drug diversion by Staff A.
-Staff A documented administration of controlled substances to residents on 11/06/23, 11/08/23, 11/09/23, and 11/10/23.

Telephone interview with the Administrator on 03/22/24 at 10:57am revealed:
-She was not sure if the facility had a policy on suspending named employees with allegations reported to the HCPR.
-She did not know if there was anything specifically written to address suspensions, she just did what the corporation's Human Resources (HR) staff told her to do.
-She thought the facility's policy was to suspend named staff during an investigation if needed but it was more toward the end of the investigation.
-When she sent a 24-hour report to HCPR, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098030	A. BUILDING: _____ B. WING _____	R-C 03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD VILLAGE	1730 PARKWOOD BLVD WILSON, NC 27895

(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 438	Continued From page 101 started on the investigation and worked with HR staff to determine whether the employee continued to work or was suspended during the investigation. -An employee would be suspended if there was an arrest or if abuse was involved. -When asked if an employee would be suspended for an allegation of drug diversion, she stated there was not a list of reasons to suspend an employee and she just worked with HR staff. -The facility would not let a staff person continue to work if a resident was at risk for harm; if someone was abusing a resident they would want to remove that staff from the facility. -If staff were diverting drugs, they would be suspended and they would immediately look at all of the medications. -The facility would pull that MA from administering medications and that MA would not administer medications from the beginning of the investigation until the end of the investigation. -But the MA could still work in the facility unless HR staff told her otherwise. -Staff A was not suspended on 11/03/24. -Staff A was suspended on 11/10/23 because during the investigation some of the staff interviewed were saying it was Staff A but it was all hearsay; there were no witnesses. -Their main prompt to suspend Staff A was because she got arrested for drug charges but she could not recall the date. -Staff A called the DRC and reported that she had gotten arrested for drug charges (not related to the allegation of drug diversion at the facility) but she could not recall the date. -She did not have an explanation as to why Staff A continued to administer medications, including controlled substances during the HCPR investigation from 11/03/23 - 11/13/23.	D 438		

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D 438	Continued From page 102 -Staff A should not have administered medications during the investigation. -She was concerned Staff A administered medications during the investigation because they did not know if she had taken the Xanax or not. Telephone interview with the DRC on 03/22/24 at 10:57am revealed: -She thought Staff A was suspended during the investigation. -She remembered telling Staff A they had received allegations against her and they would have to do an investigation and Staff A would have to stay home during the investigation. -Staff A was still on the employee roster and receiving benefits. -She did not document the conversation and she did not recall her exact words to Staff A. -The facility had a suspension form and there should be one in Staff A's personnel record if she was suspended. -She had no explanation for Staff A administering medications, including controlled substances during the HCPR investigation. Review of Staff A's personnel record on 03/21/24 revealed there was no suspension of employment form in her record. Interview with Staff A, medication aide, on 03/21/24 at 7:13pm revealed: -She last worked at the facility on 11/19/23 prior to her returning to work 01/25/24. -She took a leave from work due to a personal issue. -She requested the leave. -She had never been suspended. -She had not done anything to get suspended. The facility failed to ensure every effort was made	D 438		

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D 438	Continued From page 103 to protect residents from harm while the facility conducted a Health Care Personnel Registry (HCPR) investigation for an allegation of drug diversion by Staff A. The Director of Resident Care (DRC) was notified by Staff A during the HCPR investigation that she had been arrested and charged with drug charges (unrelated to the alleged diversion at the facility). The Administrator was aware of the drug charges while she was conducting the 5-day HCPR investigation for the allegation of Staff A diverting a resident's controlled substance at the facility. Staff A continued to administer medications, including controlled substances, to residents at the facility on 4 days during the investigation. This failure of the facility 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 03/22/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 6, 2024.	D 438		